# Teviot Valley Rest Home Limited

## Current Status: 7 February 2014

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

## General overview

Teviot Valley rest home provides rest home care for up to 14 residents. On the day of the audit, occupancy was nine residents. There is a quality and risk management system in place. The manager is a registered nurse with management experience and has been with the service since the opening of the home. She is supported by a board of trustees and another registered nurse. This audit has identified improvements are required in relation to: incident accident reporting documentation, training for staff in abuse and neglect, fridge and freezer temperatures are routinely monitored and recorded, development of care plans within specified timeframes, medications administration and documentation of controlled medication.

## Audit Summary as at 7 February 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 7 February 2014

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

### Organisational Management as at 7 February 2014

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

### Continuum of Service Delivery as at 7 February 2014

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

### Safe and Appropriate Environment as at 7 February 2014

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

### Restraint Minimisation and Safe Practice as at 7 February 2014

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

### Infection Prevention and Control as at 7 February 2014

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

## Audit Results as at 7 February 2014

### Consumer Rights

Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights and relevant legislation. Information is made available to residents/family on the services provided and on the Code of Rights for residents at the time of admission. Information on the nationwide advocacy service is available. Policies for culturally safe services are in place and identify the importance of whanau for Maori. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Discussions with families identified that they are fully informed of changes in their family members health status. Complaints and concerns are logged in a complaints register. Improvements are required in relation to incident accident reporting documentation and training of staff in abuse and neglect.

### Organisational Management

The service has a quality and risk management plan. The service has in place a range of policies and procedures to support service delivery that are reviewed every two years. This includes: incidents/accidents; hazards; internal audits; infections; complaints and concerns; and resident/family satisfaction surveys. Corrective actions are implemented, documented and followed through to compliance. There is a documented business plan with a quality and risk plan 2013/2014. There are implemented health and safety policies that include hazard identification. The service has a documented skill mix policy for determining staffing levels and skill mixes for safe service delivery. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. The annual training plan covers a wide range of subjects and exceeds eight hours annually. All staff attend training regularly. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident records are integrated and support the effective provision of care services. Files and relevant care and support information for residents can be referenced and retrieved in a timely manner.

### Continuum of Service Delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurses who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required whereby all care plans are developed within specified timeframes. The medication management system includes policy and procedures that follows recognised standards. Staff responsible for medication administration are trained and monitored however, improvement is required in relation to staff following correct procedures for administration of medications and recording of controlled drug medications. Resident medications are reviewed by the residents’ general practitioner at least three monthly. A range of activities are available and residents provide feedback on the programme. Teviot Valley rest home has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Improvements are required whereby fridge and freezer temperatures are routinely monitored and recorded.

### Safe and Appropriate Environment

Teviot Valley rest home has a current building certificate that expires on 28 June 2014. Maintenance is carried out. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There is a lounge and dining area, and small seating areas throughout facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. There is a designated laundry, which includes secure storage of cleaning and laundry chemicals. Hot water temperatures are monitored and recorded. The service has implemented policies and procedures for civil defence and other emergencies. All staff have a current first aid certificate. There is an evacuation scheme approved by the New Zealand Fire Service. Six monthly trial evacuations occur. Emergency lighting, gas heating, and BBQ are available in the event of a power failure. A generator supplies power in the event of an emergency. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

### Restraint Minimisation and Safe Practice

There is a restraint policy is applicable to the service. There are currently no residents that require restraint or enablers. There is a restraint risk assessment tool available. The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whanau is also identified. Restraint minimisation and de-escalation of challenging behaviour is included in the in-service education programme and was last delivered in June 2013.

### Infection Prevention and Control

There is an Infection Control Programme which was reviewed in January 2014. The service has effective surveillance activities, subsequent actions and implementation of strategies for prevention and minimisation of infection. These are well documented, with graphs and data communicated to all staff. Infection Control is included in the in-service programme and was last completed April and September 2013.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Teviot Valley Rest Home Limited |
| **Certificate name:** | Teviot Valley Rest Home Limited |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Teviot Valley Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 7 February 2014 | **End date:** | 7 February 2014 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 9 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX | **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** | XXXXX |  |  | **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 | 6 | Number of staff interviewed | 4 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 9 | Total number of staff (headcount) | 12 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed |  |

## **Declaration**

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

I confirm that:

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

Dated Monday, 10 March 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Teviot Valley rest home provides rest home care for up to 14 residents. On the day of the audit, occupancy was nine residents. There is a quality and risk management system in place. The manager is a registered nurse with management experience and has been with the service since the opening of the home. She is supported by a board of trustees and another registered nurse. This audit has identified improvements are required in relation to: incident accident reporting documentation, training for staff in abuse and neglect, fridge and freezer temperatures are routinely monitored and recorded, development of care plans within specified timeframes, medications administration and documentation of controlled medication. |

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| **Outcome 1.1: Consumer Rights** |
| Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights and relevant legislation. Information is made available to residents/family on the services provided and on the Code of Rights for residents at the time of admission. Information on the nationwide advocacy service is available. Policies for culturally safe services are in place and identify the importance of whanau for Maori. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Discussions with families identified that they are fully informed of changes in their family members health status. Complaints and concerns are logged in a complaints register. Improvements are required in relation to incident accident reporting documentation and training of staff in abuse and neglect. |

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| **Outcome 1.2: Organisational Management** |
| The service has a quality and risk management plan. The service has in place a range of policies and procedures to support service delivery that are reviewed every two years. This includes: incidents/accidents; hazards; internal audits; infections; complaints and concerns; and resident/family satisfaction surveys. Corrective actions are implemented, documented and followed through to compliance. There is a documented business plan with a quality and risk plan 2013/2014. There are implemented health and safety policies that include hazard identification. The service has a documented skill mix policy for determining staffing levels and skill mixes for safe service delivery. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. The annual training plan covers a wide range of subjects and exceeds eight hours annually. All staff attend training regularly. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident records are integrated and support the effective provision of care services. Files and relevant care and support information for residents can be referenced and retrieved in a timely manner. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurses who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required whereby all care plans are developed within specified timeframes. The medication management system includes policy and procedures that follows recognised standards. Staff responsible for medication administration are trained and monitored however, improvement is required in relation to staff following correct procedures for administration of medications and recording of controlled drug medications. Resident medications are reviewed by the residents’ general practitioner at least three monthly. A range of activities are available and residents provide feedback on the programme. Teviot Valley rest home has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Improvements are required whereby fridge and freezer temperatures are routinely monitored and recorded. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Teviot Valley rest home has a current building certificate that expires on 28 June 2014. Maintenance is carried out. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There is a lounge and dining area, and small seating areas throughout facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. There is a designated laundry, which includes secure storage of cleaning and laundry chemicals. Hot water temperatures are monitored and recorded. The service has implemented policies and procedures for civil defence and other emergencies. All staff have a current first aid certificate. There is an evacuation scheme approved by the New Zealand Fire Service. Six monthly trial evacuations occur. Emergency lighting, gas heating, and BBQ are available in the event of a power failure. A generator supplies power in the event of an emergency. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a restraint policy is applicable to the service. There are currently no residents that require restraint or enablers. There is a restraint risk assessment tool available. The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whanau is also identified. Restraint minimisation and de-escalation of challenging behaviour is included in the in-service education programme and was last delivered in June 2013. |

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| **Outcome 3: Infection Prevention and Control** |
| There is an Infection Control Programme which was reviewed in January 2014. The service has effective surveillance activities, subsequent actions and implementation of strategies for prevention and minimisation of infection. These are well documented, with graphs and data communicated to all staff. Infection Control is included in the in-service programme and was last completed April and September 2013. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 40 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 88 | 0 | 4 | 1 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect | Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.3.1 | The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times. | PA Low | Training was last provided in 2011 and has been scheduled for February 2014 | Provide training for all staff in relation to abuse and neglect two yearly | 180 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Medication error in October 2013 where two doses of panadol was found in resident room. Reported in progress notes for increased supervision, however it was not reported via the incident process. | Ensure that all adverse events are documented to identify and manage risk. | 60 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Two of five files reviewed evidenced that the long term care plan has been developed outside the three week timeframe. | Ensure all residents have a long term care plan developed within three weeks of admission as per contractual requirements. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Advised, and observed at lunch time medication round, that staff remove all the medications from the blister packs and place on individual small containers on the bench in front of the corresponding resident named label. Medications are then taken and administered to each resident in turn; b) medication fridge temperature not monitored or recorded; and c) one controlled drug not entered in controlled drug register and not checked weekly. | Ensure all staff follow correct administration procedures to ensure the safe administration of medications to residents – check each individual medication chart, identify the resident, remove medications from blister pack, give to the resident, observe ingestion and then sign that medications have been given. b) Monitor and record medication fridge temperatures; and c) record all controlled drugs in the controlled drug register and conduct weekly checks. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | There is a thermometer on the outside of the walk-in chiller which staff check daily, however, temperatures have not been recorded for the chiller since September 2013 and the large chest freezer temperatures has not been monitored or recorded since September 2013. | Ensure the chiller and freezer temperatures are monitored and recorded as per service policy. | 60 |

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Code of Rights is clearly visible in the foyer of the facility. Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights (the code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Two caregivers were interviewed and were able to describe how the code is implemented in their everyday delivery of care. Training was provided to staff November 2012. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents rights information is available, and a poster is framed on the wall. The code of rights and advocacy pamphlets are located at the main foyer.  On admission the nurse manager discusses the information pack with the resident and the family/whanau. This includes the Code of Rights, complaints and advocacy. Residents (six) stated they were well informed about the CoR and the service provides an open-door policy for concerns/complaints. D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Discussions with six residents and three family members identified that personal belongings are not used as communal property. During the visit, staff demonstrated gaining permission prior to entering resident private areas. Interviews with residents and family members stated that caregivers always respected their privacy.  The initial and on-going assessment includes gaining details of people’s beliefs and values. Residents are addressed by their preferred name. Discussions with residents and review of care plans identified that residents are encouraged and supported to continue with their spiritual activities. Church services are provided twice a month (one service on a Sunday and another service is held during the week) at Teviot Valley rest home. Guidelines are available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality in an appropriate and discreet manner. Care plan includes support for sexuality and intimacy. Residents are supported to stay involved in the community.  There is a policy on abuse and neglect. Training was last provided in 2011 and has been scheduled for February 2014. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a policy on abuse and neglect. Interviews with manager and two caregivers, six residents, three families and review of incident forms confirm that there has been no episodes of abuse of neglect at Teviot. Training has not been provided in the past two years. |
| **Finding:** |
| Training was last provided in 2011 and has been scheduled for February 2014 |
| **Corrective Action:** |
| Provide training for all staff in relation to abuse and neglect two yearly |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are current guidelines for the provision of culturally safe care for Māori residents. There are no residents currently that identify as Māori. District Nurse belongs to Ngai Tahu and works from the same building and is able to offer advice and support if required. The service has linkages with Uru Whenua Health for support, advice and staff education. The service uses the “flip chart” produced by Southern District Health Board for quick reference and guidance. Cultural awareness training occurred as part of the annual in-service training programme, last provided August 2013. Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Teviot Valley's "a home from home" philosophy and approach flows through into each person’s care plan and this could be described by staff. Initial and on-going assessment includes gaining details of people’s beliefs and values. Each resident has their social history noted in their file, and where possible their interests and important links to the community are maintained.  Families are actively encouraged to be involved in their relative's care in whatever way they want to e.g. assisting with meals, taking them to appointments/outings etc. They are able to visit at any time of the day and are actively encouraged to participate in the resident reviews. Interventions to support these are identified and evaluated. Resident assessments focus on wellness.  Staff interviewed described the focus is on promoting their independence. There are cultural safety & awareness/spirituality policies and procedures. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies and procedures to ensure residents are free from discrimination, coercion, harassment, sexual, financial or other exploitation. Interviews with staff and management reinforced their knowledge of professional boundaries. The orientation programme is comprehensive and includes roles and responsibilities and professional boundaries. In-service training on abuse and neglect is scheduled for February 2014. There are policies and procedures in place that include (but not limited to); a) abuse and neglect, b) code of rights, c) complaints. Human resource policies include (but not limited to); a) police checks, b) house rules, c) code of conduct and d) professional boundaries. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The service has a 2014 audit schedule. Interviews with six residents and three families all spoke very positively about the care provided. There are clear ethical and professional standards and boundaries within job descriptions. D1.3: All approved service standards are adhered to. D17.7c: There are implemented competencies for staff. There are clear ethical and professional standards and boundaries within job descriptions. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms are single and there are other areas available around the facility to allow for meetings in private. The information pack is available in large print and advised that this can be read to residents.   D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry D16.1b.i: i The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b: Interviews with three relatives all stated that they are always informed when their family members health status changes, doctors’ visits and any concerns. These conversations are documented on the family contact page in resident files.  Incident Accident policy, alerts staff to the responsibility to notify family/NOK of any accident/incident that occurs. Incident forms have a section to indicate if family/whanau have been informed of an incident/accident. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Teviot Valley rest home has policies and procedures relating to informed consent and advanced directives. A review of five files identified that informed consent is collected for photos, health information and outings as part of the admission process and agreement. Resident’s sign an informed consent form that covers transportation, photographs and medical care when they enter the service. There is a resuscitation form and process. Five files reviewed had advanced directive forms appropriately completed and signed by resident. There were five admission agreements sighted which were signed by the resident and a service representative. Discussion with three family identified that the service actively involves them in decisions that affect their relatives’ lives. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Client right to access advocacy and services is identified for residents - leaflets are available in the service reception area. The information identifies who the resident can contact to access advocacy services.  The information pack provided to residents prior to entry includes advocacy information.  Staff were very aware of the right for advocacy and how to access and provide advocate information to residents if needed. Six residents and three family members that were interviewed were aware of their access to advocacy services. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Family members and residents confirm that visiting can occur at any reasonable time.  D3.1h Discussion with three family that they are encouraged to be involved with the service and care D3.1.e Discussion with four staff (manager, activities co ordinator, and two care givers) and three relatives that they are supported and encouraged to remain involved in the community and external groups such as school or kindergarten children visit. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a complaints, and feedback policy in place. There are complaint forms available at entrance way and in information pack. The complaints policy includes procedure and staff responsibility and aligns with right 10 of the code.  The service has had a Health and Disability Complaint raised against them in March 2011. The service has maintained all documentation in regard to this complaint and their follow-up action. The Health and Disability Commissioner in February 2012, found that the service had made the necessary improvements in relation to the management of falls and restraint. This audit has reviewed falls management (link # 1.3.6) and the service currently has no resident requiring restraint or enabler ( link # 2.1).  D13.3h. Complaints information is provided at entry to the service and is readily available to residents in the service. Six residents and three family members interviewed could all describe being aware of the complaints procedure. There is a complaints register with follow up documentation included. There have been no complaints in 2013 D13.3h. complaints information is provided at entry to the service and is readily available to residents in the service. Six residents and three family members interviewed could all describe being aware of the complaints procedure. There is a complaints register with follow up documentation included. |

##### **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 service has in place an experienced and qualified nurse manager who is a registered nurse. The manager has both nursing and management experience and qualifications and has been with the service since the opening of the home. There is a Nurse Manager job description. She also is PRIME trained (Primary Response in Medical Emergency) and also undertakes on-call duties with the attached medical centre. She is supported by a Board of Trustees and another registered nurse that works 16 hours a fortnight.  The service has a business plan which is reviewed annually- completed in January 2014 and included certification, staff employment, building maintenance, staff education, internal/external non-clinical emergencies, Hazard ID, infection control, review of services, incident/accident reporting, pandemic outbreak plan, and access from car park. The service has a documented quality and risk management system that reflects the organisation's values, mission and philosophy. The quality and risk management plan provides goals for measurement of achievement against key areas of the business.  There is an internal audit plan. Audits include a general summary, any issues arising and corrective actions when required. These are followed through in staff meetings. Resident surveys are completed annually. Actions are identified and followed through as required. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. ARC, D17.3di The nurse manager and registered nurse have maintained at least eight hours annually of professional development. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the absence of the manager, the registered nurse accepts this responsibility. The service has well developed policies and procedures at a service level and organisation plan is structured to provide appropriate safe quality care to people who use the service. There are relevant care and support policies, including relevant clinical procedures for the management of rest home care. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has an established quality and risk system that includes analysis of incidents, infections and complaints, internal audits and feedback from the residents. The service has policies and procedures and associated systems to provide a level of service that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.  Teviot Valley monitors progress with the quality and risk management plan through monthly staff meetings. There is an internal audit schedule and internal audits are completed. Teviot Valley has monthly staff meetings. All staff attends regularly. The staff meeting includes internal audits, resident surveys, incident and accident analysis, infection control analysis and restraints/enablers (if there are any). Minutes are maintained and are available to staff in a folder. There is documented management around non-compliance issues identified. Finding statements and corrective actions have been actioned, completed and reported to the appropriate staff via meeting minutes, communication books and at handovers.  There are implemented health and safety policies that include hazard identification. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. The service has extra supplies of food, water and equipment available in the event of a disaster. (link 1.4.7) There is an infection control manual, infection control programme and corresponding policies, which require inclusion of antibiotic resistant infections (link #3.3). There is a restraint minimisation management policy. The service is restraint free. (link # 2.2) There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the nurse manager who completes the follow up, collates and analyses data to identify trends. Results are discussed with staff through the monthly staff meeting.  All residents and families are surveyed each year (April 2013) as evidenced on review of survey forms and evaluations. Survey questions include meals, activities, medical and nursing care, privacy and care staff.  D5.4 The service has the following policies/ procedures to support service delivery; Policies and procedures align with the resident care plans 1) Continence Policy. Continence assessments were evident in resident files. Continence in service was provided to staff February 2013. 2) Challenging behaviour policy. A Challenging behaviour assessment and management plan are utilised for resident who display challenging behaviours. These include patterns of behaviour, triggers for behaviour and effects of behaviour documentation. Managing challenging behaviour in-service was provided June 2013. 3) Pain Management policy and procedure. There is an assessment tool being utilised for a resident with pain. Pain management in service was provided in January 2014.  4) Personal grooming and hygiene policy 5) Skin integrity Management policy. Skin Management in service was provided to staff in January 2014. 6) Wound care policy and procedures. Wound education was provided January 2014. 7) Transportation of subsidised residents policy and procedure includes costs, resident, and staff safety. D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner. D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident an hazard management D19.2g Falls prevention strategies such as falls assessments, sensor mats, exercise sessions. Falls prevention in-service was provided – May 2013. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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:** PA Low |
| **Evidence:** |
| D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service documents and analyses incidents and provides feedback to staff via staff meetings so that improvements are made to the service. Staff can describe the incident reporting process and their role. The service documents and analyses incidents and provides feedback to staff via staff meetings so that improvements are made to the service. A monthly analysis of incidents occurs. Two incident forms for January 2014 were reviewed ( one fall with a skin tear sustained and one skin tear) included corrective actions and demonstrate the family had been notified. There had been a medication error in October 2013 which had not been addressed through the incident accident process. Open Disclosure is included in policy/procedure. Staff are made aware of the requirement to notify statutory authorities. |

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Two incident forms for January 2014 were reviewed ( one fall with a skin tear sustained and one skin tear) included corrective actions and demonstrate the family had been notified. There had been a medication error in October 2013 which had not been addressed through the incident accident process. |
| **Finding:** |
| Medication error in October 2013 where two doses of panadol was found in resident room. Reported in progress notes for increased supervision, however it was not reported via the incident process. |
| **Corrective Action:** |
| Ensure that all adverse events are documented to identify and manage risk. |
| **Timeframe (days):** 60 *(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:** |
| Job descriptions are available for all positions and include responsibilities. These are signed and kept in staff files. There is a total of 12 permanent staff including a) nurse manager b) one registered nurse, c) one enrolled nurse, d) six caregivers, e) one activities coordinator, f) two cooks and g) one cleaner. Other staff include (on a contract basis as required); a) occupational therapist, b) physiotherapist, and c) dietitian Relevant checks are completed to validate individual qualifications and experience. A record of practicing certificates of all health professionals is maintained.   There are human resources policies for the organisation including (but not limited to): a) recruitment, b) selection, c) orientation, and d) staff training and development.   Comprehensive orientation is provided for new staff. This includes (but is not limited to); a) house rules; b) Code of Rights; c) staff code of conduct; d) complaints process; e) privacy and confidentiality; e) medication; f) fire and emergency procedures; g) philosophy of care, mission and values; h) moving and handling; i) incidents/accident reporting; and j) infection control.   An appraisal is conducted with each new staff member 11 weeks after commencement of work. Annual appraisals have been completed for 2013/2014 in all six files reviewed.  A comprehensive In-service education programme is in place. The annual training plan covers a wide range of subjects and exceeds the required eight hours annually.  An individual education file shows attendance/competencies for staff education. Monthly staff meetings include an education session and all staff attends regularly.  All caregivers are required to complete the National Certificate at level 2.   D17.7d: The manager has a Diploma in Primary and Rural Nursing and has a post graduate Certificate in Advanced Clinical Nursing. She is also PRIME qualified. Manager has attended at least eight hours training pertaining to management of a rest home. |

##### **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 documented rationale for determining staffing levels and skill mixes for safe service delivery. There is an effective roster that provides sufficient and appropriate coverage for the effective delivery of care and support.   The service has contracted health professionals who provide supporting services (e.g. physiotherapist, OT). There is 24 hour registered nurse cover.   Staffing is: Week days Nurse Manager Mon-Fri 08.30 - 17.00 Weekends 1 RN or EN 06.45 - 15.15 + 1 on call   AM = 1 caregiver 06.45 - 15.15 (every day) PM = 1 caregiver 15.00 - 23.00 1 and caregiver 1645 - 1945 (every day) Night = 1 caregiver 23.00 - 07.00 (every day)   Activity Coordinator - Mon-Fri 1330-1600 |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered at admission with the involvement of the family. There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Resident records are integrated and support the effective provision of care services. They are accessible to relevant staff. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

## **Outcome 1.3: Continuum of Service Delivery**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy for resident admissions that includes responsibilities, assessment processes and timeframes. Needs assessments are required for entry to the rest home service. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. Three family members and six residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for five resident files sampled. The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission agreement. |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whanau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a policy and process that describe resident’s admission and assessment procedures. A registered nurse (nurse manager) undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission. The long term care plan is developed within three weeks of admission in three of five files viewed. Improvements are required in this area. In all resident files sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Advised by the nurse manager that interRAI assessments have been conducted for all residents (currently nine) - evidenced in five of five resident files reviewed. Six monthly reviews or earlier if resident health changes are completed by the nurse manager with input from the care staff, the activities coordinator and any other relevant person. Activities care plans are incorporated in to the long term care plan. Care plans are used by nursing and care staff to ensure care delivery is in line with the residents assessed needs. Handover occurs at the end of each duty that maintains a continuity of service delivery. There is a communication folder which staff read that includes reviewed policies The nurse manager and an on-call registered nurse shares on-call and after hours and weekends cover. There is also support from the adjacent medical centre and practice nursing staff.  Medical assessments are completed within two working days of admission by the general practitioner (GP) as evidenced in the medical notes of five resident files sampled. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. The GP is on annual leave and was unable to be interviewed. The covering locum was not familiar with the residents and therefore was not interviewed. The medical centre senior practice nurse interviewed advised that residents are either seen in the home or attend appointments in the adjacent medical centre for three monthly reviews. The GP also visits residents who are unwell and provides more frequent visits if required. The practice nurse states the staff are caring and that residents receive very good care.    There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) dietary profile b) Norton pressure area risk assessment, c) continence assessment d) coombes falls risk assessment e) pain assessment and f) challenging behaviour assessment as required. This is in addition to the use of the interRAI assessment tool. These assessments form the basis of the long term care plan. Long term care plans reviewed for five residents’ evidence comprehensive and resident focused goals and interventions. All six files identified integration of allied health including podiatry and physiotherapist.   Five rest home resident files were sampled.  Tracer Methodology:  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:** PA Low |
| **Evidence:** |
| A registered nurse (nurse manager) undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission as evidence in five of five files reviewed. The long term care plan has been developed within three weeks of admission in three of five files viewed. In all resident files sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Advised by the nurse manager that interRAI assessments have been conducted for all residents (currently nine) - evidenced in five of five resident files reviewed. Six monthly reviews or earlier if resident health changes are completed by the nurse manager with input from the care staff, the activities coordinator and any other relevant person. Activities care plans are incorporated in to the long term care plan. |
| **Finding:** |
| Two of five files reviewed evidenced that the long term care plan has been developed outside the three week timeframe. |
| **Corrective Action:** |
| Ensure all residents have a long term care plan developed within three weeks of admission as per contractual requirements. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An initial nursing assessment is completed within 24 hours of admission. The resident comprehensive long term care plan is completed within three weeks of admission for three of five files reviewed (link #1.3.3.3). The initial assessment includes: cognitive, sensory, mobility, breathing, hygiene and grooming, skin, continence, oral care, pain, safety and risk, dietary, social/values and beliefs, cultural and spiritual and sleeping. Personal needs outcomes and goals of residents are identified. There is a range of risk assessment tools available to be completed on admission and reviewed six monthly if applicable including (but not limited to); a) dietary profile b) Norton pressure area risk assessment, c) continence assessment d) coombes falls risk assessment e) pain assessment and f) challenging behaviour assessment in addition to the interRAI assessment tool. Five of five files evidenced assessments conducted using the initial assessments, risk assessments and the interRAI assessment tool. Assessments are conducted in an appropriate and private manner. All six residents interviewed are satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Six resident interviews and three family members stated they were informed and involved in the assessment process. The assessment tools link to the individual care plans. The care plans are individualised for each resident need such as (but not limited to): orientation, night cares, mobilising, food and fluids, continence, anxiety, activities of daily living, social isolation, sexuality/privacy, values and beliefs, pain, elimination, perception, communication, medical conditions, skin integrity, and cultural needs. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.  Specific care plans were in place for special needs, for example: warfarin management, diabetes management, hypertension, behaviour management, and short term memory loss. The general practitioner completes a medical admission with two working days. Families and residents interviewed confirmed their involvement. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents' files include; resident information and family contact sheet, initial nursing assessment, initial care plan, daily progress notes, observations chart, short term care plans, resident comprehensive long term care plans, risk assessments, GP medical notes, lab results, allied health reports, activities, consents, advance directives, letters, discharge summaries, and NASC assessment. Admission agreements are stored in the nurse’s station. The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. The nurse manager has commenced utilising the InterRAI assessment tool for reassessing all residents at Teviot Valley rest home (currently nine residents). Resident comprehensive long term care plans are individually developed with the resident and family/whānau who sign to acknowledge their approval of the care plan. Six residents and three family members interviewed stated they are involved in the care planning process. Five resident comprehensive long term care plans reviewed were evidenced to be up to date. Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to): orientation, night cares, mobilising, food and fluids, continence, anxiety, activities of daily living, social isolation, sexuality/privacy, values and beliefs, pain, elimination, perception, communication, medical conditions, skin integrity, and cultural needs. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.  Specific care plans were in place for special needs, for example: warfarin management, diabetes management, hypertension, behaviour management, and short term memory loss. There is evidence that residents are seen by the GP at least three monthly.  The GP signs a form stating the resident is stable and for three monthly visits. Notes are well maintained.  Short term care plans are in use for changes in health status and are recorded on a problem page. Examples sighted are cares required for skin tears, falls management, infections, and pain. Five resident files reviewed identified that family were involved. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Teviot Valley rest home provides services for residents requiring rest home level care. Individualised care plans are completed. When a resident's condition alters, the nurse manager initiates a referral to the appropriate person - GP, Geriatrician, Palliative care team, dietitian, podiatry, physiotherapist, or wound nurse specialist. The two caregivers and nurse manager interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including sling hoist, wheelchairs, walking frames, scales, transferring equipment, pressure relieving equipment.  Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.  There are currently two wounds – both skin tears. Wound care is based on up-to-date information and wound care advice is readily accessible.  Six residents and three family members interviewed confirm their current care and treatments they and their family members are receiving meet their needs. Family communication sheets record family communications, sighted in all five residents' files sampled. Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed. Staff were provided with wound management education in January 2014. All falls are reported on the resident accident/incident form and reported to the clinical manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required.  There is one full time registered nurse (nurse manager) employed by the service and one part time RN who provides cover for the nurse manager and shares the on-call after hours. Advised by the medical centre senior practice nurse that the rest home RN’s and medical centre staff work closely together to provide support and back up when required. A record of all health practitioners practicing certificates is kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals and more frequently if required. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation. Short term care plans are in use for changes in health status. |

##### **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 coordinator has been in the role for eight years and works 15 hours a week providing activities to residents in the afternoons. There is good communication between the care staff and the activities coordinator and she is aware if there have been resident changes to mobility or health status. The activities coordinator attends staff meetings. A social profile is completed for all new residents on which to base the activities plan. Each resident’s activities plan, which includes goals and objectives, plans and evaluations, is incorporated in to the long term care plan. Progress is documented and plans are reviewed six monthly. The activities coordinator meets with a new resident/family within the first two weeks of admission. The activity care plan is developed in consultation with resident/family to identify goals. Residents forward suggestions and ideas for outings, entertainments and activities to staff. The programme is planned a month ahead and displayed on a notice board. Activities programme is developed for Monday through to Sunday and includes: fortnightly church services, newspaper reading, walks, picnics, knitting, gardening, baking, crafts, sing alongs, visiting entertainers and van outings in the service's 12 seated van. The activities coordinator drives the van on outings and has a current first aid certificate. Weekend activities are co-ordinated by the care staff and include regular happy hour and movies. Residents are encouraged to maintain social and community links with some residents attending their own church. Six residents interviewed confirm they are involved in their activity plan and enjoy the activities, entertainment and outings offered. Activities observed on the day of audit included knitting group, newspaper reading, walks, gardening and karaoke. Activities are conducted in the large lounge area. The activities coordinator stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions. |

##### **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:** |
| All initial care plans were developed by an RN within 24 hours of admission and resident comprehensive long term care plans developed within three weeks of admission (with exception finding #1.3.3.3). Long term care plans are evaluated at least six monthly or if there is a change in health status. There was documented evidence that care plan evaluations were up to date in five of five resident files sampled. Overall changes in health status are documented and followed up. Care plan reviews are signed as completed by an RN. There is a three monthly clinical review by the GP. GP's review residents three monthly or when requested if issues arise or health status changes. Short term care plans are evaluated, resolved or added to the long term care plan if the problem is on-going.  The general practitioner was unable to be interviewed, however, the senior practice nurse stated that the communication from the service is appropriate and in a timely fashion. The service carries out the GP’s instructions. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service facilitates access to other medical and non-medical services. The senior practice nurse interviewed confirms the nurse manager informs the GP of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted:  Relatives (three) and residents (six) interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records. There was transfer information available in one of the files reviewed which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care. Pharmaceutical supplies are kept in the locked nurses’ station.  Four weekly medico blister packs and prn medications are provided by the local pharmacy. The nurse manager checks, signs and dates the medico pack when deliveries are made. The supplying pharmacy also collect returns and carry out six monthly pharmacy audits. There are eye drops in use, which have the date opened recorded. A medication trolley is available, however, is not routinely used.  Medication packs are stored in folders for each medication round. Advised, and observed at lunch time medication round, that staff remove the medications from the blister pack and place on a small container on the bench in front of the corresponding resident named label. Medications are then administered to each resident in turn. Medication charts were not checked and medications were not administered as soon as removed from the pack. Improvements are required in respect to this practice. The nurse manager and caregivers administer medications. A medication fridge is located in the nurses’ station however, is not monitored or recorded for safe temperatures weekly. Improvement is required in this area. Approved containers are used for the safe disposal of sharps. Controlled drugs are stored in a locked safe in a locked cupboard in the nurses’ office and two medication competent staff sign out controlled drugs. There is currently one resident with a PRN controlled drug – which has not been administered in the past six months. The controlled drug has not been entered in the controlled drug register and has therefore not been checked weekly. Improvement is required in this area. Registered nurses and caregivers have completed annual medication training and competencies. Medication management education is provided - last conducted in July 2013. Standing orders meet the required medication guidelines and a list is kept in the medication folder. There are no residents self-medicating. Nine resident medication charts were sampled (all current residents at Teviot Valley rest home). All medication charts have photo identification and allergies are noted. The medication charts are reviewed three monthly by the GP in nine of nine medication charts reviewed. Medication prescribing charts are generated by the pharmacist and each individual order is then signed off by the general practitioner. The prescribing of PRN medications evidence documenting indications for use. Advised that caregivers do not administer PRN medication without the authorisation of a registered nurse.  There is a medication error incident form and procedure in place – however, this has not been utilised for one recent medication error (link #1.2.4.3). There is a staff signature identification sheet on each administration signing form. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care. Pharmaceutical supplies are kept in the locked nurses’ station. Four weekly medico blister packs and prn medications are provided by the local pharmacy. The nurse manager checks, signs and dates the medico pack when deliveries are made. The supplying pharmacy also collect returns and carry out six monthly pharmacy audits. There are eye drops in use, which have the date opened recorded. A medication trolley is available, however, is not routinely used. Medication packs are stored in folders for each medication round. A medication fridge is located in the nurse’s station. Approved containers are used for the safe disposal of sharps. Controlled drugs are stored in a locked safe in a locked cupboard in the nurses’ office and two medication competent staff sign out controlled drugs. There is currently one resident with a PRN controlled drug – which has not been administered in the past six months. |
| **Finding:** |
| Advised, and observed at lunch time medication round, that staff remove all the medications from the blister packs and place on individual small containers on the bench in front of the corresponding resident named label. Medications are then taken and administered to each resident in turn; b) medication fridge temperature not monitored or recorded; and c) one controlled drug not entered in controlled drug register and not checked weekly. |
| **Corrective Action:** |
| Ensure all staff follow correct administration procedures to ensure the safe administration of medications to residents – check each individual medication chart, identify the resident, remove medications from blister pack, give to the resident, observe ingestion and then sign that medications have been given. b) Monitor and record medication fridge temperatures; and c) record all controlled drugs in the controlled drug register and conduct weekly checks. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** 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:** PA Low |
| **Evidence:** |
| There is a Food Services manual with policies and procedures that align with current best practice and food safety and hygiene standards. The service employs two part time cooks and one casual cook. There is a four weekly seasonal menu that has been reviewed (March 2012) by a dietitian. The nurse manager completes a dietary profile on admission, which identifies the type and texture of the residents’ food, special crockery or utensils required and any likes or dislikes. The kitchen has a copy of the profile and is informed of any dietary changes. Alternative foods are offered as required. There is a large chiller, a large chest freezer and an upright fridge. There is a thermometer on the outside of the chiller which staff check daily, however, temperatures have not been recorded for the chiller since September 2013 and the freezer has not been monitored or recorded since September 2013. Improvements are required in this area. All perishable foods are date labelled. The kitchen is well equipped with a large range, and a large cook top. There is a microwave and dishwasher that have all been checked and maintained. Staff working in the kitchen are observed wearing protective clothing such as hats, aprons and gloves. Pantry goods are rotated on delivery. There is a large pantry and the service holds enough food for at least three days. Alternative gas cooking is available if required. The service has a generator, which runs all electrical outlets including fridges and freezers. Chemicals are stored in a locked kitchen cupboard. Food service is part of the annual satisfaction survey. Corrective actions are implemented. A food services audit was conducted in October 2013.  Six residents and three family members report satisfaction with meal choices, meals are well presented (observed) and alternative meals are offered as required. Staff have completed food handling qualifications. |

##### **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:** PA Low |
| **Evidence:** |
| There is a large chiller, a large chest freezer and an upright fridge. There is a thermometer on the outside of the chiller, which staff check daily. All perishable foods are date labelled. The kitchen is well equipped with a large range, and a large cook top. There is a microwave and dishwasher that have all been checked and maintained. Staff working in the kitchen are observed wearing protective clothing such as hats, aprons and gloves. Pantry goods are rotated on delivery. There is a large pantry and the service holds enough food for at least three days. Alternative gas cooking is available if required. The service has a generator, which runs all electrical outlets including fridges and freezers in the event of power failure. |
| **Finding:** |
| There is a thermometer on the outside of the walk-in chiller which staff check daily, however, temperatures have not been recorded for the chiller since September 2013 and the large chest freezer temperatures has not been monitored or recorded since September 2013. |
| **Corrective Action:** |
| Ensure the chiller and freezer temperatures are monitored and recorded as per service policy. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies in place in for waste management, waste disposal for general waste and medical waste management. Refuse is collected from the property by an external contractor. There an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas locked areas for storage of cleaning/laundry chemicals. Product use charts are available. Hazard register identifies hazardous substance. Chemicals are stored in a locked storage cupboard until required. Gloves, aprons, and goggles are available for staff. Interviews with two caregivers and one cleaner could describe management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in February 2014. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service displays a current building warrant of fitness, which expires on 28 June 2014. The Fire evacuation scheme letter of approval is dated 2 July 2004. The rest home building is owned by the medical centre trust board and is leased to the rest home trust. Fire testing of equipment is current. One nurse manager oversees the maintenance programme with local contractors providing repairs and maintenance service. There are planned maintenance schedules. Maintenance policies and procedures are in place. Medical equipment checks and calibration is conducted in conjunction with the adjacent medical centre – next scheduled for March 2014. Hot water temperatures checks are conducted and recorded monthly by the nurse manager. On review of records it is noted that hot water temperatures are consistently recorded between 43 and 45 degrees Celsius. The facility van used for residents’ outings has a current registration and a current warrant of fitness. The interior is well maintained with a home-like décor and furnishings. There is a large communal lounge, dining area, and communal bathroom and toilet facilities. There are small seating nooks available for residents and visitors. Residents’ rooms are carpeted with carpet in the lounge and vinyl floor covering in the dining room. The corridors are wide with handrails in place. There is an internal covered area and external designated smoking area. There is easy access to the outdoors. Outdoor ramps have handrails. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with two caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. |

##### **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 bedrooms are located in two wings. All 14 rooms are single with a hand basin in each room. There are three communal toilets and two communal showers. Two of the bedrooms have their own toilet. Two rooms have a full shared ensuite. There are adequate numbers of communal toilets and showers with appropriately placed handrails. Six residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvred mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. One nurse manager and two caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a large lounge, a dining room, a small seating nook where group or individual activity can occur. The dining room is spacious and located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group.  Residents were seen to be moving freely both with and without assistance throughout the audit and six residents interviewed report they can move around the facility and staff assist them if required. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Teviot Valley rest home has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection control education and there is appropriate protective clothing available and worn (observed). Internal laundry services audit in October 2013, which achieved compliance and satisfaction with the service. There is a designated cleaner employed to cover the seven day week. The cleaner interviewed stated her duties include vacuuming, cleaning of toilets, bathrooms, hand basins. The cleaning trolley is stored in a locked room when not in use. A chemical product chart is available. The cleaner is observed wearing protective clothing. Internal cleaning services audit in September 2013 achieved compliance and satisfaction with the service Six residents and three family interviewed report satisfaction with the laundry service and cleanliness of the room/facility. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a fire and emergency procedures manual. There is currently a trained person with a first aid certificate on each shift. Teviot Valley rest home has a NZFS approved fire evacuation scheme, dated 2 July 2004. A call bell light alerts staff to the area in which residents require assistance. The home is small and advised that most visitors are known to staff and/or management. Fire drill last conducted 11 December 2013. A civil defence kit is stocked and checked six monthly. Water is stored - sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Call bell system evident and in use in the resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. The service has a diesel generator for use in the event of power failure. Heating is via radiators from a boiler system. Emergency management training occurred in January 2013. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. There is a radiator heater in each resident room and in the hall ways connected to the boiler system, with individual heat settings, which can be adjusted. Six residents and three family interviewed state the environment is warm and comfortable. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a Restraint Minimisation and Safe Practice Policy is applicable to the service. The policy includes; a) philosophy, b) purpose, c) definitions, d) authorities and responsibilities; e) voluntary restraint use; and f) procedures for approval process, assessment process, recording/documenting restraint use, processes to reduce the risks associated with restraint, processes to evaluate restraint use, mechanisms for the quality review of the restraint use. The definition of restraint and enablers is congruent with the definition in NZ8134.0. The service is restraint free. Restraint is an agenda item at monthly staff meetings. Restraint training was provided to staff - June 2013. The service has audited restraint management-September 2013. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Teviot Valley Rest Home has an Infection Control policy that includes; a) policy, b) procedure, c) infection control data, d) surveillance, e) documentation, f) corrective action, g) authority and responsibility, h) procedure for use of infection book, and i) prescribing of antibiotics and outbreak management. The Infection Control Policy includes IC Co-ordinator authority and responsibility. The manager is the infection control co-ordinator. Infection Control issues and analysis of infections is reviewed through the monthly staff meetings. The Board of Directors meets with the Manager monthly. Benchmarking is occurring with Healthcare help. Annual review of IC Programme occurred in January 2014.  There are linkages with ODHB infection control specialist. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control coordinator is the nurse manager. The Infection Control team comprises of all staff as part of the monthly staff meeting. Infection Control Coordinator describes accessing the resident's GP, ODHB Infection Control Nurse and MedLab if required. The nurse manager has access to resident information and laboratory results to assist in managing resident infections. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Teviot Valley Rest Home has an Infection Control policy that includes; a) policy, b) procedure, c) infection control data, d) surveillance, e) documentation, f) corrective action, g) authority and responsibility, h) procedure for use of infection book, and i) prescribing of antibiotics and outbreak management. The service has in place an Infection Control Manual. Policies include: a) infection book and analysis forms, b) hand washing, c) MRSA, d) info for new employees, e) standard precautions, e) flu vax, f) blood accidents, g) exposure to infections, h) staff with infections, i) residents with infections, j) policy for medical waste, k) protective clothing, l) disinfection, m) immunisations, n) cleaning spills of body substances, o) infection control guidelines, p) notifiable diseases q) nursing residents in isolation policy and procedure, and r) environment. |

##### **Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)**

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

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

#### Standard 3.4: Education **(**HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control coordinator, who is the nurse manager is responsible for providing education and training to staff in conjunction with an infection control specialist from the ODHB and Medlab. Infection Control is included in the staff orientation. Infection control coordinator attended external education with Bug Control in August 2013.   Staff individual training records identified orientation included standard precautions and infection control procedures. Infection control training becomes part of the monthly staff meetings and there is documented evidence that IC practices are discussed and evaluated through these meetings.  Staff training-Principles of infection control-April 2013; Handwashing and personal protective equipment – September 2013 Documentation includes attendance, content and evaluation of IC session. |

##### **Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)**

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an infection control surveillance-data gathering and review policy in place, which outlines the purpose and methodology for the surveillance of infections. Infection control data is collated monthly and includes surveillance analysis of multi-resistant organisms associated with anti-microbial use. Surveillance data and analysis was evident in Infection Report Folder. The IC Coordinator, has a close liaison with the GP who closely reviews infections.  Definitions of infections and rates are in place appropriate to the complexity of service provided.  The infection control programme is monitored by surveillance of infections and by infection control audits. Audits completed -Infection Control/Handwashing- December 2013; Laundry –October 2013; and Cleaning-Septemebr 2013. Corrective actions are completed and results are reported to the Staff meeting. |

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

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

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

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

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

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