

Selwyn Care Limited - Brian Wells Lodge

Current Status: 23 January 2014

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

General overview

Brian Wells Lodge provides dementia level care for up to 16 residents. On the day of the audit, there were 15 residents.

The service has a senior manager who manages two care centres. The manager is supported by a Clinical Coordinator (registered nurse).

There is a well-established senior management team across the Selwyn Village who support each care centre.

A comprehensive orientation and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care and support. Staff turnover remains low. Family and residents interviewed spoke positively about the service provided.

The two shortfalls identified in the previous audit have been addressed around behaviour monitoring and medication management.

This surveillance audit identified improvements required around wound care plans, care plan documentation and activities documentation.

Audit Summary as at 23 January 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	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 23 January 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 23 January 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 23 January 2014

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.
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Safe and Appropriate Environment as at 23 January 2014

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.
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Restraint Minimisation and Safe Practice as at 23 January 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 23 January 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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

Legal entity name:	Selwyn Care Limited		
Certificate name:	Selwyn Care Limited - Brian Wells Lodge		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Brian Wells Lodge		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 23 January 2014	End date: 23 January 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			15

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	4
Other Auditors		Total hours on site		Total hours off site	
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

Total audit hours on site	8	Total audit hours off site	6	Total audit hours	14
Number of residents interviewed	0	Number of staff interviewed	4	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	13	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	0

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:

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	Yes
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 Tuesday, 11 March 2014

Executive Summary of Audit

General Overview

Brian Wells provides dementia level care for up to 16 residents. On the day of the audit, there were 15 residents. The service has a senior manager who manages two care centres. The manager is supported by a Clinical coordinator (RN) at Brian Wells. There is a well-established senior management team across the Selwyn Village who support each care centre. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Staff turnover remains low. Family and residents interviewed spoke positively about the service provided. The two shortfalls identified in the previous audit have been addressed around behaviour monitoring and medication management. This surveillance audit identified improvements required around wound care plans, care plan documentation and activities documentation.

Outcome 1.1: Consumer Rights

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. A complaints register is up to date and includes relevant information regarding the complaint.

Outcome 1.2: Organisational Management

Selwyn Foundation has a quality and risk management system in place that continues to be implemented and monitored at Brian Wells. Policies and procedures are reviewed regularly and are updated to reflect best practice, legislation and standards. Key components of the quality management system link to the facility meetings including quality management, health and safety, infection control and staff meetings. An annual resident and relative satisfaction survey is completed. The service is active in analysing data. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Monthly benchmarking reports are produced that include incidents/accidents, infections and complaints. These are used to provide comparisons with other services. Quality improvement plans are utilised at Brian Wells to document actions to improve services. Health and safety policies, systems and processes are implemented to manage risk. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Outcome 1.3: Continuum of Service Delivery

The service uses a combination of computer based care planning and paper based information. The initial care plan and long term care plan are computer based. The service prints off a care plan summary, which is placed in the front of the resident file. This is to allow easy reference for the caregivers. The lifestyle questionnaire is also paper based. The questionnaire gives information regarding the resident past and present hobbies, likes, dislikes and other activity based information. Improvements are required around care plan interventions and wound care documentation. The caregivers provide activities to the residents. Activities are supervised and lead by the registered diversional therapist employed by the Selwyn village.

A variety of activities are provided that also reflect normal patterns of life and community contact. There is an improvement required around activity care plans.

Brian Wells has food policies/procedures for food services and menu planning appropriate for this type of service. Food is prepared off site at Selwyn Villages' main kitchen and delivered to Brian Well in the hot boxes. There is additional nutritious snacks available over 24 hours. Relatives interviewed spoke positively about the food service.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted.

Outcome 1.4: Safe and Appropriate Environment

Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted monthly by an external fire safety contractor and by the maintenance staff as sighted in documentation. The building holds a current warrant of fitness.

Outcome 2: Restraint Minimisation and Safe Practice

There are clear guidelines in policy to determine what a restraint is and what an enabler is. The process of assessment and evaluation of enabler use is the same as a restraint. Currently the service has no residents using restraint or enablers. Training has been provided around restraint, enablers and challenging behaviours.

Outcome 3: Infection Prevention and Control

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control co-ordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections, which have been completed in 2013 as per internal audit schedule.

Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	15	0	1	1	0	0
Criteria	0	39	0	1	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	33
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	The following shortfalls were identified; (i) Two wounds do not have an up to date wound care assessment and plan in place. Neuro obs have not been recorded consistently including all the observations needed and the time and they are documented and stopped when they document pupils fixed after a head injury. (Noting the progress notes document the resident is responsive). The RN on call is not documented as	(i)Ensure that wound care documentation is up to date. (ii) Ensure neuro observations are completed fully and the time documented. (iii) Ensure registered nurse completes an assessment when required. (iv) Ensure care plans include interventions that describe required care and support needed.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>reviewing the resident when the enrolled nurse informs her of the neuro observations. The care plan does not reflect the sleeping preferences of the resident. (ii) Resident two; resident with confusion and continence problems does not include management interventions in the care plan, and the care plan does not include pain management. (iii) Resident three; resident with a wound does not have a wound care plan for management and dressings are not always documented when they have been undertaken.</p>		
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	Five resident care plans reviewed do not have a documented, individualised activities care plan in place.	Ensure that each resident has an individualised activity plan in place	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

Selwyn, Brian Wells has an open disclosure policy. They continue to ensure that family are communicated with regard to resident care and services provided. Five care plans reviewed all document family involvement.

The clinical coordinator (RN) and the service manager interviewed confirmed that the service is proactive around communication with families and that they record contact with family/whanau on the family/whanau contact record (sighted). Interviews with four relatives also confirmed that family feel that the service maintained an open communication process.

The service continues to ensure that individual family meetings occur at least six monthly and the facility manager has an open-door policy. Resident/family surveys are undertaken with the most current survey in progress.

There is a communication and interpreter services procedure and access to interpreter information is available.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Four relatives stated that they are always informed when their family members health status changes.

E4.1.e A site specific Introduction to Dementia unit booklet providing information for family, friends and visitors visiting the facility is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families.

Six resident related incident forms were reviewed. All six document that family have been informed.

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

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

Attainment and Risk: FA

Evidence:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence: Brian Wells, as part of the Selwyn Foundation has a documented process for the management of complaints, which complies with the code of rights. Complaints are logged on to the computer, which records all complaints, and their progress and resolution. The Selwyn quality management team monitors the implementation of the complaints process and compliance with it as part of six monthly external compliance audits. Monthly monitoring includes complaints and complaints are graphed and benchmarked monthly. The two caregivers and clinical coordinator interviewed are aware of the complaints policy and described it well. Four family members stated that the service is very receptive to both complaints and suggestions.

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Brian Wells is a stand-alone dementia care unit located within the Selwyn Village, where the Selwyn foundation provides a variety of elderly care services. Brian Wells provides dementia level care for up to 16 residents. On the day of the audit, there were 15 residents. The service continues to implement its strategic intent through the organisation mission statement of; "To provide quality Christian care and support for the elderly". Selwyn's vision is 'To be an outstanding provider of quality aged care' There is a current strategic plan, risk and quality plan in place which the organisation monitors itself and individual units against. This is well documented at Brian Wells. Business and quality plans have strategies identified to meet the goals and key performance indicators to assess the achievement of goals. This is monitored through the quality team monthly and includes financial, customer, internal processes, knowledge and learning, significant projects, key issues - short term and long term Brian has a separate plan, which aims to provide a homelike experience for the residents in its care. The Eden philosophy is integral to the philosophy of the unit. Brian Wells is managed by a clinical coordinator who has been in the role for four years. There is also an overall manager of Brian Wells who also manages the closely located psychogeriatric unit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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.

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has standard operating procedures (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 Selwyn quality monitoring programme is implemented at Brian Wells and the service continues to monitor contractual, standards compliance and the quality of service delivery in the facility.

There is a range of meetings documented that monitor and communicate quality. The monthly quality and staff meeting, includes monitoring and discussion of H& S, internal audits, surveys, incident and accidents, IC and restraint (if in use). Reporting and discussion is documented in meeting minutes reviewed. There are clinical meetings three monthly where the service clinical coordinator meets with other registered nurses from other care centres in the Selwyn Village.

Monthly staff/ quality meetings document that staff are informed of quality information and any associated action plans are actioned as needed.

The manager reports each month on progress to the general manager.

All internal audit results, complaint, incidents, infections, wound, drug errors pressure areas and training are reported to the central office monthly.

Trend analysis graphs are generated which include comparison with previous year's results and comparison with other Selwyn homes are completed monthly. Where any facility results lay outside average, minimum and maximum data sets for over two months have an action plan generated (QIP). These action plans are monitored centrally to ensure they are followed up and action plans implemented. (sighted)

There is a set audit schedule in place and audits reviewed have been undertaken as per the schedule. Action plans are documented as needed and signed off when completed.

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: FA
Evidence: Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. D19.3b; The Selwyn foundation has robust polices to support the incident and accident reporting process. The procedure describes responsibilities relating to staff incidents and resident incidents. The quality improvement data collection process includes adverse events including services, staff and unwanted events. Incidents and accidents are recorded on the central computer system; all incidents, drug errors, complaints, compliments, falls and infections are entered and preventative actions are developed as required. Minutes of the monthly staff/ quality meetings and H&S meeting reflect a discussion of results. Six incident forms (falls) reviewed for December 2013 all demonstrated clinical follow up by a registered nurse. (link 1.3.6.1 for monitoring of neuro obs)

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Brian Wells employs a total of 14 permanent staff including the full time clinical coordinator and a part time registered nurse, As part of the Selwyn Foundation, there are human policies and procedures in place for the service, including comprehensive job descriptions for all identified roles. Five staff files reviewed including the clinical coordinator file; Job descriptions were evident in all five staff files reviewed (one registered nurse and four caregivers). Annual appraisals were documented in all five files, employments process including documented references and orientation were also documented. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Discussion with staff and management and review of the documentation confirms that a comprehensive in-service training programme in relevant aspects of care and support is in place. All training on the schedule is considered compulsory and caregivers are paid to attend. Leecare (the computerised care planning tool) training was provided, prior to the system going live, between November and January 2012 with senior staff having a two day training from the computer service provider. The clinical coordinator is booked for InterRAI training. Of the 11 caregiving staff, 10 have completed the dementia standards and one (employed for four months) has a national certificate.</p>

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a staffing policy to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The staffing rational is documented using an approved formula for calculating required hours for acuity level. Each facility enters work hours each week onto a spread sheet and this is reviewed against the national benchmark - using quarterly balanced score cards for both rest homes dementia units and hospitals. The workload monitoring policy (HR1/3) provides the formula for developing staffing levels and rosters are adjusted accordingly. Under and overs are calculated and monitored. Budgeted hours are set. As part of the Eden philosophy staff employed at Brian Wells undertake all tasks associated with resident care. This includes laundry (personal laundry only) and cleaning. Caregivers also provide activities and an additional caregiver is provided for part of the AM and PM shift to assist with activities.</p> <p>The village has two employed physio's across the village that are available to Brian Wells.</p> <p>Links to mental health service for older person as needed are established</p> <p>Interviews with two caregivers confirmed that staffing numbers were satisfactory.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence:

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service uses a combination of computer based care planning and paper based information. The initial care plan and long term care plan are computer based. The service prints off a care plan summary, which is in placed in the front of the resident file. This is to allow easy reference for the caregivers.</p> <p>The life style questionnaire is also paper based. The questionnaire gives information regarding the resident past and present hobbies, likes, dislikes and other activity based information.</p> <p>Five resident files reviewed all documented that the registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission and within three weeks, the care plan is developed.</p> <p>D16.2, 3, 4: In file files sampled the initial admission assessment, care plan summary and long term care plan were completed and signed off by a registered nurse. Medical assessments are completed on admission by the general practitioner (GP) and six monthly multi-disciplinary reviews are completed by the registered nurse with input from caregivers (four of five files – one new resident) , the GP, the activities coordinator and any other relevant person.</p> <p>Four relatives stated that they are involved in planning their care plan and at evaluation. Resident files included family contact records, which were completed and up to</p>

date in the five resident files sampled.

D16.5e: All five resident files reviewed identified that the GP had seen the resident within two working days.

The computer based nursing assessment system includes (but not limited to) continence, falls risk, pressure area, nutrition pain and challenging behaviour assessments.

Four of five files (one new resident) reviewed all included appropriate assessments and all had been updated six monthly or more often as needed,

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

The five computer based files all identified integration and links to specialist service providers as needed, allied health and GP instructions.

Tracer; resident with high falls.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The registered nurses complete residents' care plans on the computer
Care delivery is recorded on progress notes, weekly by the RN and at least daily by the caregivers. (Evidenced in all five residents' progress notes sighted). The two caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care.
All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted. Four families interviewed were complimentary of care received at the facility.
Five care plans reviewed documented that activities of daily living, links with the mental health team, and management of behaviour are documented well. Family communication and involvement in care is documented and four families state they are very much involved.
The care being provided is consistent with the needs of residents, this is evidenced by discussions with two caregivers, and four families interviewed.
Auditor observation evidenced that the caregivers provide a high standard of care, they demonstrated a caring and calm approach to the residents. There is a short-term care plan that is used for acute or short-term 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.

Attainment and Risk: PA Moderate
Evidence: Five care plans reviewed documented that activities of daily living, links with the mental health team, and management of behaviour are documented well. Family communication and involvement in care is documented and four families state they are very much involved and that the care provided is very good.
Finding: The following shortfalls were identified; (i) Two wounds do not have an up to date wound care assessment and plan in place. Neuro obs have not been recorded consistently including all the observations needed and the time and they are documented and stopped when they document pupils fixed after a head injury. (Noting the progress notes document the resident is responsive). The RN on call is not documented as reviewing the resident when the enrolled nurse informs her of the neuro observations. The care plan does not reflect the sleeping preferences of the resident (iii) Resident three; resident with a wound does not have a wound care plan for management and dressings are not always documented when they have been undertaken. (ii) Resident with confusion and continence problems does not include management interventions in the care plan, and the care plan does not include pain management.
Corrective Action: (i) Ensure that wound care documentation is up to date. (ii) Ensure neuro observations are completed fully and the time documented. (iii) Ensure registered nurse completes an assessment when required. (iv) Ensure care plans include interventions that describe required care and support needed.
Timeframe (days): 30 (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

Attainment and Risk: PA Low
Evidence: Brian Wells, as part of the Eden philosophy considers that activities are integral to the daily life of residents and the involvement of all staff including caregivers enables the facility to provide an individualised programme according to the resident need at any given time. The caregivers provide activities to the residents, with an extra care giver for each shift to assist with activities and the involvement of volunteers. Activities are supervised and lead by the registered diversional therapist employed by the Selwyn village. A variety of activities are provided that also reflect normal patterns of life and community contact. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. There is an over-arching activities programme is developed monthly. Residents have a lifestyle assessment and questionnaire completed in the first few weeks and this is in the resident file to assist care givers with providing meaningful activities to residents. However the resident files lack a robust activity plan for individual residents and this is identified as an area for improvement.

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

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

Attainment and Risk: PA Low

Evidence:

Activities are supervised and lead by the registered diversional therapist employed by the Selwyn village. A variety of activities are provided that also reflect normal patterns of life and community contact. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. There is an over-arching activities programme is developed monthly.

Finding:

Five resident care plans reviewed do not have a documented, individualised activities care plan in place.

Corrective Action:

Ensure that each resident has an individualised activity plan in place

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur. There is at least a one- three monthly review by the medical practitioner. This was evidenced in four of five care plans reviewed.

There are short term care plans to focus on acute and short-term issues. Behaviour monitoring was in place for two residents this is monitored through progress notes and behaviour monitoring forms. The clinical coordinator's evaluations are documented and include a review of behaviour and interventions. This is an improvement on the previous audit.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service uses a four weekly robotic dispensing system. Ten medication charts reviewed all documented; photo ID's, allergies recorded, signing on administration by staff, GP prescribing legible and correct. Policies and protocols are in place to manage the safe and appropriate prescribing, dispensing, administration, review, storage and disposal of medicines in order to comply with legislation, regulations and guidelines.</p> <p>There is a contract with the pharmacy. Robotic pack medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are kept in a locked cupboards in a locked dispensary. Staff sign for the administration of medications on medication sheets held with the medicines. There is a list of specimen signatures and competencies. There is a locked safe and controlled drug register. Medications are reviewed by the GP at least three monthly.</p> <p>.All caregivers' currently administering medications have completed medication competencies (sighted). Staff attend medication training annually.</p> <p>All medications from the ten charts reviewed had been signed on administration, including non-packaged medication. There is a process where the caregivers check that PRN medication is appropriate by calling the RN in the (close) neighbouring care centre. This is an improvement on the previous audit.</p>

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (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.

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Brian Wells has food policies/procedures for food services and menu planning appropriate for this type of service. Food is prepared off site at Selwyn Villages' main kitchen and delivered to Brian Well in the hot boxes. A four weekly rolling menu is implemented and changes seasonally four times a year and is approved by the Medirest dietitian. All kitchen staff completed food handling certificates. Fridge, food and freezer temperatures in the main kitchen and at Brian Wells are monitored. Food in the chillers at Brian Wells was covered and dated. Residents with special dietary needs have these needs identified their care plans and these needs reviewed periodically as part of the care planning review process. Dietary information and changes are sent to the main kitchen and also retained in the receiving kitchen. The clinical coordinator stated that she monitors meal times and observes resident's oral intake. A review of five resident files evidenced that monthly weights are undertaken and none of the resident files reviewed documented weight loss. Observation of lunch time evidenced that the meal time is calm and staff assist resident with their meals as needed, Every effort was made to cater to residents who did</p>

not want their meal and alternatives were found.
Families (four) interviewed, all confirmed satisfaction with food services.
E3.3f: there is evidence that there is additional nutritious snacks available over 24 hours.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The building holds a current building warrant of fitness that expires on 16th January 2015. All electrical equipment is checked and tagged annually. In the facility residents are able to bring their own possessions and are able to adorn their room as desired. Consideration is given to residents needs when purchasing new furniture/equipment. The physical environment is appropriate and safe. There is adequate space and external areas are well kept. Selwyn Village has a transport department and policy/protocols, which is responsible for transporting residents on outings. The transport department check drivers licenses and copies are kept at head office.</p>

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (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

Attainment and Risk: FA

Evidence:

There is a restraint minimisation procedure. The procedure includes definitions of restraint and enablers, cultural safety, privacy and dignity, approved restraints, use of enablers and the role of the restraint co-ordinator; alternative interventions; external doors; implementing restraint; assessing risk; consent; monitoring; evaluation; quality review; education; related documents. The restraint minimisation procedure states the purpose of restraint is 'To minimise the use of restraint while providing a safe environment for residents, staff and visitors. To ensure that when restraint is practised, it occurs in a safe and respectful manner for the minimum length of time'. There are no residents with restraint or enablers at Brian Wells. Staff receive education around restraint and challenging behaviour.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (the clinical coordinator) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

The service has an infection control surveillance policy implemented, which outlines the purpose and methodology for the surveillance of infections. All infections are included in the surveillance. The Selwyn IC committee with the assistance of an IC consultant has determined the Infection surveillance process.

Infections are recorded on infection forms for each infection. These forms are collated monthly. Infections are then inputted into the computer system for the quality manager to graph/benchmark.

The collated data is discussed at the combined quality/staff meeting as well as disseminated to staff via notice boards. The IC coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and the lab that advise and provide feedback /information to the service.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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