# Amberley Resthome 2013 Limited

## Current Status: 3 March 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

Amberley Rest Home is certified to provide rest home level care for up to 21 residents including up to 12 residents in serviced apartments. On the day of the audit there were 17 residents including nine who live in serviced apartments and eight who live in rest home rooms. The service was purchased by the current owners in June 2013. Residents, staff, family and the GP all commented very positively around the improvement of organisational culture under the new owners. The facility manager (who is one of the directors) has many years’ experience in the aged care sector and is supported by a very experienced clinical manager who is a registered nurse with aged care and district nursing experience. The care services are holistic and promote the residents' individuality and independence.

This audit identified improvements required by the service in the following areas; staff training, assessment reviews, admission agreements; activities care plans and repair of one bathroom.

## Audit Summary as at 3 March 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 3 March 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 3 March 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 3 March 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 low risk. |

### Safe and Appropriate Environment as at 3 March 2014

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

### Restraint Minimisation and Safe Practice as at 3 March 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 3 March 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 3 March 2014

### Consumer Rights

Amberley Rest Home’s philosophy is to provide a quality service that focuses on the individual residents and promoting independence. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents’ rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori Health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. There is an improvement required around admission agreements.

### Organisational Management

Amberley Rest Home has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Quality information is reported to bi- monthly management/ quality meetings and three monthly staff meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Amberley Rest Home has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training programme that has been implemented and staff are supported to undertake external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs. There is an improvement required around implementing the planned staff education programme.

### Continuum of Service Delivery

Assessments and care plans are completed by the clinical manager on admission and a care plan is developed in consultation with the resident and family/whanau where appropriate. Long-term care plans are developed within contractual timeframes. Care plans are evaluated six monthly. Resident files include input from other allied health professionals and this is reflected in the long-term care plans supporting an integrated approach to care. There is an activities programme that involves the wider community. Activities are planned to cover five days of the week, with some activities and entertainment occurring at weekends. A range of activities are available and these include the involvement of the residents into the community. The audit identified an improvement requiring around documentation of individual activities plans and on-going assessments.

There are policies and procedures to guide staff for a safe coordinated discharge process. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities.

The medicine management system complies with current legislative requirements and safe practice guidelines. Amberley uses Medico Douglas medicine dispensing system and all medications are checked by the clinical manager on arrival. Medicine competent caregivers administer medication all that administer medication have been assessed as medicine competent. A procedure is in place for the self-administration of medicines. All meals are prepared and cooked on site. Individual and special dietary needs are catered for.

### Safe and Appropriate Environment

The building has current warrant of fitness. There is a maintenance plan 2014 and one of the co-owners undertake maintenance work and the gardening. Residents, staff and visitors are provided with a safe secure and appropriate environment for residents at Amberley Rest Home. The outside areas are maintained to ensure safety. Since the new owners took over the business, several items of equipment have been replaced including kitchen equipment and utensils. The new owners have also purchased new bed linen and completed painting work within the facility. The service has policies and procedures for effective management of laundry and cleaning. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. Amberley Rest Home has implemented emergency response policies and procedures. Security procedures are in place. The audit identified an improvement requiring around one bathroom requiring repair.

### Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards, there is a restraint register and a register for enablers. There are currently no residents requiring restraints and no residents using enablers.

### Infection Prevention and Control

The infection control coordinator is the clinical manager who is a registered nurse. The service has infection control policies and an infection control manual to guide practice. Infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

# 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:** | Amberley Resthome 2013 Limited |
| **Certificate name:** | Amberley Resthome 2013 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:** | Amberley Resthome and Retirement Village | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 3 March 2014 | **End date:** | 3 March 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:** | 17 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 6 |
| **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 | 16 | Total audit hours off site | 14 | Total audit hours | 30 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 6 | 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) | 18 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **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 Tuesday, 15 April 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Amberley Rest Home is certified to provide rest home level care for up to 21 residents including up to 12 residents in serviced apartments. On the day of the audit there were 17 residents including nine who live in serviced apartments and eight who live in rest home rooms. The service was purchased by the current owners in June 2013. Residents, staff, family and the GP all commented very positively around the improvement of organisational culture under the new owners. The facility manager (who is one of the directors) has many years’ experience in the aged care sector and is supported by a very experienced clinical manager who is a registered nurse with aged care and district nursing experience. The care services are holistic and promote the residents' individuality and independence.  This audit identified improvements required by the service in the following areas; staff training, assessment reviews, admission agreements; activities care plans and repair of one bathroom. |

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| **Outcome 1.1: Consumer Rights** |
| Amberley Rest Home’s philosophy is to provide a quality service that focuses on the individual residents and promoting independence. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents’ rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori Health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. There is an improvement required around admission agreements. |

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| **Outcome 1.2: Organisational Management** |
| Amberley Rest Home has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.  Quality information is reported to bi- monthly management/ quality meetings and three monthly staff meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Amberley Rest Home has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training programme that has been implemented and staff are supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs. There is an improvement required around implementing the planned staff education programme. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Assessments and care plans are completed by the clinical manager on admission and a care plan is developed in consultation with the resident and family/whanau where appropriate. Long-term care plans are developed within contractual timeframes. Care plans are evaluated six monthly. Resident files include input from other allied health professionals and this is reflected in the long-term care plans supporting an integrated approach to care. There is an activities programme that involves the wider community. Activities are planned to cover five days of the week, with some activities and entertainment occurring at weekends. A range of activities are available and these include the involvement of the residents into the community. The audit identified an improvement requiring around documentation of individual activities plans and on-going assessments.  There are policies and procedures to guide staff for a safe coordinated discharge process. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities.  The medicine management system complies with current legislative requirements and safe practice guidelines. Amberley uses medico Douglas medicine dispensing system and all medications are checked by the clinical manager on arrival. Medicine competent caregivers administer medication all that administer medication have been assessed as medicine competent. A procedure is in place for the self-administration of medicines. All meals are prepared and cooked on site. Individual and special dietary needs are catered for. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The building has current warrant of fitness. There is a maintenance plan 2014 and one of the co-owners undertake maintenance work and the gardening. Residents, staff and visitors are provided with a safe secure and appropriate environment for residents at Amberley Rest Home. The outside areas are maintained to ensure safety. Since the new owners took over the business, several items of equipment have been replaced including kitchen equipment and utensils. The new owners have also purchased new bed linen and completed painting work within the facility. The service has policies and procedures for effective management of laundry and cleaning. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. Amberley Rest Home has implemented emergency response policies and procedures. Security procedures are in place. The audit identified an improvement requiring around one bathroom requiring repair. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards, there is a restraint register and a register for enablers. There are currently no residents requiring restraints and no residents using enablers. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control coordinator is the clinical manager who is a registered nurse. The service has infection control policies and an infection control manual to guide practice. Infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 40 | 0 | 5 | 0 | 0 | 0 |
| **Criteria** | 0 | 88 | 0 | 5 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 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 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | D13.1- Five out of five files reviewed showed that admission agreements were not signed by the resident or enduring power of authority. Some of these files reviewed showed that the residents were admitted to the service before the business was transferred to the new owners. The facility manager reports that new contract will be distributed to the all residents and families. This is work in progress. | Ensure that admission agreements are signed on the day of admission. | 180 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | A number of required areas including (but not limited to) infection control, wound management, abuse and neglect, falls prevention, challenging behaviour management and cultural safety are included in the 2014 training plan but have not yet been completed. | Implement the planned training schedule for 2014. | 180 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Three of five files reviewed showed that continuing needs/risk assessments are not carried out. Two files were not due for re-assessment yet. | Ensure that on-going assessments are completed when care plans are reviewed. | 180 |
| 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 | D16.5d Five of five resident files reviewed do not have individual activity plan includes the interests of the residents. | Ensure that all residents have individual activities plans. | 180 |
| HDS(C)S.2008 | Standard 1.4.3: Toilet, Shower, And Bathing Facilities | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The vinyl in the main bathroom is damaged and cannot be cleaned satisfactorily. This has already been identified by the facility manager/co-owner and she stated that a quote of repair has already been requested. | Ensure that the bathroom vinyl is repaired or replaced. | 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 1.1.1: Consumer Rights During Service Delivery **(**HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a code of rights policy. On interview, all staff (two caregivers, the clinical manager and the activities coordinator) are aware of consumer’s rights and are able to describe how they incorporated consumer rights within their service delivery. Code of Rights is discussed at three monthly resident and three monthly staff meetings. Eight of eight residents and five of five family members interviewed spoke highly of the staff’s respect of all aspects of the code of rights. Code of rights training including last occurred in October 2013. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are posters of the code of rights on display throughout the facility and leaflets in the foyer of the facility. On entry to the service, residents receive an information pack that includes a code of rights information. Large format and Maori information is also available. On interview, all staff (two caregivers, the clinical manager and the activities coordinator) stated that they take time to explain the rights to residents and their family members. Eight of eight residents and five family members confirmed that they had received information about their rights on entry to the service. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service, the clinical manager discusses the information pack with the resident and the family/whānau. This includes the code of rights, complaints and advocacy. On interview, eight of eight residents and five of five family members were able to state their understanding of the code of rights.  Health and disability advocacy service leaflets are on display in the foyer. A brochure advertising the service is also included in the information pack provided to new residents. The service can access local Maori advisory services should this be requested.  D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission information. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of personal property. All eight residents and five family members interviewed indicated staff were highly respectful and maintained resident’s privacy especially when discussing personal issues and those personal belongings are not used as communal property. Privacy training as part of code of rights training was conducted in October 2013. The resident’s initial assessments and care plans detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. All eight residents interviewed stated their needs were met. All five resident files reviewed have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this. There is a policy that describes resident’s spiritual care. Church services are conducted fortnightly with various local church denominations rotating on a roster. All residents and family members interviewed indicated that resident’s spiritual needs are being met when required. On interview all eight residents stated staff respect their rights. There are currently no married couples resident in the facility. The service includes emotional wellbeing in the care planning process. Resident preferences are identified during the admission and care planning processes and family involvement is documented. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered and discussed openly. On interview, all eight residents stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview, two caregivers described how they encouraged residents to engage in activities in the facility and to link with community activities including church and support groups and the RSA. There is a policy that describes abuse and neglect and the topic is covered at orientation and has been addressed at staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Abuse and neglect training has not yet occurred and is planned for 2014 (link 1.2.7.5). Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. Eight residents and five family members interviewed were complementary of the care provided and stated staff were very approachable and friendly D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement (link 1.1.10.2). Personal belongings are documented and included in resident files. D4.1a: Resident files reviewed identified that cultural, spiritual values and individual preferences are identified. |

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

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

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

##### **Criterion 1.1.3.2 (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:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policies/procedures. Staff training includes cultural safety at orientation. There are presently no residents who identify as Maori. Amberley Rest Home identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health policies.  Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Resident admission and on-going assessment (link 1.3.4.2) is undertaken by the clinical manager, with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual’s service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with the clinical manager and two caregivers confirm that they are aware of the need to respond to cultural differences. On interview, all staff were able to identify how to obtain support so that they could respond appropriately. A3.2: There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e). D20.1i: The service has developed a link with local Maori organisations and iwi. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has established cultural policies aimed at helping meet the cultural needs of its residents. There is a Maori health plan. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.  Family are involved in assessment and the care planning process. Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on. Agreement is reached by all parties involved in the consultation process and the care plan is implementation within the service delivery.  D3.1g: The service provides a culturally appropriate service by ensuring initial assessments fully capture residents information regarding culture and beliefs D4.1c: Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a policy that determines a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes covers harassment and exploitation. All residents interviewed reported that the staff respected them. Elderly abuse prevention training occurs at orientation and is scheduled for 2014 (link 1.2.7.5). The clinical manager supervises staff to ensure professional practice is maintained in the service.  Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies to guide practice that align with the health and disability services standards. There is a quality framework that is being implemented that supports an internal audit programme. The caregivers are encouraged to complete ACE training and an internal in-service training programme is beginning to be implemented (link 1.2.7.5).   A2.2: Services are provided at the facility that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. D1.3: All approved service standards are adhered to. D17.7c: There are implemented competencies for RN's and EN's. There are clear ethical and professional standards and boundaries within job descriptions. The new owners have introduced a wide range of improvements since purchasing the facility in June 2013. These include (but are not limited to): • New quality system purchased and implemented 10 July 2013. • New chemical contract with Ecolab as had previously used over the counter cleaning solutions. • The Ace programme has been purchased and commenced by all caregivers. • Medication bib (do not disturb medication round) was purchased to reduce distractions while administering medication. • Seven trailer loads of garden waste removed form gardens. • Regular meetings with residents and staff commenced. • Improved activities programme (confirmed by residents and family). • Refurbishments of exited rooms. • Changed main meal from 5pm to 12noon in order to aid with residents wellbeing and health. • New comprehensive maintenance program implemented and maintained. • Increased correspondence with families in the form of newsletters and registered nurse communication (confirmed by families interviewed). • New dishwasher purchased as had only a sterilizer. • Created a strong working relationship with GP and Amberley Medical Centre. (It had been strained in the past). The GP reports a vastly improved relationship). • Become a lot more involved in the greater community i.e.:- School, other rest homes, a local preschool, local church groups. • New folder implemented containing the documentation required for transfer to hospital. i.e.:- yellow envelope to create a seamless transfer of information. Commenced monthly ‘care coordination meetings’ in January 2014 involving a senior caregiver, the clinical manager and the activities coordinator to improve communication among disciplines around residents. |

##### **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:** |
| Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Twelve incidents/accidents forms were viewed for February 2014. The forms includes a section to record family notification. Four of twelve forms reviewed indicated family were informed or if family did not wish to be informed. The other three forms were for cognitively able residents who have signed as part of the consent form that they only wish to have families notified of serious incidents involving transfer to hospital. On interview eight residents, five family members and two caregivers all stated that family are informed following changes in the resident’s health status. The clinical manager interviewed stated that they record contact with family/whanau in resident’s files. Contact records were documented in all five resident files reviewed.  A residents/relatives meeting occurs three monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan. There is a policy that describes the availability of interpreter services when required.  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: Five of five family members interviewed stated that they are always informed when their family members health status changes. D11.3: The information pack is available in large print and advised that this can be read to residents. |

##### **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:** PA Low |
| **Evidence:** |
| Informed consent and advanced directives policy was issued in July 2013 and complies with current legislative requirements and the Code of Rights. Implementation of these policies are evident in the five resident files reviewed. Advanced directive forms are completed by the residents. Interviews with two caregivers confirmed understanding of informed consent including daily choices and communication. Informed consent is included in the code of rights and advocacy training which was last provided in 2013.  Five family members and eight residents interviewed stated that informed consent and advanced directives discussed with them on entry to the service and reported that they always being provided with plenty of information to allow informed choices. Residents' choices and decisions in terms of medical interventions and preferences for daily living are documented in the care plans and progress records. Amberley has a new admission contract, which complies with ARC contract requirements; however admission agreements are not always signed. |

##### **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:** PA Low |
| **Evidence:** |
| Amberley has a new admission contract, which complies with ARC contract requirements. |
| **Finding:** |
| D13.1- Five out of five files reviewed showed that admission agreements were not signed by the resident or enduring power of authority. Some of these files reviewed showed that the residents were admitted to the service before the business was transferred to the new owners. The facility manager reports that new contract will be distributed to the all residents and families. This is work in progress. |
| **Corrective Action:** |
| Ensure that admission agreements are signed on the day of admission. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an advocacy policy. Staff receive training on advocacy services. Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with two caregivers, eight residents and five family members informed they are aware of advocacy and how to access an advocate. D4.1d: Discussion with five family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.  D4.1e: The resident file includes information on resident’s family/whānau and chosen social networks. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. On interview, all residents and family members confirmed this. The facility engages with other local facilities that provide similar services. D3.1h; Discussion with five family members stated that they are encouraged to be involved with the service and care. D3.1.e: Discussion with all staff and five family members confirm that they are supported and encouraged to remain involved in the community and external groups such as church and RSA visits. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with eight residents and five family members inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints There is a complaints register. A sample of the only two complaints for 2014 (there were none from the commencement of the new owners until the end of 2013) were reviewed. Verbal and written complaints are documented. All complaints are recorded in the complaints register. All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants.  Discussions with eight residents and five family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with two caregivers stated that concerns/complaints were discussed at three monthly staff meetings. D13.3h: A complaints procedure is provided to residents within the information pack at entry. |

##### **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:** |
| Amberley Rest Home is a purpose built facility comprising 12 serviced apartments approved for rest home level care and eight rest home beds. The service has up to 21 beds which includes 12 in the serviced apartments to provide care to residents. The service is currently providing care for 17 residents (including nine in serviced apartments).  The new owners commenced operations in late June 2013. Residents, family, the GP and staff report a greatly improved service under the new owners. Amberley Rest Home has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined.  The quality process being implemented includes regularly review of policies (a new quality system was purchased in July 2013 and at this time no policies have required reviewing), an internal audit programme and a health and safety programme that includes hazard management. Three monthly staff meetings and two monthly management/quality meetings discuss key components of the quality system and any issues are reported (minutes viewed). There is an internal audit schedule that aligns with the business plan and is implemented and a corrective action plan used to manage shortfalls.  The facility manager (who is one of the directors) has many years’ experience in the aged care sector and is supported by a very experienced clinical manager who is a registered nurse with aged care and district nursing experience.  ARC,D17.3di (rest home), The manager has completed 12 hour 1:1 training in MYOB, has received 1:1 mentoring from an external quality consultant and has undertaking mentoring with two other local aged care providers. Job descriptions for all management and the clinical manager positions outline their authority, accountability and responsibility. There is registered nurse cover (the clinical manager) 20 hours per week plus on call as required. |

##### **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 facility manager, the clinical manager oversees the management of Amberley Rest Home.  D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies and quality improvement programme includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a quality framework that is being implemented. The facility manager directly involved in operations at the facility and the clinical manager supports her in this role. There is a current business plan that includes objectives/goals and a quality assurance plan, which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (including two caregivers, the clinical manager and the facility manager); inform an understanding of the quality activities undertaken at Amberley Rest Home. Resident meetings occur three monthly (minutes viewed). Eight of eight residents interviewed are aware meetings are held. Annual satisfaction surveys are undertaken. This occurred in January 2013 and surveys have just finished being returned so are not yet collated. A review of returned surveys shows very positive feedback about the service. All residents and relatives interviewed stated they are regularly asked for feedback regarding the service.   D5.4: The service has policies/ procedures to support service delivery; Policies and procedures align with the client care plans. D10.1: The death of a resident 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 and hazard management. D19.2g: Falls prevention strategies such as physiotherapy reviews, instruction around prevention in care plans and falls risk reviews are in place.  Policies and procedures are in place. As these are new in July 2013, they are not yet due for review. The facility manager and clinical manager manage quality systems. The quality programme is being implemented. Information is reported through the three monthly staff meetings and two monthly management/quality meetings. Meetings discusses key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. . Policy and procedure documents no longer relevant to the service are removed and archived safely. Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. The facility does not use restraint or enablers.  There is a 2013/2014 internal audit programme, which includes all aspects of service delivery and the facility. All issues found in the completed audits have identified corrective action plans and resolutions. Results of audits are discussed in management/quality and staff meetings where appropriate.  All staff interviewed could describe the corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme. Amberley Rest Home has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be well utilised. Two caregivers interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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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 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the clinical manager who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the staff meetings and management/quality meetings.  Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification.  A sample of 12 incidents/accidents from February 2014 were viewed. The facilities policy and procedure on incident management were implemented. 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. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of the clinical manager is current. The service also maintains copies of other visiting practitioner’s certification including GP, pharmacist and dietitian. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, reference checks and training. There is an annual appraisal process in place and appraisals are current in all files reviewed. There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with two caregivers described the orientation programme that includes a period of supervision. The caregivers reported that supervision could be extended if needed. This was verified by the facility manager and the clinical manager. The service has a training policy and a comprehensive schedule for in-service education in 2014 including speakers and dates has been developed. Training in 2013 and 2014 to date has included chemical safety, continence, first aid, rights and advocacy and fire safety. A number of required areas including (but not limited to) infection control, wound management, abuse and neglect, falls prevention, challenging behaviour management and cultural safety are included in the 2014 training plan but have not yet been completed. This is an area requiring improvement. Medication competencies are completed for all caregivers who administer medication. These are checked by the clinical manager. |

##### **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:** PA Low |
| **Evidence:** |
| The service has a training policy and a comprehensive schedule for in-service education in 2014 including speakers and dates has been developed. Training in 2013 and 2014 to date has included chemical safety, continence, first aid, rights and advocacy and fire safety. |
| **Finding:** |
| A number of required areas including (but not limited to) infection control, wound management, abuse and neglect, falls prevention, challenging behaviour management and cultural safety are included in the 2014 training plan but have not yet been completed. |
| **Corrective Action:** |
| Implement the planned training schedule for 2014. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All family members and residents interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the clinical manager will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The clinical manager covers the facility manager during absences and holidays. Residents and relatives interviewed stated they felt there were sufficient staff to meet the needs of residents. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate).  All resident files are hard copy files. Information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident’s files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home level setting. The service keeps a resident register.  Amberley Rest Home has a control of documents and records process that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Hard copy resident files are stored securely and protected from unauthorised access by being held at the nurses’ station in a secured cabinet. Old files are individually archived and locked in a secure area for 10 years Resident records are up to date and reflect residents’ current overall health and care status. Records can be accessed only by relevant personnel. Care plans and progress notes are legible, signed and dated by the staff member recording the information. Medical notes and allied health input are signed and dated appropriately.  D7.1: Entries are legible, dates and signed by the clinical manager or caregiver including designation. |

##### **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:** |
| Residents are assessed prior to the admission to the service by local needs assessors. Interview with the facility manager confirms communication with all appropriate referring agencies prior to the residents’ admission, regarding residents level of care requirements. Resident’s needs assessments are kept in the file. The facility manager stated that prospect consumers are informed of the requirement to have a needs assessment during the enquiry process. The clinical manager stated that many referrals come directly from needs assessors or consumers who already have completed needs assessments.  Four out of five families interviewed confirmed that they were informed about entry criteria to the home prior to entry to the service and one family member interviewed was not involved in the admission process, therefore she was unable to comment. |

##### **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 facility manager stated that if a resident is declined access to the service they will be informed of alternative services available to them and referred back to the original referrer for other options that may assist them to meet their needs. All enquiries are documented by the facility manager and she stated that they have not declined entry to the service since last audit. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Amberley has 21 bed capacity and on the day of audit, there were 17 residents. There is one resident under 65 years of age and this resident is funded by ACC. There are no residents requiring wound care, pressure care or palliative care.   D16.2, 3, and 4: The five files reviewed identified that in all five files an assessment was completed within 24 hours and all five files identified that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the clinical manager and amended when current health changes. The clinical manager (RN) is employed for 20 hours a week and also is on call.  Three out of five care plans evidenced evaluations completed at least six monthly. Two files were not due for review yet.  D16.5e: Five resident files reviewed identified that the GP had seen the resident within two working days. At least three monthly medical reviews are completed. More frequent GP review was evidenced as occurring on review of residents’ files with acute conditions. A range of assessment tools were completed in resident files on admission but re assessments were not always completed six monthly (link 1.3.6.1).  Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Five files reviewed identified integration of allied health and a team approach is evident. There is a contracted GP that visits Amberley at least on a monthly basis or as required. At interview the GP stated that the clinical manager provides timely referrals and her clinical decision is excellent. The GP is available 24 hours a day.  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:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a comprehensive assessment process that was evident in all five resident files reviewed. A number of assessment tools are used to establish levels of support. These include but is not limited to a) continence, b) falls, c) pressure area risk assessment d) nutritional assessment, e) pain assessment) geriatric depression scale g) mobility assessment and behaviour assessment. All five residents’ files reviewed include completed assessment tools and the needs and risks are followed into the care plans. Files reviewed also included medical assessments and physio therapy assessments. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the clinical manager to develop the initial assessment. All resident’ files sampled evidenced an initial assessment and care plan with reference to the information gathered on admission. |

##### **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:** |
| A review of five resident files indicated the use of short term and comprehensive long term care plans, which address all care needs of these residents. These also reflect variances in resident health status. They are current and there is evidence of six monthly reviews. The care plan is completed within three weeks by the clinical manager, providing a holistic approach to care planning with resident input ensuring a resident focussed approach. Care plans are individualised and were evident of having recently been updated.  D16.3k, Short term care plans are in use for changes in health status.  D16.3f; Five of five resident files reviewed had documented evidence of family involvement.  Five residents file reviewed showed that interventions that is to be provided by the staff is current, and there is evidence of discussions by residents and family members. Two caregivers interviewed confirm that care plans are accurate and up to date. Amberley ensures access to regular GP and this is confirmed at the GP interview. |

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Amberley provides services for residents requiring rest home level of care and the care being provided is consistent with the needs of residents. This is evidenced through interviews with the clinical manager, two caregivers, families, eight residents. Care plans reviewed were well written, comprehensive and provide clear direction to staff.  Amberley has residents with low acuity level and all residents are mobile with or without a mobility device. Five residents files reviewed evidence de-escalation of challenging behaviour, appropriate management of insulin dependent diabetes, proper management of high falls risk and monitoring, and a timely response to chest pain.  Family communication and involvement in care is very well documented. Five families and eight residents interviewed confirmed their current care and treatments meet their needs. The staff are observed to be very caring towards residents who are well looked after. A review of long term care plans, short term care plans, evaluations and progress notes demonstrate integration. The clinical manager is responsible for the education programme and ensures that all staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the clinical manager. Care delivery is recorded and evaluated by caregivers on each shift and this evidenced in all five residents' progress notes. When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral. Staff are considerate of residents' needs as evidenced on the day of audit. Residents’ weight is recorded on admission and monitored monthly. An audit was completed in January 2014 around weight monitoring.  D18.3 and 4 Dressing supplies are available and staff interview confirm adequate continence and dressing supplies. On the day of audit, there are no residents requiring wound care. The clinical manager interviewed described the referral process and related form for referral to a wound specialist or continence nurse if required. Staff received training around continence management but wound care training was not provided (link 1.2.7.5). The audit identified an improvement requiring around on going assessment process. |

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A review of long term care plans, short term care plans, evaluations and progress notes demonstrate integration. The clinical manager is responsible for the education programme and ensures that all staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the clinical manager. Care delivery is recorded and evaluated by caregivers on each shift and this evidenced in all five residents' progress notes. When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral. Staff are considerate of residents' needs as evidenced on the day of audit. Residents’ weight is recorded on admission and monitored monthly. An audit was completed in January 2014 around weight monitoring.  D18.3 and 4 Dressing supplies are available and staff interview confirm adequate continence and dressing supplies. On the day of audit, there are no residents requiring wound care. The clinical manager interviewed described the referral process and related form for referral to a wound specialist or continence nurse if required. Staff received training around continence management but wound care training was not provided (link 1.2.7.5). |
| **Finding:** |
| Three of five files reviewed showed that continuing needs/risk assessments are not carried out. Two files were not due for re-assessment yet. |
| **Corrective Action:** |
| Ensure that on-going assessments are completed when care plans are reviewed. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Amberley employs an activities coordinator who also has an administrator role. Activities offered 2-3 hours a day and additional hours available for outings. Caregivers also involved in providing the program. The programme varies and is based on resident’s capabilities and interests. Daily activities are noted on the white board.  Individual activities assessment are completed with residents and their families. These includes significant life events, past occupations, places lived, hobbies and interests, favourite activities. A record of attendance is maintained. Residents interviewed spoke very positively of the programme and stated that they are able to provide feedback and suggestions for activities.  A range of activities are available and these include the involvement of the residents into the community. Resident interviews confirm that the programme reflects resident’s interest in the environment and they have choice in their level of participation. However the audit identified an improvement requiring around documentation of individual activities plan. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Amberley employs an activities coordinator who also has an administrator role. Activities offered 2-3 hours a day and additional hours available for outings. Caregivers also involved in providing the program. The programme varies and is based on resident’s capabilities and interests. Daily activities are noted on the white board.  Individual activities assessment are completed with residents and their families. These includes significant life events, past occupations, places lived, hobbies and interests, favourite activities. A record of attendance is maintained. Residents interviewed spoke very positively of the programme and stated that they are able to provide feedback and suggestions for activities. |
| **Finding:** |
| D16.5d Five of five resident files reviewed do not have individual activity plan includes the interests of the residents. |
| **Corrective Action:** |
| Ensure that all residents have individual activities plans. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.4a Long term care plans are evaluated at least six monthly, or when health care changes occur.  Detailed assessment tools are utilised on admission. Staff interview confirmed that they were informed of changes. Care plan audit was completed February 2014 and required corrective actions are completed.  There is documented evidence of GP review at least every three months and on an as required basis. Although clinic assessments were not always documented (link 1.3.6.1), there is documented evidence of alteration to the long term care plans following review of care needs where there were changes in the resident’s health status and care needs prior to the full care plan review. Short term care plans are instigated at times when health is compromised such as infections, wound care and high falls risk.  D16.3c: Long term care plans are developed by the clinical manager within three weeks of admission.  Families (five) state they are supportive of the care provided and that the needs of their family member are being met. Residents (eight) state that the staff are very approachable and very happy with the care they receive. |

##### **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:** |
| Document review showed that referral to another health and disability services occur. Two out of five residents’ files had evidence of referral to and from other health services such as the local DHB specialists, ACC and psychogeriatric services. An effective multi-disciplinary team approach is maintained. Progress notes and medical notes detail relevant processes, which are implemented. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies and procedures to guide staff for a safe coordinated discharge process. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. The service uses yellow envelops during transfer to the another service ensuring that all relevant information are provided such as the transfer form, medication charts, consent forms and advanced directives.  Family members are involved at all stages of the transfer and discharge processes. Document review and the family interview confirmed this occurs. |

##### **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:** FA |
| **Evidence:** |
| The medicine management system complies with current legislative requirements and safe practice guidelines. Amberley uses the blister pack medicine dispensing system and all medications are checked by the clinical manager on arrival. Medicine competent caregivers administer medication and the clinical manager advised that 90% of the staff are medicine competent. Sample files (five) reviewed showed that medicine competencies are maintained yearly.  Medications are kept in the locked medication room or locked medication trolley.  Controlled drugs are stored safely and there is one resident using a controlled drug on the day of audit. Controlled drugs and the controlled drug book are audited and the controlled drug count was found to be correct.  Administration of medication at midday was observed by the auditors and safe practice guidelines are implemented.  There are no expired medications. All eye drops are dated on opening. PRN medications administered are dated and timed.  Medication charts have been reviewed three monthly by the GP and this was evident in all medication charts reviewed.  A procedure is in place for the self-administration of medicines. Clinical manager confirmed that there is one resident who self-medicates. This resident is under 65 years of age and maintains current medicine competency. The clinical manager stated that self-medication is monitored and recorded in the medication file on a daily basis. These are sighted in the medication folder. Medication charts and signing records are legible, signed, dated and written in ink. Each prescription entry is signed by the GP. Specimen signatures are recorded. Ten residents’ medication charts viewed confirmed this. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Amberley employs two cooks and two kitchen hands who prepare all meals on site. The night caregiver prepares food at the beginning of the shift for the main meal that is served at lunchtime. The kitchen opens to the dining room and food directly served to residents from the kitchen. There is a designated cleaning roster and cleaning equipment for the kitchen. Storage of food is appropriate and fridge/freezer and food temperatures are monitored and are within the required range. There is a five weekly rolling winter and summer menu that is reviewed by a registered dietician on16 September 2013 and recommendations are followed up. Each resident has an individual nutritional assessment on admission. Those assessed with requiring special or modified diets have these needs met. Residents with food allergies have these documented.  Interview with kitchen staff confirmed that they have completed food handling training but the facility manager is unable to locate their certificate therefore they are all booked to undertake training on 3 April 2014.  Residents interviewed expressed satisfaction with the food services.  The clinical manager stated that food supplements are provided as required and currently there is no resident requiring special diets. Drinks are provided for residents throughout the day. Weight monitoring and nutritional assessments are completed. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Amberley has waste management policies and procedures for the safe disposal of waste and hazardous substances. There is an incident reporting system that includes investigation of these types of incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. |

##### **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:** |
|  |
| **Corrective Action:** |
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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 building has current warrant of fitness. There is a maintenance plan 2014 and one of the co-owners undertakes maintenance work and the gardening. He works one a day week and weekends. Any maintenance requirements identified by staff are brought to the owner’s attention for action. Residents and staff interview confirmed that any repairs/maintenance is appropriately actioned (link 1.4.3). Electrical testing tags on several items of electrical equipment were observed. Corridors allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails are appropriately located around the hallways and in the bathrooms. On the day of audit, auditors observed that residents are using their mobility device safely and one resident with motorised wheelchair was observed to be considered towards other’s safety. Safe use of mobility device is monitored and documented in the resident’s file. Residents interviewed confirmed the internal and external environment of the facility is appropriate to their needs and aids their independence. Staff interviewed stated that since the new owners took over the business, several equipment is replaced including kitchen equipment and utensils. The new owners have purchased new bed linen and completed painting work within the facility.  There is adequate access to safe outdoors areas and shade is provided. |

##### **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:** PA Low |
| **Evidence:** |
| The 12 licence to occupy units have a full ensuite of shower, toilet and basin. The nine rest home bedrooms have hand basin. There is a full access shower toilet bathroom and two toilets for communal use. The audit identified that the bathroom vinyl is in need of repair. |

##### **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:** PA Low |
| **Evidence:** |
| The 12 licence to occupy units have a full ensuite of shower, toilet and basin. The nine rest home bedrooms have hand basin. There is a full access shower toilet bathroom and two toilets for communal use. |
| **Finding:** |
| The vinyl in the main bathroom is damaged and cannot be cleaned satisfactorily. This has already been identified by the facility manager/co-owner and she stated that a quote of repair has already been requested. |
| **Corrective Action:** |
| Ensure that the bathroom vinyl is repaired or replaced. |
| **Timeframe (days):** 90 *(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 rest home and units have sufficient space to allow residents to mobilise independently in their rooms. There is sufficient space to allow residents to be moved between rooms in an ambulance stretcher if required. Two caregivers interviewed stated there was sufficient room to move around personal space with resident’s mobility devices. One resident is observed using motorised wheelchair within the facility. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a separate lounge and dining area. There are other seating areas for privacy and relaxation and every resident has a personal bedroom for private interactions. Eight residents interviewed confirmed that they are happy with the communal areas provided and meet their needs. |

##### **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:** |
| There is a small laundry and clean and dirty area is clearly labelled. All laundry is done on site and a laundry staff is employed for 10 hours a week. Some of the laundry is completed by the caregivers when they completed care duties. Staff use appropriate personal protection equipment in the laundry. Amberley Rest Home has policies and procedures for effective management of laundry and cleaning. Laundry and cleaning processes are monitored for effectiveness by internal audits, which were last completed on 24 February 2014.  Use of chemicals are monitored by Eco Lab and Material safety data sheets (MSDS) are located in the laundry. There are designated areas for storage of cleaning/laundry chemicals in the laundry and where the cleaning trolley is stored. These are separated from resident access by a locked stable door. |

##### **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:** |
| Fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence boxes are available (sighted). The staff stated that they have spare blankets and alternative cooking methods if required. There is sufficient water stored to ensure for three litres per day for three days per resident. The staffing level provided adequate numbers of staff to facilitate safe care to rest home level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme on 23 October 1987. There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse on site available and /or on call to all residents 24 hours per day, seven days per week. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. |

##### **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:** |
| Amberley Rest Home is heated by centrally controlled under floor heating with bedrooms having individually thermostatic controls. All areas of the facility are well heated and ventilated. Main lounge area has a wood burner. Rest home bedrooms have large windows and units have glass sliding doors with an opening window. |

##### **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 policy and manual with associated procedures and templates. The policy states that the use of restraints is kept to a minimum and that care staff who may be involved in restraint and enabler use have sufficient knowledge and skill to be able to ensure resident safety. The restraint policy and procedure includes definitions such as use of restraint, types of restraint permitted, use of enablers, enablers permitted, client rights, assessment, discussion, restraint alternatives, monitoring and removal. The service does not currently use restraints or enablers. The service identifies enablers as items, which are voluntarily used for safety. The restraints policy defines enablers as being voluntary use of equipment e.g. for safety for the resident. Restraint minimisation and challenging behaviour training has not yet occurred (link 1.2.7.5).  The service has clear documentation to guide staff in the use of restraint and enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The role of the infection control (IC) coordinator is held the clinical manager who is an RN and has been in the post since the change of ownership in June 2013. The IC coordinator can access external specialist advice from GP's, laboratories and DHB IC specialists when required. The IC programme is appropriate for the size and complexity of the service. The programme is approved and the clinical manager reports it will be reviewed annually by the coordinator and facility manager and external expertise when required (the programme has not yet been operational for a year). IC is a standing agenda item at the three monthly staff meetings and two monthly management/quality meetings (minutes viewed). Staff are informed about IC practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC coordinator and entered into the infection register.  There is a job description for the IC coordinator including the role and responsibilities of the position. IC is part of the audit schedule and is undertaken six monthly. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine. |

##### **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 clinical manager is the IC coordinator. IC matters are taken to all staff and management/quality meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. The coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Access to specialists from the DHB, laboratories and GP’s is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Amberley Rest Home has infection control policies and an infection control manual, which reflect current practise. The IC programme defines roles and responsibilities of the IC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator. The IC coordinator can access external specialist advice to do this. D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The IC coordinator is the clinical manager (RN), who has undertaken specialist IC training in the form of a three-day block course as part of her postgraduate diploma in gerontology. . All new staff receive infection control education at orientation including hand washing and preventative measures. The clinical manager has developed a comprehensive staff infection control-training programme. This is scheduled to be implemented in March 2014 (link 1.2.7.5). Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents.  The IC coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the three monthly staff and two monthly management/quality meetings (minutes viewed). The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. Internal audit of infection control is included in the annual programme and occurs six monthly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting. |

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

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

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

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

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

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