

Milton Adams Limited

Current Status: 7 April 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

Cromwell House Hospital is a 47 bed aged care facility providing rest home, hospital and dementia care. The facility is privately owned and operated. On the day of audit there were 18 residents receiving hospital level care, four residents receiving rest home level care and 19 receiving dementia care, making the total 41. There have been no changes in the facility, staffing structure, management or systems since the last audit.

There is evidence that indicates the residents are treated with respect and dignity and have their rights upheld. An expected level of care and support is being provided, which is endorsed by the fact that there are no areas of improvement identified in consumer rights, restraint minimisation and infection prevention and control. However, five areas for improvement have been identified. Two relate to human resources, one relates to medicine management and two relate to the environment.

Audit Summary as at 7 April 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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 7 April 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 7 April 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 7 April 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 7 April 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Restraint Minimisation and Safe Practice as at 7 April 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 7 April 2014

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.
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Audit Results as at 7 April 2014

Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and services provided, is fully available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Staff training takes place on an annual basis, reinforcing delivery of care based on the rights of the residents and their family and their freedom of choice. Staff are aware of the need to offer as much choice as possible to residents given that most have dementia or diminished competence to make choices.

Complaints processes are implemented and complaints and concerns are actively managed with evidence of resolution of issues raised.

Residents and family interviewed praised the care provided and particularly state that staff are approachable with excellent support provided.

Organisational Management

Cromwell House Hospital is governed by three directors. The purpose, values, scope, direction and goals of the organisation are displayed and reflect the services provided. Day to day operations are the responsibility of the facility manager who has appropriate skills and experience.

The organisation has a quality and risk management system that is monitored and reviewed to generate improvements in practice. The required policies, procedures and work instructions are in place and accessible. Goals for quality are defined and achievement towards these are reported and communicated during regular staff meetings and manager reports. The organisation also implements an internal monitoring programme and corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The risk management and adverse event reporting system is well documented and managed.

Human resource management and employment policies are in place. There is a system for validating professional qualifications. Staffing is appropriate to meet the needs of residents over the 24 hours with experienced advice and assistance available. Sufficient orientation/induction is in place, however this has not extended to cleaning staff and an improvement is required.

There is a comprehensive in-service education programme that meets requirements and covers relevant aspects of care and support. Staff performance is monitored through annual performance appraisals. An additional improvement is required to ensure that evidence of appraisals is consistently maintained.

Resident records are secure and well maintained..

Continuum of Service Delivery

The service has admission and entry policies and procedures. Needs assessment approval is required prior to entry for rest home, hospital or dementia level of care. Service information is made available in the facility brochures and information sheets. The sample of resident records reviewed provide evidence that the registered nurse completes an initial assessment and care plan on admission with the long term care plan documented in the first three weeks. There is also comprehensive documentation of the activities assessment and plan with strategies to manage any challenging behaviour well documented. There is evidence of family participation in the development and six monthly review of the care plans. Care plans demonstrate service integration and guide all staff in cares. The diversional therapist oversees the activities programme with an individual 24-hour plan in place for all residents in the dementia unit and an afternoon and morning plan in place for other residents.

The general practitioner examines the resident within 48 hours of admission and monthly thereafter for residents in the hospital and three monthly at least for residents in the rest home or dementia unit. All residents are assessed by the physiotherapist on admission with ongoing review for those residents requiring this through weekly visits by the physiotherapist.

There are policies and procedures for medicine management and staff responsible for the administration of medicines completes annual medication competencies and education.

An improvement is required to transcribing of instructions for administration of medication.

Meal services are outsourced to Spotless with an experienced chef overseeing all aspects of the ordering, preparation and serving. All food is cooked on site and residents' nutritional needs are identified and accommodated with alternative choices provided. Meals are well presented with menu plans reviewed by a dietician. All residents and family interviewed praised the food service.

Safe and Appropriate Environment

The facility is appropriate to the needs of the residents and fit for purpose. There are two buildings on site. One building is for hospital residents and the other accommodates the rest home area and the secure dementia unit.

The buildings, facilities, furnishings and equipment are well maintained and suitable for the care and support of the residents. Applicable building regulations and requirements are met.

Well-furnished lounges, dining areas and safe external areas are accessible to all residents. Both buildings have plenty of natural light and are maintained at a comfortable temperature. All bedrooms are of sufficient size to allow for personal possessions and to accommodate mobility aids, equipment and staff caring for the resident. Additional thought has gone into ensuring the

dementia unit supports a safe and stimulating environment for the residents. This includes the use of colour, tactile and sensory areas.

Toilet, shower and bathing facilities are sufficient in numbers and adequately equipped and furnished. The temperature of hot water is monitored, however an improvement is required to ensure remedial actions are taken in the event the temperature exceeds acceptable levels.

Laundry services are contracted to an external provider and monitored for effectiveness. Cleaning services are provided in house and meet infection control requirements. The collection, storage and disposal of waste is in accord with local body requirements.

Processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency, however the call system in the dementia unit requires an improvement to ensure it is more consistent and working effectively. There are adequate numbers of staff trained in first aid and emergency situations on duty at all times. The organisation has appropriate stores and equipment in the event of a civil defence emergency or a pandemic.

Restraint Minimisation and Safe Practice

Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate that residents are experiencing services that are the least restrictive. On the day of audit there are three residents assessed as requiring the use of a lapbelt. The service has processes in place for determining restraint approval, consent from family and evidence of a comprehensive assessment and restraint plan with review completed monthly. Staff interviewed and files sampled evidence responsibilities are clearly identified and known. Resident files show that there is family input into the restraint approval processes. Staff have training in managing challenging behaviour and were observed to be skilled in the use of de-escalation.

Infection Prevention and Control

The infection control programme is clearly documented and is suitable for the facility. The infection control programme is reviewed on an annual basis. One of the clinical leaders is responsible for the facilitation and implementation of the infection control programme and staff are aware of their responsibilities, including reporting residents suspected of having an infection.

Infection prevention and control policies and procedures are sufficient and aligned with current accepted practice. Staff interviewed confirm access to the required procedures and resources. Training on infection prevention and control is provided in an ongoing manner.

Infection control surveillance is occurring for residents who develop infections. The surveillance programme is appropriate to the service setting and benchmarking is conducted with other related providers. Overall infection rates are low and trends are communicated at staff meetings, management and board reports. The use of antibiotics is monitored to ensure appropriateness.

The organisation had an outbreak of scabies in November 2013 which was well managed, contained and reported to the appropriate authorities.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Milton Adams Limited
Certificate name:	Milton Adams Limited
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Certification Audit
Premises audited:	Cromwell House Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 April 2014 End date: 8 April 2014
Proposed changes to current services (if any):	
	Dementia Services are also included
Total beds occupied across all premises included in the audit on the first day of the audit:	41

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	12
Other Auditors	XXXXX	Total hours on site	12	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	3

Sample Totals

Total audit hours on site	24	Total audit hours off site	23	Total audit hours	47
Number of residents interviewed	3	Number of staff interviewed	11	Number of managers interviewed	1
Number of residents' records reviewed	7	Number of staff records reviewed	8	Total number of managers (headcount)	1
Number of medication records reviewed	15	Total number of staff (headcount)	35	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) 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 Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Monday, 14 April 2014

Executive Summary of Audit

General Overview

Cromwell House Hospital is a 47 bed aged care facility providing rest home, hospital and dementia care. The facility is privately owned and operated. On the day of audit there are 18 residents receiving hospital level care, four residents receiving rest home level care and 19 receiving dementia care, making the total 41. There have been no changes in the facility, staffing structure, management or systems since the last audit.

There is evidence that indicates the residents are treated with respect and dignity and have their rights upheld. An expected level of care and support is being provided, which is endorsed by the fact that there are no areas of improvement identified in consumer rights, restraint minimisation and infection prevention and control. However, five areas for improvement have been identified. Two relate to human resources, one relates to medicine management and two relate to the environment.

Outcome 1.1: Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and services provided, is fully available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Staff training takes place on an annual basis, reinforcing delivery of care based on the rights of the residents and their family and their freedom of choice. Staff are aware of the need to offer as much choice as possible to residents given that most have dementia or diminished competence to make choices. Complaints processes are implemented and complaints and concerns are actively managed with evidence of resolution of issues raised. Residents and family interviewed praised the care provided and particularly state that staff are approachable with excellent support provided.

Outcome 1.2: Organisational Management

Cromwell House Hospital is governed by three directors. The purpose, values, scope, direction and goals of the organisation are displayed and reflect the services provided. Day to day operations are the responsibility of the facility manager who has appropriate skills and experience.

The organisation has a quality and risk management system that is monitored and reviewed to generate improvements in practice. The required policies, procedures and work instructions are in place and accessible. Goals for quality are defined and achievement towards these are reported and communicated during regular staff meetings and manager reports. The organisation also implements an internal monitoring programme and corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The risk management and adverse event reporting system is well documented and managed.

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There is a comprehensive in-service education programme that meets requirements and covers relevant aspects of care and support. Staff performance is monitored through annual performance appraisals. An additional improvement is required to ensure that evidence of appraisals is consistently maintained.

Resident records are secure and well maintained.

Outcome 1.3: Continuum of Service Delivery

The service has admission and entry policies and procedures. Needs assessment approval is required prior to entry for rest home, hospital or dementia level of care. Service information is made available in the facility brochures and information sheets. The sample of resident records reviewed provide evidence that the registered nurse completes an initial assessment and care plan on admission with the long term care plan documented in the first three weeks. There is also comprehensive documentation of the activities assessment and plan with strategies to manage any challenging behaviour well documented. There is evidence of family participation in the development and six monthly review of the care plans. Care plans demonstrate service integration and guide all staff in cares. The diversional therapist oversees the activities programme with an individual 24-hour plan in place for all residents in the dementia unit and an afternoon and morning plan in place for other residents. The general practitioner examines the resident within 48 hours of admission and monthly thereafter for residents in the hospital and three monthly at least for residents in the rest home or dementia unit. All residents are assessed by the physiotherapist on admission with ongoing review for those residents requiring this through weekly visits by the physiotherapist. There are policies and procedures for medicine management and staff responsible for the administration of medicines completes annual medication competencies and education. An improvement is required to transcribing of instructions for administration of medication. Meal services are outsourced to Spotless with an experienced chef overseeing all aspects of the ordering, preparation and serving. All food is cooked on site and residents' nutritional needs are identified and accommodated with alternative choices provided. Meals are well presented with menu plans reviewed by a dietician. All residents and family interviewed praised the food service.

Outcome 1.4: Safe and Appropriate Environment

The facility is appropriate to the needs of the residents and fit for purpose. There are two buildings on site. One building is for hospital residents and the other accommodates the rest home area and the secure dementia unit.

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Well-furnished lounges, dining areas and safe external areas are accessible to all residents. Both buildings have plenty of natural light and are maintained at a comfortable temperature. All bedrooms are of sufficient size to allow for personal possessions and to accommodate mobility aids, equipment and staff caring for the resident. Additional thought has gone into ensuring the dementia unit supports a safe and stimulating environment for the residents. This includes the use of colour, tactile and sensory areas.

Toilet, shower and bathing facilities are sufficient in numbers and adequately equipped and furnished. The temperature of hot water is monitored, however an improvement is required to ensure remedial actions are taken in the event the temperature exceeds acceptable levels.

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Processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency, however the call system in the dementia unit requires an improvement to ensure it is more consistent and working effectively. There are adequate numbers of staff trained in first aid and emergency situations on duty at all times. The organisation has appropriate stores and equipment in the event of a civil defence emergency or a pandemic.

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	There is currently no formal process of induction/training for cleaning staff. This includes the management of waste and hazardous substances, emergency procedures, infection control and management of challenging behaviour.	Develop a formal process of induction/orientation for domestic staff and maintain records of same.	60
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	Evidence of annual performance appraisals has not been maintained in three out of eight staff records sampled.	Maintain evidence of annual performance appraisals	60
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Four of the 15 medication files reviewed have transcribing noted on the PRN charts.	Cease the practice of transcribing.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	The system for reporting hot water temperatures does not ensure corrective actions are implemented if the temperature exceeds a safe level.	Implement the system for reporting variance when hot water exceeds the acceptable temperature.	60
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.7.5	An appropriate 'call system' is available to summon assistance when required.	PA Moderate	Although there are security cameras in the dementia unit the call system is inconsistent and not working effectively in some areas.	Explore options for a more consistent call system in the dementia unit	60

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA
Evidence: Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The service provides families and residents with information on entry to the service and this information contains details relating to the Code. Staff receive training for rights at induction and ongoing – last provided in March 2014. Discussions with staff including four care assistants (AM/PM/night) and two clinical leaders (registered nurses) show an understanding of the key principles for the Code in providing services. Residents in all areas have either a degree of dementia or are unable to verbalise their satisfaction. One resident in the rest home was able to state that the 'place is nice and staff are good'. Another resident in the dementia unit states that the service is lovely. Seven of seven family interviewed state that resident rights are upheld and staff treat residents with respect and dignity. This is observed on the day of the audit. The District Health Board contract requirements are met.

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.

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

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

Standard 1.1.2: 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

Attainment and Risk: FA

Evidence:

There is a welcome information booklet/folder that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident (as able), family and, as appropriate, their legal representative.
On-going opportunities occur via regular contact with family to discuss any issues as they arise.
Advocacy pamphlets are clearly displayed on the noticeboard with the Code displayed in English and Maori. Advocacy is brought to the attention of residents (as able) and families at admission and via the resident meetings as sighted in meeting minutes.
Interviews with family members confirms that information has been provided around advocacy.
The information pack provided to residents and family on entry includes how to make a complaint, the Code pamphlet, advocacy pamphlet.
The District Health Board contract requirements are met.

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.

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 1.1.2.4 (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.

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

Standard 1.1.3: 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

Attainment and Risk: FA
Evidence: <p>The facility provides physical, visual, auditory and personal privacy for residents. During the visit, staff demonstrated gaining permission prior to entering resident private areas. Four care assistants interviewed describe ensuring privacy by knocking before entering. The service has a policy in place that includes that personal belongings are not used as communal property. Values and beliefs information and resident preferences are gathered on admission with family involvement and information is integrated with the resident care plans. This includes cultural, religious, social and ethnic needs. Interviews with four healthcare assistants identified how they get to know resident values, beliefs and cultural differences. Family interviewed confirm that the privacy and dignity of their family member is upheld and independence encouraged. All state that the service is excellent with family describing a focus on upholding values. There are fortnightly visits by the Catholic priest and other church minister's visit as required. Residents are encouraged to attend church in the community whenever possible with family members. Interviews with family members confirm that the service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Four care assistants describe providing choice including what to wear, food choices, how often they want to shower, activities and whether they want to be involved in activities. There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training. Abuse and neglect training was last delivered in February 2014 and staff interviewed including the clinical leaders and care assistants confirm that there is no evidence of a abuse and neglect. All files reviewed (seven including three dementia, three hospital, one rest home) confirm that there is a holistic approach to documentation of assessments and plans. In the dementia unit (and throughout the service), families state that their family member was welcomed and personal pictures were put up to assist them to orientate to</p>

their new environment.

The District Health Board contract requirements are met.

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.

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.

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 1.1.3.6 (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.

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

Criterion 1.1.3.7 (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.

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

Standard 1.1.4: 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

Attainment and Risk: FA

Evidence:

There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori.

Staffs receive cultural training in June 2013. Cultural needs and support is identified in care plans.

There is a Maori health plan includes a description of how they will achieve the requirements identified in the contract.

The policies for Māori identify the importance of whānau and four care assistants and two clinical leaders interviewed discussed the importance of family involvement.

Discussion with seven family members confirms that they are regularly involved.

The service has developed a link with a kuia and kaumatua who provide support for the residents during the week.

There are no Maori staff currently although one Pacific Island staff member (Cook Island) states that she can understand Maori through speaking Cook Island Maori.

There are no Maori residents in the service.

The facility manager has completed a course in tikanga Maori through a local District Health Board.

The District Health Board contract requirements are met.

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.

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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

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

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

Criterion 1.1.4.5 (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.

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

Standard 1.1.6: 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

Attainment and Risk: FA

Evidence:

The service implements policies about recognition of individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences and four of four healthcare assistants can describe how they manage resident individual needs.

The service provides a culturally appropriate service by asking residents and family members what their cultural needs are at each assessment and including any needs in the plan and review. Values and beliefs information is gathered on admission with family involvement and is integrated into residents' care plans (sighted in seven resident care plans: three hospital, one rest home, three dementia).

Seven of seven files reviewed include the resident's social, spiritual, cultural and recreational needs.

During the admission process, a registered nurse (usually the clinical leader unless after hours) along with the resident whenever possible and family whenever possible complete the documentation and this includes recognition of the resident culture, values and beliefs.

Seven of seven family members interviewed state that their staff are supportive and caring and there is a general calm feel to the environment in all areas and particularly the dementia unit.

The District Health Board contract requirements are met.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Staff employment policies/procedures include guidelines around receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings.

Two clinical leaders and the facility manager interviewed are able to describe appropriate boundaries between staff and residents and their families.

A review of incident forms do not identify any incidents related to discrimination.

Family state that there is no evidence of discrimination (all state that the opposite is in fact true and they state that residents are fully supported despite differences).

Care plans reviewed (seven of seven) include the residents social, spiritual, cultural and recreational needs.

Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with care assistants in the dementia unit can describe how they build a supportive relationship with each resident. Interviews with four family from the dementia unit confirm the staff assist to relieve anxiety and manage any challenging behaviour well.

The District Health Board contract requirements are met.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.8: 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

Attainment and Risk: FA

Evidence:

Services are provided at Cromwell House that adhere to the health and disability services standards. There is an implemented quality improvement programme that includes performance monitoring.

Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of review.

There is a strong commitment to staff development by way of education and in-service training. Staff in the dementia unit have training in or are in the process of training in the dementia standards.

All approved service standards are adhered to with this certification audit noting that there are some requirements as part of the certification audit.

Seven of seven family interviewed praised the service for the support provided.

There are implemented competencies for care assistants and registered nurses including medication, restraint, blood sugar levels (care assistants only). There are clear ethical and professional standards and boundaries within job descriptions with a signed code of conduct.

The service benchmarks infection control data, incidents and accidents with other rest homes.

The service is taking on board new initiatives e.g. using a new incident management system from the local District Health Board and this enables staff to conduct comprehensive collation and trend analysis. The service is part of a pilot for this (refer 1.2.4).

The clinical leaders and registered nurses have links with other health care professionals e.g. the physiotherapist who visits weekly, dietician (as required), podiatrist (as needed and six monthly), community mental health nurses, nurse practitioners from the hospital, infection control nurse specialist, wound specialist, hospice etc.

The clinical leaders and the facility manager attend the District Health Board/rest home/hospital/dementia unit cluster meetings monthly to discuss falls, incidents etc.

The District Health Board contract requirements are met.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with family including if an incident or care/medical issues arise.

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 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.

Seven of seven relatives state that they are always informed when their family members health status changes.

The information pack is available in large print and advised that this can be read to residents.

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service.

Interviews with three caregivers (with staff across AM, PM and night shifts) identify that consents are sought in the delivery of personal cares and this is confirmed by three residents interviewed.

Incident forms reviewed indicate that family are informed following an incident (15 of 15 reviewed).

There are no residents currently who identify as requiring an interpreter however the staff are able to describe how an interpreter would be accessed.

Information around the dementia unit is provided to family, friends and visitors visiting the facility.

The District Health Board contract requirements are met.

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

Standard 1.1.10: 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

Attainment and Risk: FA
Evidence: <p>Residents and their families are provided with all relevant information on admission. Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services. Informed consent obtained includes the following: consent for sharing of information, consent for care and treatment, indemnity and outing consent with a copy in the activities folder. There is a consent for non-routine treatment or procedure completed e.g. for the flu injection. Specific consents obtained for procedures such as influenza vaccines have emails attached from family members/enduring power of attorney agreeing to have the vaccination. There are no advance directives used as there are no current residents identified as being competent to have a resuscitation order. Six of seven admission agreements sighted have all been signed on the day of admission. One file was signed five days after admission noting that the resident had entered the service in 2008. Discussion with three residents (brief interactions only) and seven relatives identify that the service actively involves them in decisions that affect their lives. The District Health Board contract requirements are met.</p>

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.

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 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

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

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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

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

Attainment and Risk: FA
Evidence:

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

Standard 1.1.11: 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

Attainment and Risk: FA
Evidence: Advocacy information is part of the service entry package and is on display on noticeboards and at reception in the facility. The right to have an advocate is discussed with residents and their family during the entry process and relative or nominated advocate is documented on the front page of the resident file as confirmed by the seven family interviewed. Discussion with seven of seven family interviewed (one rest home, two hospital and four dementia) identifies that the service provides opportunities for the family/EPOA to be involved in decisions. The residents' file includes information on residents family/whanau and chosen social networks as sighted in seven of seven files reviewed (three hospital, three dementia and one rest home). The District Health Board contract requirements are met.

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.

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

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

Standard 1.1.12: 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

Attainment and Risk: FA

Evidence:

The service has visiting arrangements that are suitable to residents and family/whānau.

Families and friends are able to visit at times that meet their needs.

Discussion with seven of seven families indicates that they are encouraged to be involved with the service and care including being informed of care planning reviews with an invitation to participate. One family member in another part of New Zealand states that the facility manager has gone out of the way to provide the family with information around their relative's condition and has taken time to give the information in a way that they understand.

Discussion with staff and relatives indicates that they are supported and encouraged to remain involved in the community if and when possible with outings held for residents to go out.

Visiting in the service can occur at any reasonable time.

Interviews with seven relatives confirm visitors are welcome, are included in discussions and asked if they would like a cup of tea and visitors were sighted coming and going on the days of the audit and engaging in activities with the resident.

Progress notes document family visits and all family state that they are informed at the earliest opportunity after there has been an incident. Twenty-four incident forms reviewed all confirm that family are notified after an incident.

The District Health Board contract requirements are met.

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

Consumers have access to visitors of their choice.

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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The complaints process is easily accessible to residents and families. Policies and procedures comply with Right 10 of the Code. There have been two complaints in the last 12 months. Records sighted confirm that both complaints were well managed and resolved in a timely manner, to the satisfaction of the complainant. Staff interviewed are well versed in the complaints process and support residents and families to voice their concerns. A complaints register is sighted. The register includes the dates and actions taken.</p> <p>The District Health Board contract requirements are met.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: The mission, vision and goals of the organisation are displayed and documented. The organisation is privately owned/operated and governed by the directors. The facility manager develops the annual business plan, organisational risks and quality goals. These are approved by the directors. Organisational performance is monitored regularly through monthly board reports (sighted). These report on all quality related data, staffing, occupancy, risks and key components of service delivery.

Day to day operations are the responsibility of the facility manager. The facility manager is on site five days per week. The facility manager has experience relevant to support for the older person and business management and is able to show evidence of exceeding the required eight hours annually of professional development activities related to the aged care sector.

The facility manager's curriculum vitae and job description are sighted and confirm accountabilities, authorities and responsibilities. The current organisational chart also confirms authorities and reporting lines throughout the organisation. The facility manager's performance is monitored by the directors and the annual performance appraisal is sighted.

The District Health Board contract requirements are met.

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

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

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

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

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

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

Timeframe (days): (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

Attainment and Risk: FA

Evidence:

In the event the facility manager is absent, the clinical leaders are in charge of clinical issues and the administrator manages day to day operational activities. The facility manager is on call and it is reported that the directors are easily accessible. Lines of authority and responsibilities during the absence of the facility manager are confirmed in interview with both clinical leaders.

The District Health Board contract requirements are met.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures are sufficiently documented and identify quality outcomes for key components of service delivery. Policy updates are made by those who use them, or as changes are needed. The clinical leaders ensure that the current version of all policies, procedures and work instructions are available to staff. Review dates and version numbers are sighted on the footer of all documents. All obsolete documents are identified as such, removed from circulation and a copy maintained. Staff interviewed are aware of the process for implementing new policies and procedures and policies sighted reflect the aged related contract requirements and best practice. Final approval of all policies/procedures is the responsibility of the facility manager.

The organisation has a quality programme that is implemented in practice. There is a documented business plan with organisational goals and objectives identified. Each goal has an associated outcome to ensure implementation. Achievement towards business targets is monitored and reviewed by the facility manager.

Quality improvement data is analysed to identify trends and themes. Meetings occur regularly and include complaints, incidents and accidents, health and safety, supplier performance, training, infection control, restraint and outcomes of audits. Information on key components of service delivery are also communicated to staff at monthly staff meetings and registered nurse/facility manager quality meetings. This is verified in staff interviews and meeting records sampled.

Satisfaction surveys are also conducted to confirm the organisation meets the expectations of residents/family. The 2013 results are sighted and confirm general satisfaction with services.

There is an internal audit schedule that is fully implemented. Audits are scheduled at regular intervals to cover the scope of the quality system. Completion of internal audits are delegated to staff, with oversight from one of the clinical leaders. Examples of internal audits are sighted and confirm audits are conducted as scheduled, include corrective actions, which are then communicated to staff and signed off by management.

Risk management activities and management plans are documented in the business plan. This also makes reference to hazard monitoring. A current hazard register is maintained. Adequate insurances are in place and it is reported that financial oversight is conducted by a certified accountancy service. Current risks are reported to the directors in monthly manager reports, or as needed. This is evident in management reports sighted.

The district health board requirements are met.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The organisation is piloting the local district health board system for recording and collating incidents and accidents. This includes the 'do no harm initiative' for monitoring falls and enables comprehensive analysis and identification of trends. The results are then benchmarked with similar providers in order to monitor levels within the aged care sector.</p> <p>Individual incident and accident reports are completed for each event with immediate actions noted and any follow up actions required. The clinical leaders and/or facility manager sign off each incident form with recommendations for improvement if required. Minutes of staff meetings provide evidence of discussion of incidents/accidents and actions taken. There is evidence that deficits are remedied and improvements are made.</p> <p>Recent incidents are sampled to ensure investigation, appropriate actions and closure. Related incident reports are sighted in resident files. The incidents are well documented and essential notifications are made. Emergency actions are implemented in the event of falls and critical observations documented. Communication with family members is evident and the general practitioner is notified in a timely manner. This is confirmed in both family and GP interviews.</p>

The district health board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There are written policies and procedures in relation to human resource management which comply with current good employment practice.

Eight staff files are sampled and confirm that the skills and knowledge required for each position is documented in job descriptions. Job descriptions outline accountability, responsibilities and authority. Staff files sampled have evidence of the required recruitment screening and there is a system for the validation of professional qualifications for both employed staff and external health professionals. All new staff are required to receive an orientation to the facility and to their respective role. The orientation programme includes the essential components of service delivery, including emergency procedures, however this process has not been implemented for cleaning staff and an improvement is required.

There is a planned programme of on-going education. A self learning package was implemented in 2012. This includes the topics required in the District Health Contract and records of completion are maintained. In addition, an inservice training calendar is developed annually and identifies topics to be covered. Individual training records are maintained and confirm attendance at the required training. Staff working in the dementia unit have the required dementia related qualifications. It was noted that access to training is difficult for night staff, however the facility manager has recently has an extraordinary meeting with night staff to address the mandatory training requirements.

Staff performance is monitored in an ongoing manner. Performance appraisals are conducted annually, however evidence of appraisals has not been consistently maintained and an additional improvement is required.

The not all district health board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

All staff are required to complete induction/orientation training, however the cleaner was trained by the existing cleaner and it is unclear if this included essential components.

Finding:

There is currently no formal process of induction/training for cleaning staff. This includes the management of waste and hazardous substances, emergency procedures, infection control and management of challenging behaviour.

Corrective Action:

Develop a formal process of induction/orientation for domestic staff and maintain records of same.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Low
Evidence: Training is developed and conducted to meet the individual needs of staff and contract requirements. This includes the completion of an annual performance appraisal. Evidence of completed annual appraisals could not be found in three out of eight staff.
Finding: Evidence of annual performance appraisals has not been maintained in three out of eight staff records sampled.
Corrective Action: Maintain evidence of annual performance appraisals
Timeframe (days): 60 (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

Attainment and Risk: FA
Evidence: The organisation employs 35 staff in total. This is a combination of care assistants, administration staff, cleaners, gardeners and seven registered nurses. The role of the clinical leader is shared between two senior registered nurses. There is a documented rationale for determining service provider levels and skill mix which is cross referenced to standard 8163:2005 Indicators for safe Aged-Care and Dementia-care for Consumers. The roster is sampled and confirms that staffing levels reflect the number and mix of residents, acuity of residents, lay out of facility, staff skills and experience. Skill mix is approved by the clinical leaders. The roster identifies those with current first aid certificates and medication competencies. All care assistants are required to complete the dementia training. The facility manager is available during office hours and on call 24 hours a day and residents interviewed confirm that adequate staff are accessible at all times. The district health board requirements are met.

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

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

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

Attainment and Risk: FA
Evidence: <p>Records are comprehensively documented and resident files are tidy and well maintained. In depth documentation describes the life story and current needs of the resident. Plans are written in collaboration with families where able.</p> <p>Resident records are consistently documented and care plans linked to other documented used. For example: wound assessment and management tools, restraint assessments and restraint care plans. Progress notes are maintained and all entries are legible, dated and signed as required.</p> <p>All past and present records are stored in a secure and safe manner and are not publically accessible or observable.</p> <p>The district health board requirements are met.</p>

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.

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

Criterion 1.2.9.7 (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.

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

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

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

Attainment and Risk: FA
Evidence:

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

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

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: 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

Attainment and Risk: FA
Evidence: There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. The service communicates with needs assessors and Eldernet or internet when a bed becomes available. There is currently no waiting list as the service is planning refurbishments for three rooms and is therefore leaving

them empty at present. Admissions are prioritised according to the resident's needs when there is a waiting list. Enquiry forms are maintained and there are follow up phone calls to the people on the waiting list with emails sent when required. There is an expression of interest form and the family completes this. Potential clients receive an information pack. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code), the Alzheimer's pamphlet, complaints information, advocacy pamphlet and admission agreement. Seven relatives interviewed state that they had received the information pack and had received sufficient information prior to and on entry to the service. The needs assessment approvals on the seven files reviewed indicate that level of care the resident is receiving and signed service agreements are sighted on file. The admission checklist ensures all admission documentation is completed within the timeframes. The admission agreement reviewed aligns with a) -k) of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. The District Health Board contract requirements are met.

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.

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

Standard 1.3.2: 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

Attainment and Risk: FA
Evidence: There is a declining entry section in the admission procedure. The service records document the reason for declining service should this occur and communicates this to

the needs assessment service who would communicate with the residents/family/whānau.
 The facility manager gives any potential resident other services or links through Eldernet if there are no beds available.
 The reason for declining would be if the person did not meet the level of care provided at the facility or there were no beds available.
 There are no declined records.
 The District Health Board contract requirements are met.

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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a policy and process that describe resident’s admission and assessment procedures. A registered nurse (usually the clinical leader) undertakes the assessments on admission, with the initial registered nurse assessment completed within 24 hours of admission. The seven resident files reviewed identified that in all files a nursing assessment completed within 24 hours. An initial care plan is also completed on admission. The admission information, medical notes, allied health notes, progress notes, staff input, resident and family input form the basis of the long term care plan developed within three weeks of admission. The activities assessment is completed within two weeks of admission. Medical assessments are completed within 48 hours of admission by the general practitioner (GP) in all seven resident files sampled. The GP examines the resident at least monthly for residents in the hospital and three monthly for residents in the rest home and dementia unit. Earlier reviews are evident for residents requiring more frequent monitoring. A range of assessment tools completed on admission are evident in the seven resident files sampled. All seven files include a) nutritional assessment, b) Braden</p>

pressure area risk assessment, c) continence assessment if necessary, d) coombes fall risk assessment, e) nursing assessment on admission, f) other assessments as necessary e.g. behavioural assessments. These are reviewed annually.

There is a verbal handover between shifts and written handover sheet with resident significant events documented (witnessed on the day of the audit). Daily progress notes are maintained.

All seven files identified integration of allied health professionals including general practitioner medical notes, podiatry notes, letters and referrals to other allied health professionals and specialists.

The general practitioner interviewed states that staff is experienced and there is good communication with the facility manager and the registered nurses who follow any direction given and ask for advice when required. They are also noted to escalate any change in condition quickly.

There is documented evidence in seven resident files sampled that the care plans are reviewed by an registered nurse at least six monthly or earlier if resident health changes are completed. Seven of seven resident files sampled evidenced written evaluations are completed at least six monthly.

Seven resident files are sampled.

Tracer 1: Rest home resident.

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

Tracer 2 – hospital level care:

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

Tracer 3 – dementia unit.

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

The District Health Board contract requirements are met.

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The registered nurse, (generally the clinical leaders) complete a comprehensive initial nursing assessment within 24 hours of admission. The initial assessment includes showering and grooming, skin care, mobilising, eating and drinking, cultural needs, elimination and continence, communication (hearing and sight), behaviour, pain, social and spiritual needs, sexuality and intimacy and any other needs as identified throughout the admission and assessment process.

Baseline blood pressure, pulse and weight recordings are taken on admission and recorded. The registered nurse ensures the new resident and their family have received an orientation to the facility as confirmed by family interviewed.

The initial assessment forms the basis for the long term care plan developed within three weeks of admission. The resident profile and activities assessment is completed within two weeks of the resident's admission (sighted as being comprehensively documented for all residents reviewed).

Nursing diagnosis is identified with resident goals, objectives and interventions identified.

A range of assessment tools completed on admission include (but not limited to); a) nursing assessment, b) food and nutrition information, c) Braden pressure area risk assessment, d) continence assessment if necessary, d) Coombes fall risk assessment.

All residents have a physiotherapist assessment on entry to the service – confirmed by the physiotherapist interviewed with seven files having an assessment and plan on file.

The general practitioner completes a medical assessment within 48 hours of admission (sighted in seven files reviewed).

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.5: 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

Attainment and Risk: FA

Evidence:

The initial assessment forms the basis for the long term care plan developed within three weeks of admission. There is documented evidence the care plans have been developed with the resident and family involvement where appropriate. Resident needs, goals, objectives and interventions are identified, agreed and care to be delivered is explained. The long term care plan covers all areas of support identified as follows; mobility, continence, activities of daily living, dietary needs, medication, pain management, sleep and comfort, communication/sensory, memory loss/confusion, behaviour management, respiratory function, psycho-social/cultural/sexuality/intimacy, skin/wound and any additional needs. Residents' files include; resident admission details, general consent form, needs assessment, medical notes, laboratory results, care plan documents, progress notes, behavioural assessments and monitoring forms, activities resident profile/activity care plan, accident/incident. Seven relatives confirm on interview they are involved in the development of care plans. Short term care plans are used for short term/acute needs. Short term care plans describe a problem/diagnosis, objective/goal, intervention and evaluation. Short term care plans are in use for changes in health status.

The District Health Board contract requirements are met.

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.

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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service provides services for residents requiring rest home, hospital or dementia level of care. Individualised long term care plans are completed within three weeks of entry with the initial care plan guiding care and support requirements to that point. When a resident's condition alters, the registered nurses initiate a review and if required, general practitioner or specialist consultation (confirmed by the general practitioner interviewed).</p> <p>The four care assistants and two clinical leaders interviewed state that they have all the equipment referred to in care plans necessary to provide care including shower chairs, high rise toilet seats, transfer belts, chair scales, hoists, pressure cushions, walking frames, wheelchairs.</p> <p>Relatives interviewed state the residents needs is being met and they are receiving appropriate clinical and medical care.</p> <p>Dressing supplies are available and a treatment room is stocked for use.</p> <p>Continence products are available (sighted) and resident files include a urinary continence assessment, bowel management, and continence products allocation for day and night use as needed.</p> <p>The nurse leaders describe accessing nurse specialist continence advice is available as needed and they could describe the referral process.</p> <p>Wound assessment, wound management plan and wound dressing application records are in place for the two wounds. There is evidence of ongoing evaluations. Short term care plans are used for any short term needs etc skin graze, UTI, wound (now resolved). The clinical leaders interviewed described the referral process should they require assistance from the wound care specialist.</p> <p>Pain assessments are completed whenever necessary.</p> <p>Monitoring forms sighted include blood sugar levels, neurological observations after falls involving a suspected head involvement, weight monitoring, blood pressure and pulse. The registered nurses inform the GP regarding changes in resident health status, suspected infections, new admission, medication requests and these are filed in the resident files.</p>

In the seven files reviewed, all include appropriate support described and provided in line with their assessed needs.

The District Health Board contract requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The diversional therapist (DT) has been at the facility since 2011 and worked as an activities coordinator until graduating in 2013. The diversional therapist is currently completing nursing training.</p> <p>The diversional therapist visits the service at least monthly to monitor the activities programme.</p> <p>There are two full time activities coordinators – one in the hospital/rest home and one in the dementia unit.</p> <p>All resident files reviewed include a comprehensive assessment, plan, review documented monthly, attendance register documented daily and a six monthly review of the individual plan. Family document 'my life story' which also adds to the richness of the assessment.</p> <p>All hospital and rest home residents have a morning and afternoon activity plan and there is an individual activity plan over 24-hours for all residents in the dementia unit.</p> <p>There is good communication with the clinical team and the diversional therapist.</p> <p>Outing consent forms for resident outings are included in each resident file and checked prior to outings.</p> <p>Daily activities include newspaper reading, walks, scrabble, board games, hockey, bowls and crafts, happy hour, housie.</p> <p>There are a variety of entertainers and visitors to the facility including pet visits, musical groups.</p> <p>The two activities coordinators make contact with all residents daily and spend a lot of one on one time (discussion, hand massages, games, etc) with residents who do</p>

not wish to participate in group activities.

There are lounge areas in the rest home/hospital and dementia areas for group activities and entertainment.

The conservatory area has been converted into a 'snoozelen room' with shades, soothing music, sensory equipment etc with residents choosing to go to the room when they are agitated. Residents on the day were engaged in a variety of activities including board games, ball games, reading papers and magazines etc.

The facility hires a bus for transport for outings.

Seven family interviewed are satisfied with the variety of activities, outings and entertainment. They have the opportunity to provide input into the activity programme.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is review by the general practitioner regularly and at least monthly in the hospital and three monthly for residents in the rest home and dementia unit.

There is documented evidence that the long term care plan evaluations are up to date in all resident files sampled. There are written evaluations that align with each of the care plan support needs and goals identified. There is a MDT(multi-disciplinary team) approach to the review of the long term care plan.

The resident/family are invited to attend the care plan review for discussion and provide written comment.

Short term care plans are in place for short (acute) term needs. Resident files evidenced evaluation of the short term care plan with ongoing problems transferred to the long term care plan or resolved.

Seven relatives confirmed on interview they are involved in the review process of care plans.

Where progress changes prior to review, there is evidence that the care plan is updated.
The District Health Board contract requirements are met.

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

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

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

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

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

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

Standard 1.3.9: 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

Attainment and Risk: FA

Evidence:

The service facilitates access to other medical and non-medical services. The clinical leaders interviewed confirm they or other registered nurses can initiate nursing referrals for continence, wounds, assessment team (needs assessment service), mental health and psychiatric services, speech language therapist. The general practitioner initiates specialist referrals. There is consultation and notification of referrals made and residents/families are informed of referrals and options.

There is a visiting podiatrist at least six monthly.

The physiotherapist visits the service weekly.

One file reviewed showed an example of where a resident's condition had changed and the resident was reassessed for a different level of care. This was managed in a timely manner.

One family noted discussion around appropriate services for the resident should they want to be transferred to another part of New Zealand. Discussion is recorded in the resident notes with copies of emails on file.

The District Health Board contract requirements are met.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.10: 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

Attainment and Risk: FA

Evidence:

There is a policy that describes guidelines for death, discharge, transfer, documentation and follow up. The information is copied and sent with a resident transferring to hospital includes; transfer form, resident details, copy of the medications, general practitioner letter unless in an emergency, copy of the relevant progress notes and any other relevant information.

Hospital discharge letters and nursing care summaries are received on discharge or transfer back to the facility and these are included in the resident file.

The family interviewed confirm that they are notified of transfers. The clinical leaders describe notifications being made to the appropriate departments regarding transfers from the facility and death.

The District Health Board contract requirements are met.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There are policies and processes that describe the stages of medicine management. Clinical leaders and registered nurses administering medications complete medication education and practical observations before being registered as medication competent on the medication signing list.
Annual competency assessments and education is provided.
There is a pharmacy contracted to provide the robotic packs and all other pharmaceuticals. All medications received are checked by the registered nurse on duty. Any discrepancies are fed back to the pharmacy.
Expired medications and returns are collected by the pharmacy.
All eye drops in used are dated on opening.
The locked medication trolley is kept locked and there is a locked medication room in the hospital and dementia unit.
Medication that requires refrigeration is kept in a fridge in the locked medication room. The temperature is monitored – within appropriate range.
There are no residents able to self-administer medications
The 15 medications charts sampled all have photo identification and allergies noted.
There is evidence of general practitioner medication reviews three monthly.
The medication administration signing sheets are correctly signed for regular medications with the time of administration documented. There are no gaps on the signing sheet.
There is no transcribing noted in 11 of the 15 medication PRN charts reviewed.
The District Health Board contract requirements have been met apart from the following.
An improvement is required to transcribing of information on the PRN charts.

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

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

Attainment and Risk: PA Low

Evidence:

Eleven of the 15 medication files do not show any evidence of transcribing.

Finding:

Four of the 15 medication files reviewed have transcribing noted on the PRN charts.

Corrective Action:

Cease the practice of transcribing.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service outsources the food services to Spotless. The chef interviewed (national manager) provides oversight of the service and ensures that staff are trained appropriately with menus in place. The chef has an extensive history of working in the armed services and in the District Health Board and visits the service at least monthly with role modelling described.</p> <p>There are two cooks who provide meal services seven days a week.</p> <p>There is a summer and winter menu that has been reviewed by the dietician and the winter menu is currently in the process of being reviewed and a new one rolled out – dietician involvement in the current review sighted.</p> <p>The cook receives a resident food and nutrition information form and is notified of any changes to resident's dietary needs as confirmed by the cook interviewed.</p> <p>The cook maintains a resident dislikes list with any allergies or special diets recorded on a white board. Alternative meals and choices are offered for residents with dislikes/other food preferences.</p> <p>Dietary requirements such as vegetarian, pureed or soft diets are accommodated with the service also offering a gluten free diet to one resident in the service.</p> <p>The chef audits the service twice a year and receives feedback on the meals and menu suggestions predominantly from staff and family noting that currently most residents are not able to feedback a lot of information.</p> <p>The kitchen is well equipped and there is pantry storage with all dry goods in sealed, labelled containers and stored off the floor.</p> <p>There are daily fridge, freezer and dishwasher temperatures recorded.</p> <p>Hot food temperature is checked during cooking and prior to serving.</p> <p>Chemicals are stored in a locked cupboard.</p> <p>Staff are observed wearing hats, aprons and gloves. There is a kitchen cleaning schedule in place.</p> <p>Seven family and three residents interviewed are complimentary of the meals.</p>

The chef confirms that staff have been trained in safe food handling both through orientation and through ongoing training sessions provided by the chef.
The kitchen is very clean on the days of audit.
Additional snacks are available to residents in the dementia unit over a 24 hour period.

The District Health Board contract requirements are met.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.1: 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

Attainment and Risk: FA
Evidence: <p>There are adequately documented procedures for the management of waste and hazardous substances. Related policies make reference to the National Poisons Centre and emergency and chemical data safety sheets are stored with the chemicals.</p> <p>Hazardous substances include domestic rubbish, domestic chemicals, hygiene products, single use items and blood/body fluids/products. These are identified on the current hazard register. Cleaning chemicals are kept secure and sufficient protective equipment is observed.</p> <p>There has been no reported incidents/accidents regarding waste or hazardous substances.</p> <p>The district health board requirement is met.</p>

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.

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 1.4.1.6 (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.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The building and facilities are well maintained and suitable for the care and support of elderly residents. The facility has two buildings. One is the hospital and the other is separated into the secure dementia unit and rest home area. All areas provide a range of different indoor and outdoor settings and there is a range of low stimulus areas in the dementia unit which can be used when required.

Applicable building regulations and requirements are met. The current building warrant of fitness is sighted for both facilities.

Both buildings are set on sufficiently sized grounds and gardens. There are evenly surfaced pathways and external seating in the gardens. Ramps are kept moss free with safe handrails. There is adequate parking for both staff and visitors.

There are separate lounge and dining areas. The corridors and doorways in the hospital are wide enough to accommodate equipment and mobility aids. There is adequate furniture and equipment throughout. Equipment is observed to be well maintained, calibrated and appropriate to the needs of residents. Environment hazards are identified and monitored; however in the event a variance is identified the current reporting system has not consistently ensured that resident safety is maintained at all times.

The maintenance contractor is on site as required and records sighted provide evidence of ongoing maintenance activities.

The district health board requirements are met.

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

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

Attainment and Risk: PA Low

Evidence:

There is a system for monitoring hot water and hot water records are sighted. These show that several bedrooms have recorded temperatures over 45 degrees Celsius (50 -51). Staff taking the temperatures have not reported this to the clinical manager (as required) so that remedial actions and/or repeat checks can be made/verified.

Finding:

The system for reporting hot water temperatures does not ensure corrective actions are implemented if the temperature exceeds a safe level.

Corrective Action:

Implement the system for reporting variance when hot water exceeds the acceptable temperature.

Timeframe (days): 60 (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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.3: 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

Attainment and Risk: FA

Evidence:

There is a combination of shared toilet/bathroom facilities and private/shared ensuites. These are sufficient in number and well maintained in line with infection control requirements. Residents and family members interviewed voiced no concerns regarding the toilet/bathing facilities.

The district health board requirement is met.

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action: .
Timeframe (days): 30 (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

Attainment and Risk: FA
Evidence: Residents have private rooms, with the exception of one shared room in the hospital wing. The room is sufficiently set up to provide privacy and is shared by two women whom it is reported benefit from the company. All rooms have adequate space for equipment and care. Residents and family members interviewed voiced no concerns regarding personal space/bed areas. The district health board requirements are met.

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.

Attainment and Risk: FA
Evidence:

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

Standard 1.4.5: 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

Attainment and Risk: FA
Evidence: All areas have adequate and well furnished lounge and dining areas. These areas are well utilised and sufficiently sized. Low stimulus areas are available in the dementia unit. Residents and family members interviewed voiced no concerns regarding the communal dining areas. The district health board requirements are met.

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.

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

Standard 1.4.6: 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

Attainment and Risk: FA

Evidence:

All laundry services are contracted out to a local supplier. It is reported at interview with the facility manager that the supplier was provided with the Ministry of Health Laundry Guidelines for Rest Homes and Small Hospitals on commencement of the contract. This agreement has been in place since 2010. The facility manager reports satisfaction with the service with minimal concerns. Dirty laundry is packed into appropriate laundry bags, stored safely and picked up/returned every second day.

Day to day cleaning is completed by two cleaners during the week and care assistants on the weekends. The newest cleaning staff was trained in the use of equipment and chemicals by the existing cleaner, however the orientation process was not conducted in a formal manner and an improvement is documented in human resources.

Cleaning and laundry hazards are documented. Material data safety sheets are displayed. Adequate personal protective equipment is sighted throughout the facility. Cleanliness and laundry standards are monitored through annual internal audits. Documented cleaning guidelines are available as are duty schedules. The facilities are observed to be clean on the days of the audit.

Chemicals are provided by an external provider who provides additional training and monitoring. All chemicals are safely stored.

The facility manager ensures any concerns regarding maintenance/cleaning are followed up in a timely manner and this is confirmed in family/resident interviews.

The district health board requirements are met.

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.

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 1.4.6.3 (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.

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

Standard 1.4.7: 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

Attainment and Risk: PA Moderate
Evidence: <p>Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency, however the call system in the dementia unit requires an improvement to ensure consistency and accessibility. There is a security code on the external gate and the section is fully fenced. Staff conduct a round in the evenings to ensure all doors and windows are secure. There are security cameras inside both buildings and sensor light outside. The dementia unit is secure.</p> <p>The fire service has approved the current evacuation plan for both buildings (dated 2000) and records of biannual fire evacuations are sighted. Fire systems and emergency evacuation equipment is checked annually, with monthly inspections. Both buildings have fire cells which are separated by fire doors. A sprinkler system is in place and fire extinguishers are sighted. Evacuation procedures are displayed throughout. An emergency assistance register is documented which identifies those who require additional assistance (and emergency contacts) in the event of evacuation.</p> <p>Disaster plans are documented for a range of emergencies and the organisation is a member of the city council disaster relief plan. Outbreak management and pandemic planning is also documented in line with the district health board guidelines. Adequate civil defence supplies are available and include the required equipment and stores. There is adequate food and water supplied in the event of an emergency. The building has emergency lighting in the event of a power failure and there is a BBQ and stored gas bottles.</p> <p>All staff receive training in the management of emergencies during orientation and thereafter six monthly in fire evacuation training/drills. All staff have also completed first aid training.</p>

The district health board requirements are met.

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.

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 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

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 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

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

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 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

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

Attainment and Risk: PA Moderate
Evidence: Calls bells are accessible and within reach for residents in the hospital area and the rest home area, however the nurse call system is not as accessible and/or working effectively in the dementia unit. Some rooms have call bells, others do not, and in dining room the call system is not working. There are security cameras in the dementia unit which monitor communal areas.
Finding: Although there are security cameras in the dementia unit the call system is inconsistent and not working effectively in some areas.
Corrective Action: Explore options for a more consistent call system in the dementia unit
Timeframe (days): 60 (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.

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

Standard 1.4.8: 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

Attainment and Risk: FA
Evidence: Both buildings have plenty of natural light. All rooms have at least one good sized window and temperature is maintained through the use of raditors and air conditioning. There are no concerns voiced by residents, or family regarding the temperature of the facility. There is a designated smoking area out the front of the facility for residents who smoke. The district health board requirement is met.

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.

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 1.4.8.2 (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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The restraint minimisation policy and procedure and the safe practice policy includes a) definitions, b) use of restraint is a last resort only, c) methods of restraint permitted within Cromwell House, d) use of enablers, e) enablers permitted, f) client rights, g) assessment, discussion and restraint alternatives, h) restraint care planning, i) monitoring and removal, j) restraint episode evaluation, k) restraint coordinator, l) staff training, m) restraint meeting.

Related forms include: restraint or enabler assessment, care plan, consent form, restraint and enabler register; care plan for client requiring restraint; restraint episode evaluation form.

The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.

There are no residents with enablers and three residents using a lap belt as restraint. While bedrails are identified as being able to be used, the clinical leaders state that they are not used in the service as they cause more injury than prevent.

The clinical leaders confirm that any use of an enabler would be voluntary.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

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

Attainment and Risk: FA

Evidence:

The restraint coordinator is the clinical leader who is a registered nurse with over 15 years' experience in aged care. Lines of authority are documented in the restraint policy and include clear terms of reference for the restraint committee that meets monthly. The restraint coordinators able to describe the responsibilities.

There is a responsibilities and accountabilities description in the restraint policy that includes responsibilities for key staff in the service. The service has an approval process (as part of the restraint policy) that is applicable to the service.

The process of determining any use of restraint is discussed and agreed to by the restraint coordinator, the general practitioner and the family with other registered nurse and clinical leader input involved in the decision making process.

The two resident files reviewed (hospital) with restraint indicated that key people identified signed off the use of restraint and are present at the review of the use of the restraint.

Staff are observed on the days of the audit de-escalating any issues for residents through the management of challenging behaviour. Staff have had training around managing challenging behaviour in 2013.

The dementia unit is noted to be very calm during the days of the audit and family members interviewed confirm that there is a peaceful atmosphere when they are in there.

The District Health Board contract requirement is met.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

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

Attainment and Risk: FA

Evidence:

A restraint assessment that includes strategies tried, risks, cultural needs and any issues is completed as part of the consent and assessment form in use. Interventions and risks identified through the assessment process are transferred into a restraint care plan (sighted in two files reviewed where restraint is identified). Restraint documentation identifies the involvement of family – confirmed by one family member interviewed.

Assessments are undertaken by the clinical leader/s or registered nurses with the restraint coordinator involved.

Assessments are completed as required for individual residents.

A restraint assessment has been comprehensively documented for the two residents identified as using restraint (resident files reviewed).

Risks relating to the use of the restraint are considered along with other key areas relating to the individual resident.

The District Health Board contract requirement is met.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

(a) Any risks related to the use of restraint;

(b) Any underlying causes for the relevant behaviour or condition if known;

(c) Existing advance directives the consumer may have made;

(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

(f) Maintaining culturally safe practice;

(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

(h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

Monitoring and observation processes are included in the restraint policy. Approved restraints are documented in the policy. The restraint care plan is documented for residents requiring restraint that identifies interventions and care required.

Falls risk and challenging behaviour assessments and plans are completed for the two files reviewed for residents using a lap belt.

A restraint register is in place with correct identification of the residents using a lap belt.

Staff are trained in restraint minimisation – last provided in June 2013 and managing challenging behaviour - last provided in March 2014 (training records sighted).

The resident requiring restraint is monitored hourly to two hourly when restraint is in use - monitoring forms sighted as being completed with minimal use of the restraint.

Other interventions are documented as being used.

Frequency of monitoring is tailored to individual resident needs as described by the restraint coordinator.

The assessment and consent form identify that other strategies had been tried prior to restraint being used and all risks associated with the use of restraint is documented.

The restraint coordinator describes restraint being used as the very last strategy after other interventions have been tried.

The District Health Board contract requirement is met.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The restraint evaluation includes the areas identified around future options to avoid the use of restraint, review of frequency of use and effectiveness as part of the care plan and restraint review and the impact the restraint has had on the resident.
They also review the behavioural management plan and any incidents relating to the behaviours in the context of using restraint.
Family have participated in the evaluation for the use of restraint for the residents requiring this in the file reviewed – confirmed by one family member interviewed.
The restraint episode evaluation completed monthly includes documentation of evaluation of the restraint including outcomes achieved through the use of the restraint.
The District Health Board contract requirement is met.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The restraint coordinator states that the use of any restraint is reviewed at the time of the six-monthly individual resident care plan evaluation as well as monthly at the restraint meeting (minutes sighted for 2014).

The restraint coordinator reviews and updates the restraint register at least monthly and as any resident is identified as using restraint.

The restraint programme is reviewed monthly as a whole and further training opportunities, changes to policy are considered at these meetings. Care plans related to the use of restraint are also reviewed.

All staff interviewed including the two clinical leaders and four care assistants confirm knowledge of the use of restraint and enablers. They can also describe strategies used to de-escalate behaviour and these were sighted in use on the days of the audit.

The District Health Board contract requirement is met.

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

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

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

Attainment and Risk: FA
Evidence: One of the clinical leaders is the designated infection control coordinator and the infection control responsibilities for the role are clearly defined. The infection control programme is clearly documented and is suitable for the facility and the scope of the service. The annual review of the infection control programme ensures that infection

prevention and control processes are up to date. This was last completed in November 2013.

Residents, staff and visitors are protected from the spread of infection through signage, training and adequate equipment and resources. Staff and residents are offered influenza vaccinations.

The district health board requirement is met.

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.

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

Criterion 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.

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

Criterion 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.

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

Standard 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

Attainment and Risk: FA
Evidence: <p>The infection control programme defines appropriate responsibilities for the infection control coordinator and staff that are appropriate for the service. There is designated time and resources provided for infection control activities.</p> <p>The infection control coordinator is a nurse with relevant skills and expertise to implement the programme. The coordinator reports to the facility manager and has access to current information relevant to the size and complexity of the facility including infection control manuals, internet and expert advice from Bug Control and laboratory specialist.</p> <p>Review of resident records indicate that an infection record is maintained for each resident. The resident care plan sample includes review of any infections and the outcome of treatment. There is documented evidence that the coordinator gathers monthly reports on infection related issues. Staff meeting minutes and interviews with the facility manager and care givers confirm that information regarding infections is effectively communicated. The general practitioner is also informed if a resident has an infection.</p> <p>The district health board requirement is met.</p>

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.

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

Standard 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

Attainment and Risk: FA
Evidence: <p>Documented policies and procedures are in place for the prevention and control of infection. The protocols are appropriate for the facility and reflect current accepted good practice and legislative requirements. Policies and procedures are developed and reviewed annually.</p> <p>Policies and procedures include hand washing, cleaning and sterilisation, standard precautions, isolation, outbreak management, management of staff with infections, health and safety, and a list of notifiable diseases. A pandemic plan is documented and standard definitions are used for surveillance reporting.</p> <p>The district health board requirements are met.</p>

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.

Attainment and Risk: FA
Evidence:

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

Standard 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

Attainment and Risk: FA
Evidence:
Inservice education on infection prevention and control is provided by a suitably qualified person. The infection control coordinator is a registered nurse and has completed the Ministry of Health infection prevention and control e-learning certificate in 2014 and bug control training 2012.
The infection control coordinator provides the inservice education. Education in infection prevention and control is provided during orientation and in an ongoing manner. Training records sampled confirm that in-service education has been provided in the last 12 months. Care assistants interviewed advise education to residents primarily includes the prevention of spreading infections and assisting with hand hygiene prior to meals.
The district health board requirement is met.

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.

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

Criterion 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.

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

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

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

Attainment and Risk: FA
Evidence: <p>The infection surveillance programme is appropriate for the facility and the level of care provided. Infections and the use of antibiotics is monitored and collated reports and trends are reported at staff meetings. Infection rates are collated and analysed for trends.</p> <p>Benchmarking is conducted with other related providers. Benchmarking includes types of infections and antibiotics used. The organisation has a low infection rate, however there was a scabies outbreak in November 2013. This was well management and all residents were treated. The outbreak was over within one month. The general practitioner reported the outbreak to the public health unit.</p> <p>The resident care plan sample includes review of any infections and the outcome of treatment. The general pratitioner is also informed if a resident has an infection.</p>

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

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

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

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

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

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