

# Mossbrae Healthcare Limited

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Current Status: 15 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

Mossbrae Healthcare provides rest home and hospital level care for up to 64 residents. There were 12 residents requiring rest home level care and 49 requiring hospital care. The service continues to implement a quality and risk management programme identifying quality improvements through a variety of activities. The service is managed by an experienced registered nurse. The manager is supported by an assistant manager (registered nurse) who provides clinical oversight and management, there are registered nurses on duty at all times. The service continues to provide care to residents based on the services mission and philosophy of care. Staff interviews and the documentation review identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required around the resuscitation policy, the caregiver training programme, conducting assessments, developing individual activities goals and plans, care planning for respite residents, aspects of medication management, hot water temperature monitoring, calibration and servicing of equipment and infection prevention practices.

## Audit Summary as at 15 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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

#### Consumer Rights as at 15 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.		Some standards applicable to this service partially attained and of low risk.
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#### Organisational Management as at 15 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.		Standards applicable to this service fully attained.
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#### Continuum of Service Delivery as at 15 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 medium or high risk and/or unattained and of low risk.
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#### Safe and Appropriate Environment as at 15 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 15 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 15 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.		Some standards applicable to this service partially attained and of low risk.
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## Audit Results as at 15 April 2014

### Consumer Rights

The support provided to residents at Mossbrae is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance, residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Residents and their families are kept informed, and there is documentation to evidence communication with families. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent is sought on admission and reviewed. Advanced directives are not recorded as the service has a no resuscitation policy. Improvements are required in this area. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

### Organisational Management

Mossbrae has an organisational philosophy, which includes a vision, mission statement and strategic objectives.

Mossbrae is a privately owned facility, the owners visit the service every three months and meet with the management team and residents. The manager has been in the role for 10 years and is supported by the owners, an assistant manager, registered nurses and care staff. The facility is guided by a set of policies and procedures. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. Improvement is required whereby caregiving staff continue to be provided with a recognised training programme. Staffing levels are safe and appropriate.

### Continuum of Service Delivery

Resident files reviewed include service coordination centre assessment forms. The facility information pack is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or enduring power of attorney. A registered nurse assessment, including a variety of risk

assessments are completed on admission and reviewed six monthly following admissions. Residents and/or family have input into the development of care plans. There are improvements required around completion of required risk assessments including, pain, pressure area, and nutritional and completing assessments and current care plan for respite residents.

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. A social profile is completed on admission and activities progress notes/evaluations are recorded. Improvements are required whereby all individual activity care plans include goals and interventions. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly and there is a separate programme for the rest home and the hospital.

Policies and procedures around medication detail service provider's responsibilities. Registered nurses and caregivers who are responsible for medication administration have attended in-service education for medication management and complete a medication competency annually. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are improvements required around removing expired medication, competency assessments for self-administering residents, six monthly controlled drug stocktake and signed prescribed medication chart for respite resident.

The service has transfer and discharge procedures. The staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital.

A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and the chef and the cook have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

### **Safe and Appropriate Environment**

Mossbrae has a current building certificate that expires on 10 June 2014. Scheduled and reactive maintenance is carried out. Chemicals are stored in a locked storage area, hot water is monitored and recorded. An improvement is required whereby hot water temperatures are maintained within acceptable limits. Improvements are also required whereby medical equipment is checked, serviced and calibrated by an authorised technician.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. The service is divided into two units (31 rooms in Argyle wing and 33 rooms in Inglis wing). There are large lounge and dining areas in both units, and smaller seating areas throughout the facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. There is a designated laundry and cleaning and laundry chemicals are stored securely. There are appropriate emergency and civil defence management plans and resources in place and staff are trained in first aid and fire evacuation. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

## **Restraint Minimisation and Safe Practice**

There are a number of residents on restraint – bedrails and lap belts, which are utilised as falls prevention measures and for resident's personal safety. On the day of audit there were no residents assessed as requiring enablers. Staff attend restraint minimisation and safe practice education. Restraint registers are maintained in both units and appropriate documentation is recorded for assessment, consent, planning and monitoring of restraint. The restraint minimisation programme is reviewed annually.

## **Infection Prevention and Control**

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The infection control coordinator (registered nurse) has attended infection prevention education. Improvements are required whereby infection prevention practices are adhered to in regards to hand washing facilities in staff and visitors toilets. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## 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

<b>Legal entity name:</b>	Mossbrae Healthcare Limited
<b>Certificate name:</b>	Mossbrae Healthcare Limited
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Mossbrae Healthcare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 15 April 2014 <b>End date:</b> 16 April 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	61

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	13	<b>Hours off site</b>	6
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	13	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	3

## Sample Totals

Total audit hours on site	26	Total audit hours off site	13	Total audit hours	39
Number of residents interviewed	11	Number of staff interviewed	18	Number of managers interviewed	2
Number of residents' records reviewed	8	Number of staff records reviewed	10	Total number of managers (headcount)	2
Number of medication records reviewed	20	Total number of staff (headcount)	73	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	3

## Declaration

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

I confirm that:

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

Dated Friday, 16 May 2014

## Executive Summary of Audit

### General Overview

Mossbrae healthcare provides rest home and hospital level care for up to 64 residents. There were 12 residents requiring rest home level care and 49 requiring hospital care including one hospital respite resident. The service continues to implement a quality and risk management programme identifying quality improvements through a variety of activities. The service is managed by an experienced registered nurse. The manager is supported by an assistant manager (registered nurse) who provides clinical oversight and management, there are registered nurses on duty at all times. The service continues to provide care to residents based on the services mission and philosophy of care. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required around the resuscitation policy, the caregiver training programme, conducting assessments, developing individual activities goals and plans, care planning for respite residents, aspects of medication management, hot water temperature monitoring, calibration and servicing of equipment and infection prevention practices.

### Outcome 1.1: Consumer Rights

The support provided to residents at Mossbrae is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance, residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Residents and their families are kept informed, and there is documentation to evidence communication with families. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent is sought on admission and reviewed. Advanced directives are not recorded as the service has a no resuscitation policy. Improvements are required in this area. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

### Outcome 1.2: Organisational Management

Mossbrae has an organisational philosophy, which includes a vision, mission statement and strategic objectives. Mossbrae is a privately owned facility, the owners visit the service every three months and meet with the management team and residents. The manager has been in the role for 10 years and is supported by the owners, an assistant manager, registered nurses and care staff. The facility is guided by a set of policies and procedures. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. Improvement is required whereby caregiving staff continue to be provided with a recognised training programme. Staffing levels are safe and appropriate.

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

Resident files reviewed include service coordination centre assessment forms. The facility information pack is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or enduring power of attorney. A registered nurse assessment, including a variety of risk assessments are completed on admission and reviewed six monthly following admissions. Residents and/or family have input into the development of care plans. There are improvements required around completion of required risk assessments including, pain, pressure area, and nutritional and completing assessments and current care plan for respite residents.

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. A social profile is completed on admission and activities progress notes/evaluations are recorded. Improvements are required whereby all individual activity care plans include goals and interventions. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly and there is a separate programme for the rest home and the hospital.

Policies and procedures around medication detail service provider's responsibilities. Registered nurses and caregivers who are responsible for medication administration have attended in-service education for medication management and complete a medication competency annually. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are improvements required around removing expired medication, competency assessments for self-administrating residents, six monthly controlled drug stocktake and signed prescribed medication chart for respite resident.

The service has transfer and discharge procedures The staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital.

A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and the chef and the cook have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

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

Mossbrae has a current building certificate that expires on 10 June 2014. Scheduled and reactive maintenance is carried out. Chemicals are stored in a locked storage area, hot water is monitored and recorded. An improvement is required whereby hot water temperatures are maintained within acceptable limits. Improvements are also required whereby medical equipment is checked, serviced and calibrated by an authorised technician.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. The service is divided into two units (31 rooms in Argyle wing and 33 rooms in Inglis wing). There are large lounge and dining areas in both units, and smaller seating areas throughout the facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. There is a designated laundry and cleaning and laundry chemicals are stored securely. There are appropriate emergency and civil defence management plans and resources in place and staff are trained in first aid and fire evacuation. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

### **Outcome 2: Restraint Minimisation and Safe Practice**

There are a number of residents on restraint – bedrails and lap belts, which are utilised as falls prevention measures and for resident's personal safety. On the day of audit there were no residents assessed as requiring enablers. There are 34 hospital residents with bedrails in place overnight, one rest home resident with bedrails, and six hospital residents with lap belts in place when in wheelchairs or armchairs. Staff attend restraint minimisation and safe practice education. Restraint registers are maintained in both units and appropriate documentation is recorded for assessment, consent, planning and monitoring of

restraint. The restraint minimisation programme is reviewed annually.

### Outcome 3: Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The infection control coordinator (registered nurse) has attended infection prevention education. Improvements are required whereby infection prevention practices are adhered to in regards to hand washing facilities in staff and visitors toilets. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	44	0	4	2	0	0
<b>Criteria</b>	0	94	0	4	3	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0	0	0	0

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives	PA Low	The current service	Provide documented	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		that are made available to service providers are acted on where valid.		philosophy and policy to 'allow natural death' translates that no resuscitation is provided to residents. This policy does not provide opportunity for residents to make an informed choice or decision regarding options for resuscitation in the event of an acute medical, life threatening episode. No resuscitation decision forms are in place for seven of eight files reviewed and no evidence that GP's are involved in the decision making process.	evidence that all residents are given the opportunity to make an informed decision regarding resuscitation with input from general practitioners.	
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	While, pain, nutritional and pressure area assessment are completed in the initial assessment for long term Residents, on-going assessments were not in place for; (i) Pain assessments not completed for two rest home residents and six hospital residents. (ii)	(i), (ii), and (iii) Ensure that assessments are completed for all identified needs of the resident; (iv) Ensure that a new assessment is completed every time a resident is admitted.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				Pressure area assessment not completed for one rest home resident, (iii) Nutritional assessment not completed for one hospital resident. (iv) No new assessments completed for respite hospital resident.		
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	(i) Of the eight files reviewed, seven permanent resident's files (five hospital and two rest home) did not show evidence that activity goals and plans were developed. (ii) One hospital respite resident did not show evidence that a current care plan had been developed. The care plan sighted was dated January 2014 from a previous respite admission and did not evidence that it had been reviewed to ensure that it was current.	(i)Ensure that activity goals and plans are developed for every resident. (ii) Ensure that respite residents have a current care plan developed for each admission.	90
HDS(C)S.2008	Standard 1.3.12: Medicine	Consumers receive medicines in a safe	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	and timely manner that complies with current legislative requirements and safe practice guidelines.				
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	(i)One respite hospital resident does not have a signed medication chart. The GP has provided a printed list of medications including dosage, times and PRN medications. This list is not signed by the GP. (ii) Each resident has individual standing orders in place. On review of 20 resident medication orders, eight standing orders were last reviewed in 2012. (iii) There is no evidence that six monthly controlled drug stocktake have been completed.	(i) Ensure that all respite residents have signed medication charts by the GP. (ii) Ensure that standing orders are reviewed annually by the GP, (iii) Ensure that controlled drugs stocktake is completed six monthly.	30
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	Staff are signing for medication administered that they do not witness as being taken.	Ensure staff sign for medication that is witnessed as taken.	30
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 Moderate			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant,	PA Moderate	a)Hot water	a) Ensure hot water	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and equipment comply with legislation.		temperature recordings reviewed for 2013 and year to date 2014 are consistently recorded between 44 and 48 degrees Celsius; b) medical equipment including chair scales and oxygen concentrators have not been checked or calibrated since October 2012.	temperatures in resident areas are within acceptable limits; b) ensure that all medical equipment is checked and calibrated by an authorised technician as per manufacturer's instructions.	
HDS(IPC)S.2008	Standard 3.1: Infection control management	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.	PA Low			
HDS(IPC)S.2008	Criterion 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.	PA Low	It was noted on a tour of the facility that two staff toilets and one visitors toilet have communal cloth hand towels in use for hand hygiene. These were removed on the first day of audit.	Ensure that all hand washing facilities (for residents, staff and visitors) have single use, hand drying facilities to prevent the risk of spread of infection	60

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (eight caregivers, two activities coordinators, three registered nurses, two enrolled nurses, one assistant manager, and one manager) confirm their familiarity with the Code. Interviews with 11 residents (two rest home and nine hospital) and seven relatives (three rest home and four hospital) confirm the services being provided are in line with the Code of rights.
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Code of rights and advocacy training is provided during new staff orientation, and as a regular in-service education and training topic (last provided in June 2013).
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### 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.

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

The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with 11 residents and seven relatives identify they are well-informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Three monthly resident/relative meetings (minutes sighted for March 2014 for both Argyle and Inglis wing) are held providing the opportunity to raise concerns in a group setting. The most recent annual satisfaction survey (March 2014) includes the question relating to privacy, dignity and rights with respondents replying they are either satisfied or very satisfied.

Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a Code of rights pamphlet, and advocacy and Health and Disability Commissioner information.

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

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records. Discussions with 11 residents and seven relatives confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.</p> <p>D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.</p> <p>D14.4 There are clear written instructions provided to residents and family on entry regarding responsibilities of personal belongings. Personal belongings are documented and included in residents' files.</p> <p>Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. All 11 residents and seven relatives confirm the service is respectful. A resident satisfaction survey is carried out annually to gain feedback. Survey questions relating to privacy, respect, and satisfaction with care reflect residents and families are satisfied or very satisfied.</p> <p>D4.1a: Residents' files include their cultural and /or spiritual values when identified by the resident and/or family.</p> <p>The information pack, provided to residents and their families, includes the home's philosophy of care. Discussions with 11 residents confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Eight care plans reviewed (two rest home and six hospital) identify specific individual likes and dislikes. Three married couples reside at Mossbrae in the Inglis wing and each couple share a double room together. All of these residents have comprehensive documentation in their respective care plans around the need for staff to respect their privacy and time together.</p> <p>The abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training on abuse and neglect is a mandatory requirement and last provided in December 2013.</p> <p>Discussions with the manager and assistant report there have been no identified incidents of abuse or neglect.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is a cultural safety policy and Maori health plan in place. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.</p> <p>There were no Maori residents living at the facility at the time of the audit. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori healthcare providers.</p> <p>D20.1: The service utilises a local Maori representatives on an as-needed basis for consultation. These contacts are identified in policy.</p> <p>Interviews with eight caregivers, two enrolled nurses and three registered nurses confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau.</p> <p>A3.2 There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)</p>

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

### **Standard 1.1.6: 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:**

Care planning includes consideration of spiritual, psychological and social needs. Eleven residents interviewed (two rest home and nine hospital) indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Seven relatives (three rest home and four hospital) report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions.

D3.1g: The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the registered nurse.

D4.1c: Eight of eight care plans reviewed include the residents' social, spiritual, cultural and recreational needs.

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

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

**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:**

The staff induction programme includes a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with the manager and in staff files reviewed. Interviews with eight caregivers, two enrolled nurses, three registered nurses, one assistant manager (clinical manager) and one manager acknowledge their understanding of professional boundaries. Five registered nurses attended professional boundaries, social media and code of conduct training with the nursing council of New Zealand in March 2014.

### 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:**

The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. Resident/family satisfaction surveys reflect high levels of satisfaction with the services that are received. The manager and assistant manager are in charge of the internal audit and in-service education programmes. There is access to computer and Internet resources. There are monthly staff meetings, monthly registered nurse meetings and three monthly resident meetings.

Eleven residents and seven relatives interviewed spoke very positively about the care and support provided. Eight caregivers, two enrolled nurses, three registered nurses, two activities coordinators, one assistant manager and one manager have a sound understanding of principles of aged care.

A2.2: Services are provided at Mossbrae that adheres to the Health & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring.

D1.3: All approved service standards are adhered to.

D17.7c: There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>Policies are in place relating to open disclosure. Eleven residents interviewed (two rest home and nine hospital) state they were welcomed on entry and were given time and explanation about the services and procedures.</p> <p>A sample of incident reports reviewed, and associated resident files, evidence recording of family notification. Seven relatives interviewed (four rest home and five hospital) confirm they are notified of any changes in their family member’s health status. The manager, assistant manager, and registered nurses can identify the processes that are in place to support family being kept informed.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.</p> <p>D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p> <p>The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of</p>

entry. Families are encouraged to visit.  
D11.3 The information pack is available in large print and is read to sight-impaired residents.

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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:** PA Low

**Evidence:**

Mossbrae has policies and procedures relating to informed consent. The service has a philosophy and policy to allow natural death (and) and that no resuscitation is provided. This policy is made known to prospective residents, however, does not allow residents to make an informed choice or decision regarding options for resuscitation in the event of an acute medical life threatening episode. Advised, initial assessment ( completed by RN in as sociation with client and family) does have content that acknowledges Resident instructions and wishes re: resuscitation and end of life care. A review of eight files identified that eight of eight files included signed informed consent forms to allow for taking of photographs, collecting health information and outings as part of the admission process and agreement. There are no facility resuscitation forms and processes in place. Improvements are required in this area. One of eight resident files reviewed had completed resuscitation documentation, which had been completed prior to admission. There were admission agreements sighted which were signed by the resident or nominated representative. Discussion with seven relatives identified that the service actively involves them in decisions that affect their relatives' lives.

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

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

**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:**

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

**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.

<b>Attainment and Risk:</b> PA Low
<p><b>Evidence:</b></p> <p>Mossbrae has policies and procedures relating to informed consent. The service has a philosophy and policy to allow natural death and that no resuscitation is provided. This policy is made known to prospective residents prior to admission. A review of eight files identified that eight of eight files included signed informed consent forms to allow for taking of photographs, collecting health information and outings as part of the admission process and agreement. There are no facility resuscitation forms and processes in place, however, one of eight resident files reviewed had completed advanced directive (resuscitation decision) which the resident had completed prior to admission. Since the draft report the provider as stated "All new Residents and Families have our resuscitation policy given to them and discussed prior to entry to Mossbrae. (To date they have never declined a resident entry and no clients has declined their services because of this policy). Their initial assessment (completed by registered nurse (RN) in association with client and family) does have content that acknowledges Resident instructions and wishes re: resuscitation and end of life care".</p>
<p><b>Finding:</b></p> <p>The current service philosophy and policy to 'allow natural death' translates that no resuscitation is provided to residents. This policy does not provide opportunity for residents to make an informed choice or decision regarding options for resuscitation in the event of an acute medical, life threatening episode. No resuscitation decision forms are in place for seven of eight files reviewed and no evidence that GP's are involved in the decision making process.</p>
<p><b>Corrective Action:</b></p> <p>Provide documented evidence that all residents are given the opportunity to make an informed decision regarding resuscitation with input from general practitioners.</p>
<b>Timeframe (days):</b> 90 <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:**

An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception.

Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items.

D4.1e; The residents' files include information on residents family/whanau and chosen social networks.

Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.

D4.1d; Discussions with seven relatives (three rest home and four hospital) identify that the service provides opportunities for the family/EPOA to be involved in decisions.

### 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 client information pack informs visiting can occur at any reasonable time. Interviews with 11 residents and seven relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans.

D3.1.e Discussions with residents and relatives verify that they are supported and encouraged to remain involved in the community. Mossbrae support on-going access

to community services (e.g. church, general practitioner visits, and family outings). Entertainers are invited to perform at the facility.  
D3.1h: Discussions with families verify that they are encouraged to be involved with the service and care.

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

Consumers have access to visitors of their choice.

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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:**

A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Interviews with 11 residents and seven relatives are familiar with the complaints procedure and state any concerns or complaints are addressed. The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been two lodged complaints in 2013 and one for 2014. The 2014 complaint related to the quality of the evening meal. The facility conducted meetings with residents and the contracted food company who have made improvements to the service. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint. Complaints are discussed at quality meetings and staff meetings. D13.3h. A complaints procedure is provided to residents within the information pack at entry.

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

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

**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 1.1.13.3 (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:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>Mossbrae is a privately owned facility, which provides rest home and hospital level care for up to 64 residents – all dual purpose beds – across two units. On the days of audit there were 61 residents – 12 rest home and 49 hospital including one hospital respite resident. The two units are Argyle and Inglis, with a mixture of rest home and hospital residents in each wing. The facility is managed by an experienced registered nurse who has been in the role for over 10 years. She is supported by an assistant manager (registered nurse), registered nurses and care staff. There are clearly defined and measurable goals developed for the business plan and quality and risk management plan. The philosophy of care sets out the vision and values of the service: “As people in our own homes we are able to have an environment that allows a strong sense of our self-identity, privacy, security, and a sense of belonging. Mossbrae strives to preserve these features through promoting the individual and their health, emphasising your capabilities, fostering self-respect, valuing lifelong contributions and creating opportunities for growth and fun”. The philosophy statement is included in the information booklet, which is given to each resident and family on admission.</p> <p>An organisational chart visually describes reporting relationships for the ownership and management structure. The manager reports to the owners on a range of issues each month relating to financial management, occupancy, staff retention and recruitment and building repairs and maintenance. The owners visit three monthly to talk to staff and residents. The business plan 2010 – 2015 provides strategic direction for Mossbrae. Quality goals are set by each of the management committees – quality improvement, management, and activities. The quality goals and plans include but are not limited to: improving laundry processes, interRAI training, and resident care, staffing, and strengthening community links. The risk management plan includes a focus on financial, physical environment, resident and staff risks. Quality indicators are documented and reviewed annually at the first meeting of the year for each committee. Dates for completion are documented with evidence of on-going monitoring. The internal audit programme regularly assesses service performance.</p> <p>The manager has attended professional development in the past year relating to managing a rest home/hospital including attending regular provider meetings, human resource management, aged care association manager study day and professional boundaries for registered nurses.</p>

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> In the manager's absence, the assistant manager (registered nurse) is in charge. The manager is responsible for the day to day functions of the organisation, including oversight of the quality and risk management programme with support from the assistant manager. Management committee meetings are held three monthly between the

manager, assistant manager and the owners with discussion around occupancy, resident issues, and staffing.  
D19.1a; A review of the documentation, policies and procedures and from discussions with staff, identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality.

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The quality and risk management system is understood and implemented by the manager, and staff. There are clearly defined and measurable goals developed for the business plan 2010 – 2015 and the quality and risk management plan for 2014. The philosophy of care sets out the vision and values of the service: “As people in our own homes we are able to have an environment that allows a strong sense of our self-identity, privacy, security, and a sense of belonging.</p> <p>Mossbrae strives to preserve these features through promoting the individual and their health, emphasising your capabilities, fostering self-respect, valuing lifelong contributions and creating opportunities for growth and fun”. The philosophy statement is included in the information booklet, which is given to each resident and family on admission.</p> <p>A comprehensive set of policies and procedures are in place. The manager reports that new and/or revised policies are developed with input from staff. The manager signs off on all new policies. They are available for staff to read and to sign after reading.</p> <p>Policies and procedures are stored in hard copy at the facility. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed yearly unless changes occur more frequently. As a face sheet in each manual, and lists of policies and procedures that have been either recently developed or revised are documented.</p>

Key components of service delivery are linked to the quality and risk management programmes. The service has a current quality programme and a risk management plan for 2014. Quality goals are set by each of the management committees – quality improvement, management, and activities. The quality goals and plans include but are not limited to: improving laundry processes, interRAI training, and resident care, staffing, and strengthening community links. The risk management plan includes a focus on financial, physical environment, resident and staff risks. Quality indicators are documented and reviewed annually at the first meeting of the year for each committee. Dates for completion are documented with evidence of on-going monitoring. The internal audit programme regularly assesses service performance. The resident/relative survey conducted in March 2014 attracted comments, which were very positive with residents and families stating they were over all very satisfied. Survey outcomes were communicated to residents via the March 2014 resident meeting. Discussions with individual residents also occurred to address any issues that were identified via the survey process. Residents/families were surveyed around care and support, heating, cleaning, privacy, meals, communication, visiting, response to complaints, access to a doctor, activities and outings, appearance of residents, and maintenance. Management meetings are held three monthly with the owners. General staff meetings are held two monthly (minutes sighted for 19 February 2014). Quality assurance committee meetings are held monthly with standing agenda items including occupancy, incident and accident reporting, infection control, complaints and compliments, restraint, health and safety, internal audits, surveys, policies and in-service education. Resident and family meetings are held three monthly in each wing– minutes sighted for March 2014. Further committees include two monthly infection control, and health and safety, and monthly registered/enrolled nurses meetings. Discussion is held at residents meetings around food, activities, concerns or complaints, personal cares, laundry and cleaning with minutes posted on the resident notice board.

The internal audit programme involves monitoring areas of quality and risk including activities, care plan audit, cleaning, hand hygiene, continence, infection control, residents' rights, laundry, behaviours, and privacy of information, restraint, safety, and waste management. The manager is responsible for ensuring all internal audits are completed. Tasks are delegated to the assistant manager and to staff where appropriate. On review of the completed audits for 2013 and 2014 year-to-date, it is noted that the actual audits are being completed as per the audit schedule with corrective actions implemented and reviewed.

Data that is collected is analysed, evaluated and communicated to staff. Corrective actions are put into place where opportunities for improvements are identified. Results of the internal audits are discussed in the quality assurance committee, staff meetings, and three monthly management meetings.

Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register. The register is updated as new hazards are identified. Risks and hazards are monitored through the internal audit programme (sighted).

D10.1: Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

D19.3: there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g: Falls prevention strategies include closely observing residents who are at risk of falling, use of mobility aids, correct footwear and exercise and walking groups.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.3.4 (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):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D19.3b; There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

Adverse events (including but not limited to: falls, skin tears, bruising, challenging behaviours, medication errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by a registered nurse. Data is collected and collated on a monthly basis. Results are communicated to staff at the staff meetings, health and safety meetings, quality assurance meetings and registered nurse meetings (meeting minutes sighted).

A sample of 17 incident forms were reviewed for March 2014 relating to six hospital residents. Incident reports reviewed included falls, skin tears, and bruising. One medication error from February 2014 was also reviewed. Registered nurses interviewed (three) advised that they contact family following an incident or accident and this is evident in incident forms or progress notes reviewed. Adverse events include an investigation. Follow up is conducted by the registered nurse and GP is notified if required. Either the registered nurse or assistant manager investigates all events with further follow up by the manager if required. Further care and support is documented in resident files including wound care plans, short term care plans, and/or additions to the long term care plan for six of six incident related files reviewed. The adverse events form documents the follow-up actions taken. Monthly incident/accident analysis is conducted and results discussed at staff meetings. Annual collation and analysis of reports is conducted.

Statutory and regulatory obligations are understood by the manager. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner.

### 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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are 73 staff employed at Mossbrae which includes a manager, assistant manager, registered and enrolled nurses, caregivers, housekeeping and kitchen staff and activities person. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for the registered and enrolled nurses. Practising certificates were also sighted for general practitioners, pharmacist and physiotherapist.</p> <p>Ten staff files were randomly selected for review (the assistant manager, two registered nurses, one enrolled nurse, one kitchen assistant, one activities coordinator and four caregivers). Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, evidence of a completed orientation programme including evidence of competency. All staff have a current first aid certificate. Staff undergo initial and annual performance appraisals, evident in ten of ten staff files reviewed. One staff member file reviewed commenced employment in the past three months.</p> <p>Mossbrae has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently (evidenced in the completed orientation checklists for one new caregiver). Interviews with eight caregivers confirm their orientation to the service was thorough. All ten staff files reviewed reflected evidence of an orientation programme that had been completed.</p> <p>Discussion with the registered and enrolled nurses and caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and year to date for 2014 with a plan in place for the remainder of 2014. The annual training programme exceeds eight hours annually.</p> <p>Caregivers interviewed have completed either the national certificate in care of the elderly or similar NZQA qualifications. The caregiver training programme was previously provided by a local tertiary institution; however, this contract is no longer available. There is currently no specific caregiver training programme in place at Mossbrae. Advised that the service is currently looking at training provider options for continuation of a caregiver education programme.</p>

A system is in place to identify, plan, facilitate and record on-going education for staff. All staff are required to attend training for the following: fire safety and evacuation, infection control, restraint minimisation, first aid, manual handling and topics relating to the code of rights including privacy, informed consent, the complaints process and open disclosure. The education and training plan for 2013 included the following: fire training, infection control, code of resident's rights, restraint, health and safety, safe chemical handling, elder abuse, nutrition and hydration, first aid, continence, medication management, moving and handling, standard precautions. Education is provided either as face to face sessions, self-directed reading and learning or attendance at off-site sessions. The assistant manager and one registered nurse have completed interRAI training and one registered nurse is in the process of completing. Attendance rates at education are recorded and evidence good levels of attendance by staff. All staff complete hand hygiene competency. Registered nurse and senior caregiver competencies include blood sugar monitoring, PEG feeds, medications, wound care, and insulin administration. Registered nurses also complete IV certification, subcutaneous injection and subcutaneous fluid administration and two yearly syringe driver competency. A tracking process is in place to ensure competencies are completed and this is managed by the assistant manager.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

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

**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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> A service provision policy is in place, which includes staffing levels and skills mix. Staffing rosters were sighted. Part time and casual staff fill casual shifts and no agency staff are available. The manager and assistant manager both work fulltime. There is at least one registered nurse on duty at all times. Between Monday and Friday there is one registered nurse (RN) plus either another RN or an enrolled nurse (EN) on duty with extra RN cover provided by the manager and assistant manager. On the

weekends there are two RN's on duty for am and pm shift. Both wings (Argyle and Inglis) have the same roster with caregivers providing a mixture of short and long shifts during the am and pm shifts. At night there is one RN on duty and two caregivers. The manager and assistant manager are available after hours for clinical and non-clinical service issues. There is further support from general practitioners, and St Johns ambulance service if required. Care staff interviewed advised that they are well supported by the manager and registered nurses. Other staff include a manager's assistant, two activities coordinators, kitchen assistants, housekeeping and laundry staff and a maintenance person. Activities are provided from 9am until 3pm by two activities coordinators with a further 12 hours spread throughout the week. Staff turnover is reported by the owner/ manager as low. Staffing levels are altered according to resident numbers and acuity. Three general practitioners interviewed confirm that staffing is appropriate to meet the needs of residents. Eleven residents and seven relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.

**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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurse's station. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</p> <p>D7.1 entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.</p> <p>Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.</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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

**Criterion 1.2.9.10 (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):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy for resident admissions that includes responsibilities, assessment processes and timeframes. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whanau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. Seven relatives (three rest home and four hospital) and eleven residents (two rest home and nine hospital) interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for five resident files sampled. The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission agreement.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The admission policy describes the declined entry to services process. Mossbrae records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whānau back to the referral agency The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

**Finding:**

**Corrective Action:**

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

### **Standard 1.3.3: 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:**

In all long term resident's files (two rest home, five hospital) sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Reviews are conducted three-six monthly or earlier if resident health changes. These are conducted by the registered nurse with input from the care staff, activities coordinator, general practitioner (GP) and relatives. Handover occurs at the end of each duty that maintains a continuity of service delivery. There are communication books, which staff read. The nurse manager and assistant manager share on-call after hours and the weekends. Medical assessments are completed within two working days of admission by the GP as evidenced in seven of the eight files sampled (one hospital resident was a respite resident – link 1.3.4.2). It was noted in residents files reviewed that the GP has assessed the residents as stable and is to be seen three monthly.

The three GPs interviewed stated that the service contacted them in a timely manner, providing information required to assess the residents. The service always carried out any observations and interventions as prescribed.

There is a range of assessment completed on admission and this includes, head, respiratory/cardiovascular, digestive, reproductive, skin, sleep patterns, language, speech, falls risk (water low assessment), dietary requirements, dietary management, pain, orientation, mental ability, mood, mobility, perception/sensory, social history, life history, sexuality/privacy, cultural/spiritual values and level of personal ability.

The service has recently commenced using InterRAI and the assistant manager reports a total of 15 residents in the facility have completed InterRAI assessments. Long term care plans reviewed for seven of eight files sampled evidenced comprehensive and resident focused goals and interventions. All seven files identified integration of allied health (plus one hospital respite resident).

The sample of files reviewed included two rest home and six hospital:

Tracer Methodology Rest Home:

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

Tracer Methodology Hospital:

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

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

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

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> PA Low
<p><b>Evidence:</b></p> <p>In seven of eight files sampled (two from the rest home and six from the hospital), an initial nursing assessment and initial care plan is completed within 24 hours of admission. One hospital level respite resident has not had assessments conducted for current admission. There is a range of assessments completed on admission and this includes, head, respiratory/cardiovascular, digestive, reproductive, skin, sleep patterns, language, speech, falls risk (water low assessment), dietary requirements, dietary management, pain, orientation, mental ability, mood, mobility, perception/sensory, social history, life history, sexuality/privacy, cultural/spiritual values and level of personal ability.</p> <p>The long term care plan is completed within three weeks. The data gathered is then used to plan resident goals and outcomes including dressing and hygiene needs, skin integrity, mobility, nutrition, sleep patterns, elimination, pain, orientation, perception and communication, cultural, spiritual, and social and intimacy need, safety, and breathing. Assessments are conducted in an appropriate and private manner. Two rest home residents and nine hospital residents reported being satisfied the support provided. Assessments are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessments process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessments and care plans. Seven relatives and eleven residents interviewed stated they were informed and involved in the assessment process. The assessment tools link to the individual care plans. The care plans are individualised for each resident need as detailed in the long term care plan. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. The service has recently commenced using InterRAI and the assistant manager reports a total of 15 residents in the facility have completed InterRAI assessments and an associated care plan. Pain assessment has not been completed for two rest home and six hospital resident files reviewed. Pressure area assessment has not been completed for one rest home resident. Nutritional assessment has not been completed for one hospital resident. No new assessments were completed for the respite hospital resident. This is an area that requires improvement.</p>

**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.

<b>Attainment and Risk:</b> PA Low
<p><b>Evidence:</b></p> <p>In seven of eight files sampled (two from the rest home and six from the hospital), an initial nursing assessment and care plan is completed within 24 hours of admission and the long term care plan is completed within three weeks. Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes. Assessments are conducted in an appropriate and private manner. Assessments are detailed and include input from a general practitioner, support</p>

services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission. InterRAI assessment tool has been utilised for 15 residents at Mossbrae.

**Finding:**

While, pain, nutritional and pressure area assessment are completed in the initial assessment for long term Residents, on-going assessments were not in place for; (i) Pain assessments not completed for two rest home residents and six hospital residents. (ii) Pressure area assessment not completed for one rest home resident, (iii) Nutritional assessment not completed for one hospital resident. (iv) No new assessments completed for respite hospital resident.

**Corrective Action:**

(i), (ii), and (iii) Ensure that assessments are completed for all identified needs of the resident;  
(iv) Ensure that a new assessment is completed every time a resident is admitted.

**Timeframe (days):** 90 (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:** PA Low

**Evidence:**

A review of seven of eight resident files include; resident information, initial nursing assessment, initial care plan, comprehensive long term care plan, short term care plans, daily progress notes, observation charts, risk assessment ( # link 1.3.4.2) GP medical notes, lab results allied health reports activities, consents, letters, discharge summaries and NASC assessments. The initial care plan is developed from the initial assessment and identifies areas of concern or risk.

Resident's comprehensive long term care plans are individually developed with the resident and the family. Eleven residents and nine family members interviewed stated they were involved in the care planning process. Seven resident comprehensive long term care plans were evidenced to be up to date. Nursing diagnosis, goals outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to); dressing and hygiene needs, skin integrity, mobility, nutrition, sleep patterns, elimination, pain, orientation, perception and communication, cultural, spiritual, social and intimacy need, safety, and breathing. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. There is evidence that the long term care plans were reviewed three- six monthly. Of the eight files reviewed, seven permanent resident's files (five hospital and two rest home) did not show evidence that activity goals and plans were developed. One hospital respite resident did not show evidence that a current care plan had been developed. The care plan sighted was dated January 2014 from a previous respite admission and has not been reviewed or signed off by an RN to indicate that the plan is still current. This is an area that requires improvement.

There is evidence that the residents are seen by the GP at least three monthly. The GP notes are well maintained.

Short term care plans are used for acute changes in health status. Examples sighted included infections, wounds, and decline in health status. Three files evidenced that family were involved.

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> A review of eight resident files identifies the use of short term and long term care plans. These reflect variances in resident health status. Of the eight files reviewed, seven permanent resident's files (five hospital and two rest home) did not show evidence that activity goals and plans were developed. One hospital respite resident did not show evidence that a current care plan had been developed. The care plan sighted was dated from a previous respite admission
<b>Finding:</b> (i) Of the eight files reviewed, seven permanent resident's files (five hospital and two rest home) did not show evidence that activity goals and plans were developed. (ii) One hospital respite resident did not show evidence that a current care plan had been developed. The care plan sighted was dated from a previous respite admission and did not evidence that it had been reviewed to ensure that it was current.
<b>Corrective Action:</b> (i) Ensure that activity goals and plans are developed for every resident. (ii) Ensure that respite residents have a current care plan developed for each admission.
<b>Timeframe (days):</b> 90 (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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Mossbrae provides services for residents requiring rest home and hospital care. Individual care plan are completed. The eight caregivers, two enrolled nurses and three registered nurses interviewed stated that they have all the equipment referred to in the long term and short term residents care plans necessary to provide the care required. These include wheelchairs, walking frames, weighing scales, transferring equipment pressure relieving equipment, residents safety equipment, electric beds, continence supplies, gowns, masks, aprons and gloves. Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. On the day of the audit supplies of these products were sighted (calibration and servicing of equipment is overdue as per #1.4.2.1).

There are currently 25 wounds being treated including five pressure areas, two leg ulcers, six skin tears, one bruise, eight lesions, one surgical wound, one suture line, and one fungal wound. Wound assessments, management plans and evaluations were completed and evidenced for all wounds. The assistant manager has a diploma in wound care.

The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided in 2013.

All falls are reported on the incident forms and reported to the registered nurse/assistant manager/nurse manager. Falls risk assessment is completed on admission and reviewed three – six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required and this was evidenced for one hospital resident.

There are registered nurses employed 24/7 by the service as well as an assistant manager and nurse manager. A record of all health practitioners practising certificates is kept. Resident's needs are assessed using pre admission documentation, doctor's notes and the assessments tools, which are completed by a registered nurse. Care plans are goal orientated and reviewed three – six monthly. Care plans are updated to reflect intervention changes following review or change in health status.

During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents and relatives interviewed were able to confirm that privacy and dignity was maintained

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are three activities coordinators at Mossbrae who are responsible for the planning and delivery of the activities programme. One of the activity staff has been at Mossbrae for 19 years (five years in activities) and works five and a half hour a days for five days per week. One staff member works 10 hours per week and has been at Mossbrae for 10 years (always in activities) and one staff member has been at Mossbrae for eight months and works 16 hours per week. There are always two staff on duty for activities and three on Wednesday and Thursday. Activities are held between 9am and 3pm. One of the staff works in the rest home and one in the hospital. The activities staff plan the main events at the beginning of the year. They link with the Dunedin activities group and meet monthly to share ideas about activities programmes. The Mossbrae activity staff meet every two months and also with the manager on a regular basis to discuss the programmes. There is a separate programme for Inglis and Argyle units. Afternoon activities are often combined. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events with family involvement. Of the eight files reviewed, seven permanent resident's files (five hospital and two rest home) did not show evidence that activity goals and plans were developed (link #1.3.5.2). The programme includes residents being involved within the community with social clubs, churches and schools. A record is kept of individual resident's activities and monthly progress notes completed. There is a wide range of activities offered that reflect the resident needs including but not limited to: knitting club, bowls club, baking club, craft club, men's club, floral club, newspaper reading, visiting other facilities, quizzes, church services, outings, entertainment, music and one on one visits. Participation in all activities is voluntary. During the audit, school children visit and one on one visits were observed. The activity programme is displayed on the resident's notice boards and a copy is evident in every resident's room. Mossbrae has its own van for transportation. The activity staff have current first aid certificates.

### **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:**

All initial care plans were developed by the registered nurse on the day of admission and residents comprehensive long term care plan developed within three weeks of admission (with exception of the one hospital respite resident). Long term care plans are evaluated three- six monthly of if there is a significant change in health status. Here was documented evidence that care plan evaluations were up to date in all eight files sampled. Changes in health status trigger an update on the care plan. Care plan reviews are signed as completed by the registered nurse There is at least a three monthly review by the medical practitioner or when requested if issues arise or health status changes. Three GP's interviewed stated that the communication from the service is appropriate and in a timely fashion and that the service carries out instructions. They advised that they have confidence in the skills and knowledge of the registered nurse and management team to safely care for residents. Short term care plans were evident for current and previous wounds, skin tears and urinary tract infections. STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  The registered nurses described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, GP, dietitian and physiotherapist. Discussions with the registered nurses and nurse manager identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist and physiotherapist.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**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 are policies to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.

Progress notes document communication with family/EPOA regarding the transfer and updates on residents' condition.

**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 Moderate

### Evidence:

The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accordance with the guidelines: 2011 medicines care Guides for Residential care.

The service has policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents except the hospital respite resident, have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by the GP. Mossbrae uses four weekly blister pack system. Medication charts record prescribed medications by the residents' general practitioners and these are kept in the medication folders. One respite hospital resident does not have a signed medication chart. This is an area that requires improvement.

The medication folders include specimen signatures. There is a signed agreement with the pharmacy. Medications are delivered by the pharmacist and are checked on arrival by the registered nurse. Any pharmacy errors recorded and fed back to the supplying pharmacy. Medication profiles are legible, up to date and reviewed at least three monthly by the GP. Each resident has an individual standing orders form and these have not been reviewed annually for all residents. This is an area requiring improvement.

Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for: allergies and duplicate names. Education on medication management occurred in June 2013. Registered nurse and senior caregiver competencies include blood sugar monitoring, PEG feeds, medications, wound care, and insulin administration. Registered nurses also complete IV certification, subcutaneous injection and subcutaneous fluid administration and two yearly syringe driver competency. A tracking process is in place to ensure competencies are completed and this is managed by the assistant manager.

Medication charts have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term and PRN medication. The service has in place a form, signed by the GP, that the resident can be left with medication to take unsupervised. The staff giving the resident the medication then signs for this on the signing sheet. This is an area that requires improvement.

There are two medication trolleys, one in each wing of the facility. Both are kept in locked treatment rooms. Controlled drugs are stored in a locked safe in each of the facility wings and two medication competent persons must sign controlled drugs out. There is no evidence that six monthly drug stocktake has been completed. This is an area that requires improvement. Staff sign for the administration of medications on medication signing sheet. There were four expired medications sighted on one of the medication trolleys (Inglis wing). This is an area that requires improvement. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. Registered nurses and senior caregivers administer medicines. There is a signed agreement with the pharmacy.

### 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 Moderate

### Evidence:

The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice

in accordance with the guidelines: 2011 medicines care Guides for Residential care.

The service has policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by the GP. Mossbrae uses the four weekly blister pack system. Medication charts record prescribed medications by the residents general practitioners and these are kept in the medication folders

**Finding:**

(i) One respite hospital resident does not have a signed medication chart. The GP has provided a printed list of medications including dosage, times and PRN medications. This list is not signed by the GP. (ii) Each resident has individual standing orders in place. On review of 20 resident medication orders, eight standing orders were last reviewed in 2012. (iii) There is no evidence that six monthly controlled drug stocktake have been completed.

**Corrective Action:**

(i) Ensure that all respite residents have signed medication charts by the GP. (ii) Ensure that standing orders are reviewed annually by the GP, (iii) Ensure that controlled drugs stocktake is completed six monthly.

**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:**

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**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service has a signed form that the GP has indicated that the resident can be left with medication to take unsupervised. Staff conducting the medication round, give the medication to the resident to take at a later time. The staff member, having given the resident the medication, then signs for this on the administration signing sheet but has not witnessed the safe ingestion of the medication.

<b>Finding:</b> Staff are signing for medication administered that they do not witness as being taken.
<b>Corrective Action:</b> Ensure staff sign for medication that is witnessed as taken.
<b>Timeframe (days):</b> 30 (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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Mossbrae has a contract with ACE food services to provide all meals. All food is prepared by ACE production kitchen in Dunedin, which has a credit rating from Dunedin City Council. The operations manager of ACE has a diploma in hotel catering an administration and has been employed with the company for ten years. ACE employs qualified chefs to prepare the food. Food is delivered to Mossbrae in hot boxes three times a day, including morning and afternoon tea. Temperature of hot food is checked at ACE kitchen prior to departure and then again at Mossbrae by the kitchen assistant prior to serving to residents. Evidence of this was sighted. Here are two workable kitchen serving areas at Mossbrae where delivered food is transferred to bain-maries and then served to residents. There are eleven kitchen assistants employed. They are responsible for checking food temperature and checking fridge temperature daily. Kitchen assistants have food safety training. There is a summer and winter four week rotating menu and this has been approved in 2013 by a dietitian. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. There is minimal stores of food on site, which includes snacks such as bread, eggs, sandwiches, cheese and biscuits.

ACE have emergency food supplies as required and have procedures in place to supply the facility in emergencies. Food sighted in the fridges was covered and dated. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed three- six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to ACE food services by the registered nurse as reported by the operations manager. A copy of residents dietary requirements are available in the kitchen as reported by the kitchen hand and sighted. There is also a white board in the serving kitchen with resident's special dietary profiles. This can be viewed only by the kitchen staff. Special diets being catered for include pureed diets and soft diets. Weights are recorded weekly/monthly as directed by the registered nurses. Residents report satisfaction with food choices, meals are well presented. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks. The operations manager for ACE has attended residents/relatives meeting to receive feedback regarding food services and has made changes accordingly.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are policies in place in for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Sluice rooms are locked. Bulk chemicals are stored in a locked storage area adjacent to the facility until required. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interviews with eight caregivers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in July 2013.

#### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> The service displays a current building warrant of fitness, which expires on 10 June 2014. Hot water temperatures checks are conducted and recorded monthly by the

maintenance person. Hot water is provided via a diesel-powered boiler, which provides hot water and heating throughout the facility. Facility policy states that hot water can be set between 43 and 50 degrees Celsius. Hot water temperature recordings reviewed for 2013 and year to date 2014 are consistently recorded between 44 and 48 degrees Celsius. Improvements are required in this area.

The service has two standing and four sling hoists, which were last checked in 2012. Oxygen concentrators and chair scales were last calibrated and serviced in October 2012. Improvements are required in these areas. Annual testing and tagging of electrical equipment has been conducted. The interior is well maintained with a home-like décor and furnishings. Each wing at Mossbrae have a large communal lounge and dining area, with other small sitting areas. In the Argyle wing, there are 31 single rooms and in Inglis wing, there are rooms for 33 residents. Three rooms in Inglis are double rooms and are currently occupied by three married couples. There are sufficient communal toilets and showers facilities within easy access of resident rooms. There are small seating nooks available for residents and visitors. Residents were observed to safely mobilise throughout the facility. There is an external designated smoking area. There is easy access to the outdoors. Outdoor ramps have handrails. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with eight caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** PA Moderate

**Evidence:**

The service displays a current building warrant of fitness, which expires on 10 June 2014. Hot water temperatures checks are conducted and recorded monthly by the maintenance person. Hot water is provided via a diesel-powered boiler, which provides hot water and heating throughout the facility. Facility policy states that hot water can be set between 43 and 50 degrees Celsius. The service has two standing and four sling hoists, which were last checked in 2012. Oxygen concentrators and chair scales were last calibrated and serviced in October 2012.

**Finding:**

a) Hot water temperature recordings reviewed for 2013 and year to date 2014 are consistently recorded between 44 and 48 degrees Celsius; b) medical equipment including chair scales and oxygen concentrators have not been checked or calibrated since October 2012.

**Corrective Action:**

a) Ensure hot water temperatures in resident areas are within acceptable limits; b) ensure that all medical equipment is checked and calibrated by an authorised technician as per manufacturer's instructions.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Five rooms in Argyle and two rooms in Inglis wing have full ensuites. The remainder of the rooms have shared facilities. The number of toilets and showers provided is adequate. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Eleven residents (two rest home and nine hospital) interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets (with exception of staff and visitors – refer finding #3.1.1). Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well-signed and identifiable and vacant/in-use signs.</p>

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There is a large lounge and dining room in each wing with another large lounge in Argyle wing, a large lounge in Inglis and a conservatory in Inglis wing. Other small seating nooks are in each wing. The dining rooms are spacious, located directly off the kitchen/servery areas. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit and 11 residents interviewed report they can move around the facility and staff assist them if required.

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

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

**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 1.4.6: 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:**

Mossbrae has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. Staff attend infection control education and there is appropriate protective clothing available.

Housekeeping staff are employed to attend to cleaning duties. Manufacturer's data safety charts are available. Eleven residents and seven relatives interviewed report satisfaction with the laundry service and cleanliness of the room/facility. Resident satisfaction survey conducted in March 2014 included questions around laundry with 100% satisfaction with the service. Laundry audit conducted in February 2014 and cleaning audit conducted in August 2013.

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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:** FA

**Evidence:**

The service has policies and procedures and training for civil defence, other emergencies and security. Emergency training is included in all new staff orientation. All shifts have a trained first-aider. The New Zealand Fire Service approved the fire evacuation scheme on the 8 July 2005. Fire evacuation drills have occurred six monthly - last conducted on 8 November 2013. A civil defence emergency kit is readily available in the maintenance shed and there is sufficient water stored and accessible in case of emergency. Battery operated emergency lighting, extra torches, gas cooking and diesel powered hot water and heating in use/available. The service is able to obtain a generator from within the community if required in an emergency. Fire alarms and hose reels are checked by a contracted company. Testing and tagging of electrical appliances was last conducted in March 2014. Call bells are evident in resident's rooms, dining and living areas, corridors and toilets/bathrooms. Security policies and procedures are in place. There is a procedure for additional resident supervision to maintain safety.

### 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:**

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

**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.

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

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

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

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated via a diesel powered boiler and radiator system, which can be controlled in each resident's room. Eleven residents and seven relatives interviewed state the environment is warm and comfortable.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

**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

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### 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:**

Mossbrae has policies and procedures on restraint minimisation and safe practice. The manager is the restraint coordinator at Mossbrae. Policy states that enablers are voluntary. There are no residents using enablers and 35 residents assessed as requiring restraint. Restraint in use includes bedrails and lap belts. Thirty-four hospital residents and one rest home resident have bedrails in situ at night as a falls prevention and safety measure. There are six hospital residents with a lap belt in place when in a wheelchair to prevent unsafe behaviours, which result in falls. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort.

Policy also includes definitions for restraint and enablers.

Documentation includes a restraint register for each wing, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms. Restraint education last provided for staff in September 2013 with associated questionnaire and competency.

#### **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.

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

## **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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes key responsibilities for the restraint coordinator, who is also the manager (RN). Restraint use is a regular agenda item in quality assurance and health and safety meetings. Restraint use approval group is part of the quality assurance committee. Staff interviews confirm their understanding of using restraint only as a last resort, is not used for behaviour control and is used as a falls prevention measure and for resident safety and security. Documentation includes restraint register, restraint assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms as evidenced in five hospital resident files reviewed. Restraint education last provided for staff in September 2013. Staff have completed restraint questionnaire and competency.

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Assessments are undertaken by the registered nurse in partnership with the resident and their family/whanau. All restraint assessments are reviewed by the restraint coordinator (manager) as sighted in the six hospital residents' files sampled (five with bedrails and one with lap belt/bedrail). The six files sampled identified that restraint assessment has been conducted for all six residents with restraint. Consent forms are completed for the residents requiring restraint.

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The manager is the restraint co-ordinator. She receives advice and input from the resident's general practitioner and family/whanau. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. Approved restraints include lap belts and bedrails. Six resident files with restraint were reviewed – five bedrails and one bedrail and lap belt. There is evidence that six of six resident's care plan includes reference to the restraint. Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and the expected outcome. Restraint monitoring forms are in place. Six of six restraint files reviewed had a consent form detailing the reason for restraint and the restraint to be used. Monitoring forms are completed. The service has a restraint register in each wing that records sufficient information to provide an auditable record of restraint use.</p>

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

**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 coordinator or RN on duty reassesses each resident using restraint for their on-going restraint needs. The restraint coordinator monitors the review of safe restraint practice. A system of evaluation and review of the restraint for the resident takes place three-monthly. This review assesses the following: alternative strategies explored, desired outcome and whether it is being achieved, whether the restraint used is the least restrictive option, the duration of the restraint, the impact the restraint has on the resident, and were policies and procedures followed. Family/whanau participate in evaluations. Use of restraint is discussed at quality assurance meetings, health and safety meetings (meeting minutes sighted) and at three monthly clinical reviews for each resident.

#### **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.

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

**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.

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

## 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 is responsible for ensuring restraint use is actively minimised, monitored and reviewed for each episode of restraint use. She is also responsible for the review of the restraint programme. This includes the review of restraint policies and procedures and review of the education programme for staff regarding the use of restraints and enablers (evidenced in an interview with the restraint coordinator and review of the internal restraint audit that takes place annually – April 2013).

Episodes of restraint use, trends and progress made in minimising restraint are reviewed to ensure the restraint is only used when necessary, appropriate and safe.

Improvement note:

the service is encouraged to re-evaluate the use of restraint at Mossbrae with the view to reducing the number and incidence of restraint use.

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

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

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## 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:** PA Low

**Evidence:**

Mossbrae has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by an external provider (Bug control) and signed off by the assistant manager who is the service infection control nurse. There is an infection control team, which meets two monthly, and infection control is an agenda item at quality assurance meetings and staff meetings. Discussion and reporting of infection control matters and consequent review of the programme is conducted at these meetings. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff (November 2013 and April 2014). Annual review of the infection control programme was last conducted in May 2013 and is now due for the 2013-year programme. Hand washing facilities are available for staff and residents throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised. It was noted on a tour of the facility that two staff toilets and one visitors toilet have communal cloth hand towels in use for hand hygiene. These were removed on the first day of audit. Improvements are required in this area.

### 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:** PA Low

**Evidence:**

Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff (November 2013 and April 2014). Annual review of the infection control programme was last conducted in May 2013 and is now due for the 2013-year programme. Hand washing facilities are available for staff and residents throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised.

**Finding:**

It was noted on a tour of the facility that two staff toilets and one visitors toilet have communal cloth hand towels in use for hand hygiene. These were removed on the first day of audit.

**Corrective Action:**

Ensure that all hand washing facilities (for residents, staff and visitors) have single use, hand drying facilities to prevent the risk of spread of infection

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 3.1.9 (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):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The assistant manager (registered nurse) is the infection control (IC) nurse. She is supported by the manager, registered nurses and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has attended infection control training. The IC nurse and staff have good external support from the local laboratory infection control team and IC nurse expert at Southern DHB. The infection control team is representative of the facility and includes the assistant manager, one registered nurse, one enrolled nurse and one senior caregiver.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are infection control policy and procedures appropriate to for the size and complexity of the service.  
D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed and updated by the manager and assistant manager to ensure best practice information is included. The policies and procedures were last updated and reviewed in April 2013. Mossbrae's infection control policies

include (but not limited to): hand hygiene, standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse (assistant manager). All infection control training is documented and a record of attendance is maintained. Infection control education was provided in November 2013 in relation to hand washing and hand hygiene, and standard precautions. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. All staff complete an infection control questionnaire. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. No outbreaks have been reported for the past two years. Any resident suspected of having gastro-enteritis is immediately isolated as a precaution. Residents are informed of infection prevention matters that is appropriate to their needs and this is documented in medical records. The registered nurse is attended Bug control infection control education in November 2013 and is due to attend outbreak management at the DHB in May 2014.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Infection surveillance is an integral part of the infection control programme and is described in Mossbrae's infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment,

follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the quality assurance meetings, infection control committee meetings, RN meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Results of infection surveillance are graphed for staff to view and posted on the staff notice board.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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