# Selwyn Care Limited - Selwyn Park

## Current Status: 8 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

Selwyn Park is a purpose built facility that is owned by the Selwyn Foundation. The facility provides residential care for up to 90 residents at rest home, dementia and hospital (medical or geriatric) level care.

Selwyn Park has an experienced facility manager who has a physiotherapy background and has been in the role for one and a half years. The manager is supported by a clinical coordinator (registered nurse) who has been in the role since April 2013.

There is a Selwyn 2013 to 2017 strategic plan. Selwyn Park has a well-established quality and risk management system and the mechanism for monitoring progress, the system is being implemented.

All residents and relatives interviewed spoke very highly about the care and support provided by staff and management.

This audit has identified areas requiring improvement around complaint documentation, a facility specific business plan, completing neurological observations following a head injury and restraint monitoring.

## Audit Summary as at 8 April 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | 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 8 April 2014

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

### Organisational Management as at 8 April 2014

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

### Continuum of Service Delivery as at 8 April 2014

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 8 April 2014

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

### Restraint Minimisation and Safe Practice as at 8 April 2014

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

### Infection Prevention and Control as at 8 April 2014

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

## Audit Results as at 8 April 2014

### Consumer Rights

The Selwyn mission statement reflects Selwyn Park’s objective to deliver services that are responsive to the ageing person and their family. Residents and relatives spoke positively about care provided at the facility. There is a Maori health plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Standard operation procedures are implemented to support residents’ rights. Annual staff training supports staff's understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. There are policies and procedures, a complaints policy and procedure is provided to residents/relatives. There is an improvement required around complaint documentation. Residents and family interviewed verified on-going involvement with community.

There are systems in place to ensure residents and their family are being provided with information to assist them to make informed choices and give informed consent. Staff interviews confirm staff have an understanding of informed consent processes. Residents and family state they have been made aware of and understand the informed consent processes and that appropriate information is provided.

### Organisational Management

Selwyn Park is a part of the Selwyn Foundation. Selwyn Park has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to staff and facility meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Benchmarking and analysis of quality data occurs on a monthly basis. Benchmarking reports demonstrate that the data collected has reflected care and service. This audit has identified areas requiring improvement around a facility specific business plan and completing neurological observations following a knock to the head.

There are human resources standard operation procedures including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and mandatory study days for staff on core topics. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff input into rostering.

### Continuum of Service Delivery

Selwyn Park has a documented entry criteria, which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input, conducted in timely manner and is coordinated to promote continuity of service delivery. Residents or their family have input into the development and review of care plans. The registered nurse develops updates and evaluates the residents' care plans at least six monthly. Short-term care plans are developed for residents who have a change in condition. Residents interviewed state they are satisfied with the standard of care provided by staff and that interventions noted in their care plans are consistent with meeting their needs.

There is a planned activities programme that involves residents in the community and in house. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. Residents interviewed confirm the programme is varied and they can choose what they would like to participate in.

There is an appropriate medicine management system in place. Staff responsible for medicine management have attended in-service education for medication management and staff medication competencies are current. Residents’ medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Changes to residents’ dietary needs are communicated to the kitchen and special diets are noted. Residents confirm satisfaction with the meal service and that adequate fluids are provided and snacks are available between meals. There is evidence that there are additional nutritious snacks available over 24 hours. Kitchen staff have completed food safety training.

### Safe and Appropriate Environment

There are documented policies and procedures for the management of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by staff.

Documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as staff. Communal areas have furniture that is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely. External areas are available for sitting and shading are provided.

There are adequate numbers of accessible toilets/bathing facilities. This includes ensuites, visitor’s toilets and communal toilets conveniently located close to communal areas. Residents are able to access areas for privacy, if required.

Documented policies and procedures for cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are safe and hygienic storage areas for cleaning/laundry equipment and chemicals.

### Restraint Minimisation and Safe Practice

There is a restraint minimisation standard operation procedure. The procedure includes definitions of restraint and enablers, cultural safety, privacy and dignity, approved restraints, use of enablers and the role of the restraint co-ordinator; alternative interventions; external doors; implementing restraint; assessing risk; consent; monitoring; evaluation; quality review; education and related documents.

The service currently has six residents requiring restraint and no residents requiring enablers. This has reduced from 11 residents using restraint one year ago. There is an improvement required around restraint monitoring.

### Infection Prevention and Control

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator who is a registered nurse is responsible for coordinating/providing education and training for staff. The infection control coordinator has attended training. Infection control training is provided yearly for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking infection control data.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## Introduction

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

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

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

## Audit Report

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| --- | --- |
| **Legal entity name:** | Selwyn Care Limited |
| **Certificate name:** | Selwyn Care Limited - Selwyn Park |

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

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| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Selwyn Park | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 8 April 2014 | **End date:** | 9 April 2014 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 81 |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 6 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3 |

## Sample Totals

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 15 | Total audit hours | 31 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 14 | Number of staff interviewed | 13 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 9 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 81 | Number of relatives interviewed | 9 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

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

Dated Friday, 9 May 2014

## Executive Summary of Audit

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| **General Overview** |
| Selwyn Park is a purpose built facility that is owned by the Selwyn Foundation. The facility provides residential care for up to 90 residents at rest home, dementia and hospital (medical or geriatric) level care. Occupancy on the day of the audit was 32 residents at rest home level care, 34 residents at hospital (geriatric) level care and 15 residents in the dementia unit. There are currently no residents requiring care under the medical aspect of the contract.  Selwyn Park has an experienced facility manager who has a physiotherapy background and has been in the role for one and a half years. The manager is supported by a clinical coordinator (registered nurse) who has been in the role since April 2013.  There is a Selwyn 2013 to 2017 strategic plan. Selwyn Park has a well-established quality and risk management system and the mechanism for monitoring progress, the system is being implemented. All residents and relatives interviewed spoke very highly about the care and support provided by staff and management. This audit has identified areas requiring improvement around complaint documentation, a facility specific business plan, completing neurological observations following a head injury and restraint monitoring. |

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| **Outcome 1.1: Consumer Rights** |
| The Selwyn mission statement reflects Selwyn Park’s objective to deliver services that are responsive to the ageing person and their family. Residents and relatives spoke positively about care provided at the facility. There is a Maori health plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Standard operation procedures are implemented to support residents’ rights. Annual staff training supports staff's understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. There are policies and procedures, a complaints policy and procedure is provided to residents/relatives. There is an improvement required around complaint documentation. Residents and family interviewed verified on-going involvement with community.  There are systems in place to ensure residents and their family are being provided with information to assist them to make informed choices and give informed consent. Staff interviews confirm staff have an understanding of informed consent processes. Residents and family state they have been made aware of and understand the informed consent processes and that appropriate information is provided. |

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| **Outcome 1.2: Organisational Management** |
| Selwyn Park is a part of the Selwyn Foundation. Selwyn Park has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to staff and facility meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Benchmarking and analysis of quality data occurs on a monthly basis. Benchmarking reports demonstrate that the data collected has reflected care and service. This audit has identified areas requiring improvement around a facility specific business plan and completing neurological observations following a knock to the head. There are human resources standard operation procedures including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and mandatory study days for staff on core topics. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff input into rostering. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Selwyn Park has a documented entry criteria, which is communicated to residents, family and referral agencies.  Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input, conducted in timely manner and is coordinated to promote continuity of service delivery. Residents or their family have input into the development and review of care plans. The registered nurse develops updates and evaluates the residents' care plans at least six monthly. Short-term care plans are developed for residents who have a change in condition. Residents interviewed state they are satisfied with the standard of care provided by staff and that interventions noted in their care plans are consistent with meeting their needs. There is a planned activities programme that involves residents in the community and in house. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. Residents interviewed confirm the programme is varied and they can choose what they would like to participate in.  There is an appropriate medicine management system in place. Staff responsible for medicine management have attended in-service education for medication management and staff medication competencies are current. Residents’ medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary.  Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Changes to residents’ dietary needs are communicated to the kitchen and special diets are noted. Residents confirm satisfaction with the meal service and that adequate fluids are provided and snacks are available between meals. There is evidence that there are additional nutritious snacks available over 24 hours. Kitchen staff have completed food safety training. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| There are documented policies and procedures for the management of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by staff.  Documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as staff. Communal areas have furniture that is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely. External areas are available for sitting and shading are provided. There are adequate numbers of accessible toilets/bathing facilities. This includes ensuites, visitor’s toilets and communal toilets conveniently located close to communal areas. Residents are able to access areas for privacy, if required.  Documented policies and procedures for cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are safe and hygienic storage areas for cleaning/laundry equipment and chemicals. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a restraint minimisation standard operation procedure. The procedure includes definitions of restraint and enablers, cultural safety, privacy and dignity, approved restraints, use of enablers and the role of the restraint co-ordinator; alternative interventions; external doors; implementing restraint; assessing risk; consent; monitoring; evaluation; quality review; education and related documents.  The service currently has six residents requiring restraint and no residents requiring enablers. This has reduced from 11 residents using restraint one year ago. There is an improvement required around restraint monitoring. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator who is a registered nurse is responsible for coordinating/providing education and training for staff. The infection control coordinator has attended training. Infection control training is provided yearly for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking infection control data. |

## Summary of Attainment

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 46 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 4 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 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 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Eight complaints do not have a written acknowledgement and seven complaints do not have a written response documenting the outcome that is sent to the complainant. | Ensure that there is a written acknowledgement and outcome response provided to all complainants. | 90 |
| HDS(C)S.2008 | Standard 1.2.1: Governance | The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.1.1 | The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | A 2014 Selwyn Park business plan that contains site specific goals and objectives has not yet been developed. | Develop a business plan for Selwyn Park that has site specific goals and objectives. | 180 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Two of four incident forms sampled where the resident had experienced a head injury did not have a full regime of neuro obs completed (noting that one of these had two sets of neuro obs taken but these were not continued). | Ensure that neuro obs are completed for all residents with a knock to the head. | 90 |
| HDS(RMSP)S.2008 | Standard 2.2.3: Safe Restraint Use | Services use restraint safely | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Low | Three of three restraint-monitoring forms sighted show that restraint is not always monitored within stated timeframes. | Ensure all restraints are monitored within stated timeframes. | 90 |

## Continuous Improvement (CI) Report

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

## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Code of Rights (the Code) is clearly visible throughout the facility. A code of rights and responsibilities standard operation procedure (SOP) is implemented and staff could describe how the code is implemented in their everyday delivery of care. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training. Code of rights training last occurred in March 2013 as part of a mandatory study day and 79 staff attended. Interviews with five caregivers (two from the rest home, two from the hospital and one from the dementia unit), determined an understanding of the key principles. Code of Rights is discussed at resident and staff meetings (minutes viewed). Fourteen residents (five from the hospital and nine from the rest home) and nine family members (three from the hospital, two from the rest home and four from the dementia unit), interviewed spoke highly of the staffs respect of all aspects of the Code of Rights. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service provides information in different languages and/or in larger print if requested. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. Information is also given to next of kin or EPOA to read and discuss with the resident in private. On entry to the service, the facility manager, the clinical coordinator or a registered nurse discusses the information pack with the resident and the family/whanau. This includes the Code of Rights (CoR), complaints and advocacy information.  The service notice board includes information on advocacy and advocacy pamphlets are available throughout the facility. Information on complaints and compliments includes information on advocacy. The information pack includes advocacy pamphlets. The service can access local Maori advocacy services should this be requested. The facility chaplain also acts as an advocate for residents. Interviews with residents (14), identified they are well informed about the code of rights. The service provides an open-door procedure for concerns or complaints. Interviews with family members (nine), confirmed they are informed of the code of rights. D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, CoR pamphlet, and advocacy and Health & Disability (HDC) Commission information. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The privacy and confidentiality of information standard operation procedure (SOP) includes the processes around collection of information, storage of information, and access to health information (disclosure). Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of resident’s personal property. All 14 residents and nine family members interviewed stated staff were highly respectful and maintained resident’s privacy especially when discussing personal issues and that personal belongings are not used as communal property. Privacy training as part of Code of Rights training occurred in 2013 as part of the mandatory training days. The resident’s initial assessments and care plans comprehensively detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. Residents interviewed (14) stated their needs were met and staff respect their rights. Cultural safety training occurred in 2013 as part of the mandatory study days. Resident files (nine), reviewed have individual demographic information recorded including residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this. There is a spiritual care SOP. There is a chapel located within the facility and pastoral staff are available for the residents. Multidenominational services are conducted in the facility at least three times each week. Grace is said for all meals and residents comment positively around this in resident meeting minutes. There is a chaplain employed four hours per week. There are various churches locally and residents are encouraged to attend these. All residents and family members interviewed indicated that resident’s spiritual needs are being met when required. There is currently one married couple in the facility. The couple have appropriate information in their care plans regarding staff giving them time together and privacy. This was evidenced at the time of audit. The service includes emotional wellbeing in the care planning process. Resident preferences are identified during the admission and care planning processes and family involvement is documented. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered. All 14 residents interviewed stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview, five caregivers described how they encouraged residents to engage in activities in the facility and to link with community activities including visiting other rest homes and church groups. There is an SOP on abuse and neglect and the topic is covered at orientation and has been addressed at staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Abuse and neglect training last occurred in 2013 as part of the mandatory study days attended by 79 staff. Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. All 14 residents and nine family members interviewed were highly complementary of the care provided and stated staff were very approachable and friendly.  D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. E4.1a All four family members interviewed from the dementia unit stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.  D4.1a: Resident files reviewed identified that cultural, spiritual values and individual preferences are identified. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A3.2 There is a Maori health plan includes a description of how Selwyn Park will achieve the requirements set out in A3.1 (a) to (e) D20.1i: The Selwyn Maori health plan and the Maori partnership SOP was first developed in consultation with Maori advisors and is utilised throughout Selwyn facilities. The DHB tikanga best practice guideline is the foundation document around which the policy has been developed. This guides staff in cultural safety. Local iwi contact details are identified. The head office senior leadership team has a kaumatua position as part of the team. Special events and occasions are celebrated at Selwyn Park and this could be described by staff. The service has access to a Kaumatua who is Archdeacon of Tamaki Makaurau. He is of Ngati Kahu descent and is the priest in charge of the pastorate of the Church of the Holy Sceptre in Grafton (Auckland).  Through the admission and assessment process, cultural needs and specific requirements are identified on an individual basis. A cultural assessment tool is completed for all residents as part of their admission process. There are currently two residents that identify as Maori at Selwyn Park. Both files reviewed of the residents that identified as Maori included cultural consideration/needs and involvement of whanau.  Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. Contact with family/whanau by staff is recorded in the progress notes regarding aspects of their family/whanau member’s stay/care. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has established cultural standard operation procedures aimed at helping meet the cultural needs of its residents. There is a Maori health plan and a Maori partnership SOP. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.  Family are involved in assessment and the care planning process. Information gathered during assessment including residents cultural beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on. Agreement is reached by all parties involved in the consultation process and the care plan is implementation within the service delivery. Fourteen residents interviewed all stated that staff took into account their culture and values. Discussions with nine family members all identified that values and beliefs were considered. D3.1g The service provides a culturally appropriate service by identifying individual’s cultural beliefs and ensuring care provided is appropriate to resident’s beliefs. D4.1c Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The code of conduct is included in the employee agreement. Job descriptions include responsibility of the position, ethics, advocacy and legal issues. Signed copies of all employment documents were sighted in staff files reviewed. There is an abuse and neglect SOP that covers harassment and exploitation. All residents and family members interviewed reported that the staff respected residents. Elderly abuse prevention training occurs at orientation and on a yearly basis and includes professionalism and standards of conduct. Mandatory training last occurred in throughout 2013 around this. The registered nurses (RN's) supervise staff to ensure professional practice is maintained in the service.  There is an SOP to guide staff practice on gifts, gratuities and benefits and delegations of authority. The staff meeting includes any discussions on professional boundaries and concerns. Advised that management provide guidelines and mentoring for specific situations. Interviews with the registered nurse and the clinical coordinator who is a registered nurse described professional boundaries. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies to guide practice that align with the health and disability services standards. Selwyn endeavours to support on-going professional development and creating an environment, which supports the provision of good practice, including evidence-based care. There is a quality management system that is being implemented at Selwyn Park that supports an internal audit programme. The caregivers are encouraged to complete ACE NZQA level training and an internal in-service training programme is implemented. Both the facility manager and the clinical coordinator attend external training sessions appropriate for their positions. The organisation is a member of the NZACA and supports managers to attend the conference each year. The Selwyn Park facility manager attended the full three-day conference in August 2013. Sessions from the conference are then presented to other managers who have been unable to attend, and summarised for other members of the senior leadership team. A2.2: Services are provided at Selwyn Park that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. D1.3: All approved service standards are adhered to. D17.7c: There are implemented competencies for care workers and registered nurses that include medication, restraint and care planning. There are clear ethical and professional standards and boundaries within job descriptions. Selwyn Park has instituted a number of examples of good practice. These include: • Area specific staff meetings (hospital, dementia unit, rest home) have resulted in increased staff attendance, area specific brain storming and problem solving, increased accountability, ownership, and empowerment and ability to review and analyse KPI’s and narrow down root cause analysis. • Appointment of team leaders in each area (hospital, dementia unit, rest home) and appointment of senior registered nurse have resulted in accountability for care plan schedules, admissions, assessments, GP reviews, wound plans, bowel maintenance and general health and wellbeing of the residents, consistency for staff and families, continuity of care for residents and families, more timely response to residents needs including health and wellbeing and presence of management during the weekends to ensure 24/7 visibility of management. • Group block training ACE education days for staff to assist with learning opportunities have resulted in assisting with learning for those staff members where English is a second language, interactive learning experience with whiteboard and real life stories, the ability to ask questions on the spot and peer based reviews. • Falls posters to display to staff occurrence and number of falls per month have resulted in an easy visual display for all staff to read and understand where falls have occurred within the month and facility and an exciting way of delivering the same message to engage staff in the education and prevention of residents falls. • Started a buddy system within the facility to enable staff members to be responsible for resident’s rooms to eliminate the risk of infection through rotting fruit and food. This has resulted in many residents with staff buddy’s finding piles of rotting grapefruit, flowers, other residents property, dirty linen, solid continence products, food and uplifted Selwyn Foundation property in a timely manner and returned or destroyed, decreased incidents of bug invasions due to rotting fruit, decreased incidence of dirty linen being found in piles in residents wardrobes and has prevented potential incidents from occurring. It has also helped settle residents that would otherwise believe their items are lost or stolen. • The clinical coordinator wrote to the mayor about shifting and creating a bus stop outside Selwyn Park to help the residents keep out of the sun and the winter weather. They have managed to get the bus stop shifted so they stop outside of the gates to Selwyn Park and the bus stop structure will be built later this year or early 2015. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| 'D11.3 The information pack is available in large print and advised that this can be read to residents Accident/incidents management procedures alert staff around frank open disclosure and their responsibility to notify family/next of kin of any accident/incident that occurs.  The registered nurses (three) interviewed stated that they record contact with family/whanau in the progress notes. Progress notes were documented in all files reviewed. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Eleven incident forms (a sample from March 2014) reviewed identified that family were notified. Families often give instructions to staff regarding what they would like to be contacted about and when, should an accident/incident of a certain type occur. This is documented in the resident files.  A residents/relatives meeting occurs bi monthly and issues arising from the meeting are fed back to staff meetings. There are a combination of resident meeting for individual units and full facility resident meetings. Issues raised generate an investigation and quality improvement plan (QIP). There is an annual satisfaction survey. Feedback from the survey indicated residents and family are satisfied with the service. There is a communication and interpreters services SOP. A list of language lines and government agencies is available. Access to DHB interpreter services is available. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b Family members (nine) stated that they are always informed when their family members health status changes. D11.3 The information pack is available in large print and advised that this can be read to residents if required. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Nine residents’ files (three rest home, three hospital and three dementia) were reviewed for records pertaining to informed consent processes. The residents' files sampled record documented informed consent, advance directives and not for resuscitation orders. All nine admission agreements sampled are signed by resident or their legal representative and facility representative. Discussions with residents and family identify that the service actively involves them in decisions that affect their lives.  Five caregivers, one clinical coordinator and three registered nurses interviews confirm that they are familiar with the requirements relating to informed consent. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an SOP that describes advocacy services and processes regarding residents rights to advocacy services. Staff last received training on advocacy services as part of code of rights training during mandatory training days in 2013 (attended by 79 staff). Information about accessing advocacy services and advocacy contact details is available in the entrance foyer and throughout the facility. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. The chaplain acts as an advocate to residents. Advocate support is available if requested. Interview with caregivers (five), residents (14) and nine family members, informed they are aware of advocacy and how to access an advocate. Local Maori advocacy services can be accessed if required. D4.1d; Discussion with nine family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.  D4.1e: The resident file includes information on resident’s family/whānau and chosen social networks. ARC D4.1e: The resident file includes information on resident’s family/whanau and chosen social networks. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D3.1.e Discussion with five caregivers, three registered nurses, the clinical coordinator and the activities staff and 14 residents indicates that residents are supported and encouraged to remain involved in the community and external groups such as local schools and regular inter rest home competitions. D3.1h: All nine family members interviewed stated they could visit at any time and that they are encouraged to be involved with the service and care. Visitors were observed coming and going during the audit. D3.1.e: Residents are encouraged to be involved in community activities including RSA and church groups and maintain family and friends networks. On interview all staff (five caregivers, three registered nurses, the clinical coordinator and the activities staff), stated that residents are encouraged to build and maintain relationships. On interview, all residents and family members confirmed this. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The complaints SOP documents the responsibility of the facility manager to ensure all complaints (verbal or written), are fully documented and thoroughly investigated. There is a complaints process flowchart. A record of all complaints per month are entered into the Selwyn database. The number of complaints received each month is reported monthly to care services via the facility benchmarking report. Complaints forms are prominent around the facility.  Eleven complaints were reviewed for 2014 to date. All complaints include evidence of investigation and follow up in the form of a meeting with the complainant or a phone conversation with the complainant. However, eight complaints do not have a written acknowledgement and seven complaints do not have a written response documenting the outcome that is sent to the complainant. Two complaints are still open. This is an area requiring improvement. Verbal complaints are also included and actions are documented. Discussion with 14 residents and nine family members confirmed they were provided with information on complaints and complaints forms and all described having a concern addressed immediately.  The service had one complaint to the DHB in July 2013 and another in March 2014 and one complaint to the Health and Disability Commission around care provided in March 2012 that has not yet been signed off as closed by the Health and Disability Commission. The July 2013 DHB complaint related to the management of continence and heating in the dementia unit. In response to this complaint, the service has had every resident in the facility reassessed by an external continence provider company to ensure they are using the best product for them. All residents have on-going continence assessments at least six monthly in nine of nine files sampled (three from the dementia unit, three from the hospital and three form the rest home). The service also has a policy where residents in the dementia unit are not woken in the mornings and allowed to wake naturally. If a resident has wet night clothes or bedding when they awake this is reported and the continence product in use reviewed to assess if an absorbent product is required. The service has also checked all heaters and ensured these are working and these checks are on-going. Two heat pumps were installed in July 2013 and additional heaters were installed in each of the toilets. The unit was checked at 8.30 am on the second day of the audit and found to be warm and the staff interviewed report it is warm at all times. The second DHB complaint relates to a resident who was admitted to the DHB hospital and had a grade three pressure area. The DHB referred this to the reportable events committee and the facility manager and group residential care manager have met with the funding and planning manager around this in the week prior to the audit. The pressure area had been identified when it appeared at the facility and reported on an incident form and a wound management plan developed. The nature of the resident’s medical conditions means that despite a wound management plan and appropriate dressing the pressure area had deteriorated quickly as confirmed by the clinical coordinator. An internal investigation showed that the clinical coordinator was not made aware of the pressure area in a timely manner and a process has now been introduced where the clinical coordinator must now be informed of all incidents within 24 hours. The investigation by the DHB is on-going. The complaint to the health and disability commission relates to the care of a resident in July 2012 and the service has implemented a number of new processes since this time. Management of weight loss: The staff weigh all residents monthly (or more often if needed) and the weights are provided to the clinical coordinator who enters them into the resident database, which holds all resident weights since mid-2012. This allows the clinical coordinator to be aware of any emerging weight loss issues. The database calculated the % weight change since the previous month and over the last six months. Selwyn Foundation policy is that action is taken if the resident has lost more than 5% of body weight in the past month or more than 10% in six months. However Selwyn Park is more proactive and if a resident has lost any weight the family are notified and the resident is entered on a monthly action sheet to be completed by the senior registered nurse in each area to document all actions taken as a result of the resident losing weight and provide this back to the clinical coordinator who then checks that the documented actions have occurred. Cognitively able residents who have lost weight are provided a monthly menu to record for a month what they do and do not choose to eat on the menu to ensure their dietary preferences are being catered to. All dietitian reports are now also cc’ed to the clinical coordinator, the team leader and the senior RN in that area so the clinical coordinator can ensure that all recommended actions are implemented. Appropriate and timely weight loss interventions were noted in the files of three residents (one dementia, one rest home and one hospital) who have lost weight. Restraint: The facility has decreased restraint use and the three files sampled of residents using restraint show that alternatives were identified and were unsuccessful prior to restraint being used. Sighted in use to minimise restraint use are sensor mats, landing pads and low, low beds. Wherever possible, particularly in the dementia unit there are always staff in the common areas to ensure that residents not safe to walk alone are supervised. The three restraint files sampled show all files have a restraint assessment, a plan around this. There remains an issue around restraint monitoring (link 2.2.3.4). Transfer within the facility: As a result of this complaint the service now treats any resident transferring between units (levels of care) within the facility as a new admission, with and initial assessment and care plan completed on the day of transfer, GP review within 48 hours of transfer and a full new comprehensive set of assessments and a new long term care plan developed. This is monitored monthly by both the clinical coordinator and the group residential care manager using the clinical compliance audit tool (sighted for past six months).This process was confirmed by the review of one residents file for a resident who had transferred from hospital to rest home level care. D13.3h: A complaints procedure is provided to residents and family members within the information pack at entry. E4.1biii: There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:  1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Eleven complaints were reviewed for 2014 to date. All complaints include evidence of investigation and follow up in the form of a meeting with the complainant or a phone conversation with the complainant. Two complaints are still open. Verbal complaints are also included and actions are documented. Discussion with residents and family members confirmed they were provided with information on complaints and complaints forms and all described having a concern addressed immediately. |
| **Finding:** |
| Eight complaints do not have a written acknowledgement and seven complaints do not have a written response documenting the outcome that is sent to the complainant. |
| **Corrective Action:** |
| Ensure that there is a written acknowledgement and outcome response provided to all complainants. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

## Outcome 1.2: Organisational Management

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Selwyn Park is a purpose built facility that is part of a larger village. The facility provides residential care for up to 90 residents at rest home, dementia and hospital (medical or geriatric) level care. Occupancy on the day of the audit was 32 residents at rest home level care, 34 residents at hospital (geriatric) level care and 15 residents in the dementia unit. There are currently no residents requiring care under the medical aspect of the contract.  Selwyn has an overall mission statement "to deliver quality services that are responsive to the ageing person and their family.” The organisational model of care is called "The Selwyn Way.” The four key values within the model are care, independence, wellness and diversity. A copy of the model is given to residents and family members in the information pack.  The Selwyn Foundation is a charitable organisation that is governed by nine appointed board members. There is a chief executive officer who heads the organisations leadership team and he reports to the board. A leadership team chart with photos and job titles and a copy of the organisations strategic plan is given to residents and family members as part of the information pack on entry to the service. The organisation wide strategic plan for 2013 to 2017, which contains broad organisational strategic goals. There is a senior management level, organisation wide business plan that contains goals that align with the organisations strategic plan. A 2014 Selwyn Park business plan that contains site specific goals and objectives has not yet been developed. The 2013 goals were reviewed and progress documented with the organisations general manager – operations. Selwyn has robust quality and risk management systems implemented across its facilities. Across all Selwyn, facilities collated data including accidents/accidents, infection control (IC), complaints and restraint is analysed and benchmarked internally. Selwyn also benchmarks with another NZ provider. Selwyn Park has an experienced facility manager who has a physiotherapy background and has been in the role for one and a half years. She is supported by a clinical coordinator (RN) who has been in the role for since April 2013 and has a post graduate certificate in health science and is currently completing a post graduate diploma in this. There are job descriptions for both positions that include responsibilities and accountabilities.  Selwyn provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend meetings and training at head office. The organisation is a member of the NZACA and supports managers to attend the conference each year. Sessions from the conference are then presented to other managers who have been unable to attend, and summarised for other members of the senior leadership team. ARC, D17.3di (rest home): The manager and clinical coordinator have maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. The manager attended the three day New Zealand Aged Care Association conference in 2013 and attends biannual full day Selwyn manager’s trainings including two in 2013. In addition, she attended three DHB managers’ seminars in 2013. E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is an organisation wide strategic plan for 2013 to 2017, which contains broad organisational strategic goals. There is a senior management level, organisation wide business plan that contains goals that align with the organisations strategic plan. |
| **Finding:** |
| A 2014 Selwyn Park business plan that contains site specific goals and objectives has not yet been developed. |
| **Corrective Action:** |
| Develop a business plan for Selwyn Park that has site specific goals and objectives. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the absence of the facility manager, the clinical coordinator oversees the management of the facility. The service has standard operations procedures to guide practice that are appropriate for rest home, dementia and hospital level care. D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement and risk management programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Selwyn Park has a quality and risk system that is being implemented. The facility manager is directly involved in operations at the facility and the clinical coordinator supports her in this role. Interviews with five caregivers, three registered nurses and the clinical coordinator and review of meeting minutes demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, and also to the organisation's management team. The service has standard operations procedures (SOP's) and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All Selwyn facilities have access to all organisational standard operation procedures. These procedures have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of SOP's are detailed to allow effective implementation by staff. A number of core clinical components including infection control and restraint have education packages for staff, which are based on their SOP's and were developed by the director of nursing. SOP's are reviewed at head office level and feedback is gained at facility level. The service has a health and safety management SOP and this includes the identification of a health and safety rep. Security and safety procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Health and safety and a hazard register is completed. Health and safety internal audits are completed. Analysis of results is completed and provided across the organisation. Key components of the quality management system link to the Selwyn Park combined staff/quality/ IC/restraint and health and safety meetings. There is a separate meeting in each unit (rest home, hospital and dementia) one month and a full staff meeting the next month. All meetings cover the set agenda for the combined meeting format. There is also a monthly registered nurses meeting. Each department provides quality reports on a monthly basis. Analysis and benchmarking information is discussed at monthly unit or staff meetings. Monthly accident/incident data is entered into the Selwyn data base and a head office representative develops a monthly quality improvement report for each facility. Benchmarking graphs are generated from the data. The service has linked the complaints process with its quality management system and complaints are benchmarked. The service also communicates this information to staff and at other relevant meetings so that improvements are facilitated. There is an infection control register, which is held electronically in which all infections are documented each month. Infection control rates, outbreaks and results of satisfaction surveys are reported to the care services team at staff meetings or sooner if required. A range of infection control internal audits are planned and undertaken three monthly throughout the year. Results are forwarded to the staff meetings.   All facilities restraint coordinators meet six monthly at head office. These meetings include a comprehensive review of restraint/enabler use. Restraint and enabler internal audits are completed three monthly. Selwyn Park has significantly reduced the restraint usage in the past year. There is a quality and risk management process being implemented at Selwyn Park. Monitoring programme includes (but not limited to); cleaning, hot water, laundry, medication, call bells and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues and scores are entered into the database. Any audit that scores less than 100% has a quality improvement plan (QIP) generated electronically. QIP's are investigated and corrective actions implemented in determined timelines. Reviews and closure of QIP's are documented. Selwyn is active in analysing data collected and QIP management. Benchmarking reports are generated throughout the year to review performance over a 12 month period. The service continues to collect data to support the implementation of QIP's. Feedback is provided to all facilities via graphs. There is an annual resident and separate relative satisfaction survey completed by Press Gayney each year. This was last completed in 2013 and Selwyn Park was compared with 98 similar facilities in Australasia. The Selwyn Park overall result was in the 65th percentile. Respondents were asked to prioritise areas in terms of importance to them and the top 10 priority areas were identified. Selwyn Park is currently in the process of raising QIP’s for areas where they performed less well, relating to the priorities identified.  D19.3 There are implemented risk management and health and safety SOP's in place including accident and hazard management. D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| D19.3b; The service collects incident and accident data. There is an incident reporting standard operations procedure and an incident/injury management process that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise or prevent further incidents. The service documents and analyses incidents/accidents, unplanned or unwanted events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Two of four incident forms sampled where the resident had experienced a head injury did not have a full regime of neurological observations completed (noting that one of these had two sets of neurological observations taken but these were not continued). This is an area requiring improvement. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the staff meetings reflect a discussion of results.  Eleven incident forms (a sample from March 2014) were reviewed and all demonstrated clinical follow up by a registered nurse/clinical coordinator and changes to care plans have been implemented undertaken when indicated (link 1.2.4.3).  D19.3c Selwyn has a standard operations procedure that describes responsibilities around reporting of serious event. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service had a gastric outbreak in February 2014 (not norovirus) and another in March 2014 (results not yet back to confirm norovirus). Public Health was notified of each outbreak in a timely manner. |

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| D19.3b; The service collects incident and accident data. There is an incident reporting standard operations procedure and an incident/injury management process that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise or prevent further incidents. The service documents and analyses incidents/accidents, unplanned or unwanted events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the staff meetings reflect a discussion of results.  Eleven incident forms (a sample from March 2014) were reviewed and all demonstrated clinical follow up by a registered nurse/clinical coordinator and changes to care plans have been implemented undertaken when indicated. |
| **Finding:** |
| Two of four incident forms sampled where the resident had experienced a head injury did not have a full regime of neurological observations completed (noting that one of these had two sets of neurological observations taken but these were not continued). |
| **Corrective Action:** |
| Ensure that neuro obs are completed for all residents with a knock to the head. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A register of qualified nurses practising certificates is maintained (viewed). There are comprehensive human resources SOP is including recruitment, selection, orientation, staff training and development. Nine staff files reviewed (the clinical coordinator, one registered nurse, the diversional therapist, one cleaner and five caregivers), all had up to date performance appraisals.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies. New staff are buddied during orientation and during this period, they do not carry a clinical load. Completed orientation booklets are on staff files. Staff interviewed (five caregivers, three registered nurses, the clinical coordinator and the activities staff), were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The Selwyn education standard operation procedure identifies the mandatory training for core topics and refresher training required for each role and the frequency that this is required to be completed. The mandatory trainings are divided over two training days and each training day is repeated several times throughout the year. In 2013, 79 of 79 staff (at that time) attended mandatory training day one and 77 of 79 staff attended mandatory training day two. The annual education schedule is being implemented. There are core-training packages in key areas including infection control and restraint.  Caregivers are encouraged to complete ACE. Currently of 49 caregivers, six have completed the national certificate including Aged Care Education (ACE) core, advanced and dementia, one has completed dementia and advanced, and a further 16 have completed ACE dementia. Twenty-two residents are enrolled to complete an ACE qualification in 2014. External education is available via the DHB. There is evidence on RN and the clinical coordinator staff files of external training. Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality/staff meetings.  A competency programme is in place. Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.  D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, restraint and care planning. E4.5d: The orientation programme is relevant to the dementia unit and includes a session on how to implement activities and therapies. E4.5e: There is an appropriate orientation for agency staff although these are very rarely used in the dementia unit. E4.5f: There are 19 caregivers who work in the dementia unit. Seventeen have completed the ACE dementia standards and the other two caregivers (who are new) are enrolled to commence this. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. The service has a staffing levels SOP implemented, which determines that the facility manager or the clinical coordinator, will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. There is a clinical coordinator who works five weekdays per week at Selwyn Park plus on call Monday to Friday and on second call to the senior registered nurse at weekends. She is supported by a senior registered nurse who works in the hospital that assumes responsibility for the whole facility in weekends including on call in the weekends. There is a team leader who is a registered nurse in the rest home and hospital five days per week and in the dementia unit three days per week. The hospital team leader supports the senior registered nurse on the three days they work together. The team leaders and senior registered nurse have different responsibilities. Additionally there is one extra registered nurse from 0800 hours to 1200 hours in the hospital, one who works 1445 to 2315 and another who works 1700 to 2100. There is also a registered nurse from 2245 to 0715 hours.  The clinical coordinator covers the facility manager during absences and holidays. A regional Selwyn physiotherapist provides physiotherapy services for the facility four hours per week. Urgent cases outside of the physiotherapy hours can be taken to the physiotherapist’s rooms if possible. All residents and family members interviewed stated that they felt there was sufficient staffing. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The 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 support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. There is a clinical records authorisation SOP. Resident files are protected from unauthorised access by being held in a secure room and noncurrent files are archived. Care plans and notes are legible and where necessary signed and dated by a registered nurse (RN). All resident records contain the name of resident and the name of the person completing the documentation.  Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.  D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. SOP's contain the service name. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy and procedures for entry to services are recorded and implemented. The facility manager interview confirms access and entry processes are followed. There is a facility information pack available for residents and their family. Resident information pack is sighted and contains all relevant information.  Resident files sampled demonstrate all needs assessments are completed for rest home, hospital or dementia level of care. Interviews with fourteen residents (nine rest home and five hospital) and nine family (two rest home, three hospital and four dementia) confirm the admission process was conducted by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.  The service provides information to potential referral sources. This facility operates 24 hours a day, seven days per week. The admission agreement defines scope of service and includes all contractual requirements.  Nine residents' files (three rest home, three hospital and three dementia) were sampled. All residents' admission agreements sampled evidence residents' and facility representative sign off. D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility. D14.1 Exclusions from the service are included in the admission agreement. D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Systems to decline resident entry to the service are documented. The scope of the service provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the facility manager. The facility manager states resident will be declined entry if not within the scope of the service or if a bed is not available at the time. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) is conducted with resident and/or family input, within required timeframes and the service is coordinated to promote continuity of service delivery.  Clinical staff (three registered nurses (RN), one clinical coordinator (RN) and five caregivers) interviews confirm residents and/or family members are involved in all stages of service provision.  Fourteen of 14 resident (nine rest home and five hospital) interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews. All nine resident files evidence there is integration of allied health personnel and a team approach to service delivery. All nine residents' files (three rest home, three hospital and three dementia) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations.  Family communication sheets are maintained, sighted in all residents' files reviewed. Copies of the registered nurses, GPs and other allied health providers practising certificates are kept on file by the management team.  All nine resident files reviewed identify that the general practitioner (GP) had seen the resident within two working days of the resident’s admission to the facility. It was noted in all nine resident files sampled that the GP has assessed the resident as stable and able to be seen one or three monthly. The GP visits the facility two days a week or more frequently as required, confirmed at GP interview.   An initial nursing assessment, initial care plan and goals of care are individually developed on admission.  Five of five caregivers( two from rest home, two from hospital and one from dementia unit), three registered nurses ( one from rest home and two from hospital), interviewed describe a verbal and written handover at the beginning of each shift where any issues or changes in resident status are discussed. The auditor evidenced verbal briefing from morning to an afternoon shift.  General practitioner (GP) interview was conducted and confirms the GP has been providing medical services for the facility for around four years. The interview with the GP confirms that staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff.  Tracer Methodology hospital. XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology rest home. XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer Methodology Dementia XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical coordinator (RN) or registered nurses undertake the assessments on admission. The initial admission assessment and the initial care plan is completed on admission, evidenced in all nine residents’ file reviewed. The organisation has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. Policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.  Residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider (NASC) assessments are available. The facility has appropriate resources and equipment. The clinical coordinator and RN interviews confirm that assessments are conducted in a safe and appropriate setting including visits from the doctor.  Risk assessments include (but not limited to) continence assessment, mobility assessment, nutrition assessment, pain assessment, falls risk assessment, medical, functional ability, pressure risk assessment and behavioural assessments.  Example: resident with weight loss had reassessment of nutritional needs and dietitian assessment completed. Resident with behaviours that challenge had regular evaluation of behaviour assessment including management strategies. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The residents' files sampled evidence residents' care plans are individualised and up-to-date. The long-term and short-term goals are identified and reviewed at regular intervals, at least six monthly or as needs change. Residents have input into their care planning and review, confirmed at all resident interviews. Clinical staff interviewed confirm that care plans are accurate and up to date.  Residents' files sampled evidence the clinical care/treatment/support or interventions that are to be provided by staff are current; the risk assessment findings are recorded on the care plans. The facility ensures access to regular GP care, confirmed at GP interview. The long-term care plan is completed within three weeks of resident’s admission to the facility.GP involvement occurs within 48 hours of resident’s admission.  The sample of files reviewed include; a) resident with recent admission to DHB and chronic wound b) three residents with identified weight loss, c) three residents with behaviours that challenge, d) two residents with recent infections.  Service delivery plans demonstrate service integration and input from allied health.  Fourteen resident and nine family interviews confirm care delivery and support by staff is consistent with their expectations.   D16.3k: Short term care plans are in use for changes in health status. D16.3f: All resident files reviewed identify that resident and /or family are involved. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Nine resident (three rest home, three hospital and three dementia) files were sampled. Residents' files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. GPs documentation and records are current. Selwyn Park provides services for residents requiring rest home, hospital and dementia level of care. The care being provided is consistent with the needs of residents. There is a short-term care plan that is used for acute or short-term changes in health status.  Resident care audit was conducted in February 2014 with 100% compliance.  D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available. Continence assessments including bowel management and continence products identified for day use, night use, and other management are completed on admission and reviewed six monthly. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided through the mandatory study days. The wound folder was reviewed and evidences wound assessments and wound management plans are recorded for all current wounds. There were two wounds in the dementia unit, two wounds in the rest home and 12 wounds in the hospital. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are two diversional therapists and four activities assistants employed at the facility. I interview with one diversional therapist (DT) was conducted and confirms the activities programme meets the needs of the service group and the service has appropriate equipment. There are three activities programmes; one for the rest home, one for the hospital and one for the dementia residents. Activities attendance records are maintained and were sighted.  Residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned / spontaneous activities including festive occasions and celebrations. There are interdenominational church services at the facility. A number of activities initiatives have been implemented since the last audit. These include:  • Men’s outings • Dementia residents sailing boats regularly • Vintage car club outings • Thai restaurant lunches  • Pie day • Kamo bowls competitions at Selwyn and at Kamo Home • Baking food • Nature walks • Lunch and picnics out  • Sweet stalls • Jewellery stalls • Clothing Sales • Mobile library comes to the facility for easy access to books for the residents. • SPCA therapy animals visit weekly • Spontaneous entertainment acts i.e. circus entertainer on a unicycle, blind pianist, Australian girls’ choir, and Elvis. • Second hand trade table • Riding for the disabled horse trip for residents • One of the first Whangarei residents to go over the new town bridge in the Selwyn Park van – invited by the mayor. • Craft group in rest home and newly started in hospital. Residents' meetings are held separately for the rest home and the hospital residents and minutes of meetings were sighted for May, July and August 2013.  Residents' files sampled demonstrate the individual activities care plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being.  D16.5d Monthly progress notes are written and six monthly evaluation is documented as occurring. A diversional therapy assessment documents a social history and previous interests and the care plan includes goals. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is documented evidence that the care plans were reviewed by registered nurses and amended when current health changes.  A review of nine files identify that reassessment by the registered nurse of assessment tools were completed at least six monthly and more frequently when health status changes. There is at least a three monthly review by the GP. Care plans are evaluated by the registered nurses six monthly or when changes to care occur.  D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. ARC: D16.3c: All initial care plans were evaluated by the RN within three weeks of admission. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services.  Residents’ files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. Residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident’s files evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer forms / letters / plans are located in residents' files.  The standard operation procedures describe guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy of which is kept on the resident’s file. This was sighted in one resident file where the resident had been transferred to hospital acutely. All relevant information is documented and communicated to the receiving health provider or service. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are three medication areas in the facility and all areas evidence an appropriate and secure medicine system, free from heat, moisture and light, with medicines stored in original dispensed packs.  There are two controlled drug storage areas in the facility (one in the rest home and one in the hospital) and these are secure. The controlled drug registers are maintained and evidence weekly checks and six monthly stock takes. There are two medication fridges (one in the rest home and one in the hospital) at the facility and the medication fridge temperature checks are conducted and recorded.  Residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given).  Medication rounds were observed and evidence staff are knowledgeable about the medicine administered and sign off, as the dose is administered.  Staff education in medicine management was conducted in December 2013. Eighteen medicine charts were sampled (six rest home, six hospital and six dementia). All 18 medication charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. Standing orders policy states the standing orders medications are reviewed annually by the chief medical officer (medical practitioner), confirmed by an email from The Selwyn Foundation organisation performance and development manager. Staff and GP signature logs are maintained.  All staff who administer medicines have current annual medication competency assessments. There is a clinical coordinator (RN), clinical educator (EN) and nine other RNs and 14 caregivers who have been assessed as competent to administer medicines.  There is a self-medicating resident’s policy available to guide staff practice. There are two rest home residents self-administering medication. The three monthly competency review for residents self-administering medicines are conducted. Medicines are stored safely. Interview with both residents who self-administer medicines were conducted and confirm residents’ understanding and competency to self-administer medicines.  Medication management audit was last conducted in January 2014 with 95 % compliance and corrective actions have been addressed. Emergency medication (hospital) audit was conducted in November 2013 with 100% compliance. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The food service is contracted to Medirest (Compass Group) and provided on site. The service has a kitchen manual (Medirest). Four weekly rolling menu is implemented and changes seasonally.  A copy of residents’ nutritional profiles are sent to the kitchen and a summary of all residents’ nutritional requirements is kept in the kitchen and in the two satellite serveries on site. Kitchen staff are aware of resident’s likes and dislikes, confirmed at kitchen staff interview. There is evidence of modified diets being provided e.g. diabetic menu and further nutritional supplements. There is extra food available for dementia residents, confirmed at staff interviews.  Food temperatures are taken before leaving the main kitchen, food is transported in Bain Maries to satellite serveries in the dementia unit and the hospital. All staff handling food have attended food safety training. Food safety training was provided for staff during the block study days in 2013.  Fridge, freezer and chiller temperatures are monitored and documented. Food in the chiller and freezer are covered and dated. There is adequate dry storage and pantry area. All food storage items are placed off the floor. The kitchen area was observed to be clean and tidy. Medirest staff carry out all cleaning duties, cleaning schedules and sign off sighted.   Residents' files sampled demonstrate monthly monitoring of individual resident's weight. The clinical coordinator maintains resident data base of all resident weights. Appropriate and timely weight loss interventions are noted in the files of three residents (one dementia, one rest home and one hospital) who have lost weight. There is evidence of timely GP assessment, referral to dietitian and intervention recorded as a result of dietitian assessment and recommendations. All nine residents’ files sampled record residents’ nutritional needs and interventions on residents’ care plans (link #1.1.13.).  Residents and family interviewed were satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided. |

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

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

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

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

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

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented processes for the management of waste and hazardous substances are in place. Chemical are labelled and labels are clear, accessible to read and free from damage. Material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.  There is provision and availability of protective clothing and equipment, which is appropriate to the risks associated with waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. Three sluice rooms are available for the disposal of waste and hazardous substances. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The maintenance person interviewed confirms there is a maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and reviewed during this audit along with current calibration / performance verified stickers in place on medical equipment. Staff receive education in the safe use of medical equipment and there is a system in place to review staff competency for specific equipment e.g. hoists competency, confirmed at physiotherapist interview and interview of staff and review of staff education records. Staff education records evidence manual handling training was conducted as part of the block study days in 2013. Care staff interviewed confirm that: they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment. Electrical equipment was checked on audit day by an external electrical contractor. The building holds a current warrant of fitness, which expires on 10 July 2014. There is sufficient space for residents to move around the facility freely. The hallways are wide enough with handrails appropriately placed. Residents were observed moving freely with walking aids and independently throughout the facility. There are quiet sitting areas in different parts of the facility. External areas are well maintained and walk ways are safe. There are grassed areas around the building and outdoor seating with shade. The dementia unit has secure external area that was observed to be accessible to residents.   ARC D15.3: The following equipment is available: electric beds, shower chairs, pressure relieving mattresses, hoists and lifting aids. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

#### Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is one double room at the facility. Several of the bedrooms have hand basins only, others have own toilet ensuites and some bedrooms have full ensuites. There is an adequate number of communal toilet and shower facilities. This includes ensuites, visitor’s toilets and communal toilets conveniently located close to communal areas.  The toilet, shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and washbasin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two staff. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions). Appropriately, secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Fourteen residents (nine rest home and five hospital) interviewed and nine family (two rest home, three hospital and four dementia) interviewed report that there are sufficient toilets and showers. The dementia unit has separate living, dining, bathing, toilet and outdoor area to the rest home and hospital. |

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Fourteen residents (nine rest home and five hospital) interviewed all spoke positively about their rooms. The dementia residents’ bedrooms are all single occupancy. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Adequate access is provided to lounges, dining rooms, and other communal areas throughout the facility. Residents were observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely. Residents in the dementia unit were observed to freely mobilise inside the unit and in the secure external area. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Safe and secure chemical and cleaning equipment storage areas are available and staff have appropriate and adequate access to these areas as required. Chemicals are labelled and stored safely within these areas; chemical safety data sheets are available; appropriate facilities exist for the disposal of soiled water/waste - i.e. sluice room/facilities in all three areas; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas. Residents and family interviewed state they are generally satisfied with the cleaning and laundry service. The laundry staff member interviewed advised that staff have been trained in chemical safety, infection control and waste management. Chemical safety and waste management training occurred in February 2014 and was also part of the block study days in 2013. All laundry is done on site and the laundry has commercial washing machines and driers and there is a clean and dirty flow. There is appropriate protective equipment/clothing for staff and this was observed to be used.  Cleaning audit was last conducted in March 2014 with 76% compliance and corrective actions have been addressed. Laundry audit was last conducted in February 2014 with 100% compliance. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.  The evacuation scheme was approved on 2 May 2012. The last trial evacuation was held on 16 January 2014. Staff interviews and review of files provides evidence of current training in relevant areas. There is a staff member across 24/7 with a current first aid certificate. Emergency and security situation education is provided to service providers during their orientation phase and at appropriate intervals. This includes fire safety training and emergency security situations. Staff records sampled evidences current training regarding fire, emergency and security education.  Information in relation to emergency and security situations is readily available/displayed for service providers and residents. A civil defence kit includes (but not limited to); torches, extra food supplies, blankets, and cell phones. There is a gas barbeque and two gas rings should the mains gas supply fail. There is also a generator. The service has 20 000 litres of stored water in a water tank for an emergency. An appropriate call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible / within easy reach, and are available in resident areas, e.g. bedrooms, communal showers, ensuite toilet/s, the lounge and dining room. Call bells are monitored through the internal auditing system. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **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.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area. Residents (nine rest home and five hospital) and family (two rest home, three hospital and four dementia) interviewed confirm the facilities are maintained at an appropriate temperature. The dementia unit was checked at random intervals including at 8.30 am on the second day of the audit and found to be warm and the staff interviewed report it is warm at all times (link# 1.1.13). |

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

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

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

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

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

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

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

## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a restraint minimisation procedure. The procedure includes definitions of restraint and enablers, cultural safety, privacy and dignity, approved restraints, use of enablers and the role of the restraint co-ordinator; alternative interventions; external doors; implementing restraint; assessing risk; consent; monitoring; evaluation; quality review; education; related documents.  The restraint minimisation procedure states the purpose of restraint is 'to minimise the use of restraint while providing a safe environment for residents, staff and visitors. To ensure that when restraint is practised, it occurs in a safe and respectful manner for the minimum length of time'.  There are documented definitions for restraint and enablers. The service has reduced restraint use from 11 residents one year ago to six residents at the time of audit. There are no residents using enablers and the dementia unit and rest home are restraint free. The policy states that risks associated with restraint/enabler use will be identified, minimised and documented on the assessment and consent form. All staff receive training in restraint minimisation at orientation and as part of the in-service training programme. The six monthly clinical compliance audits monitor each facilities' restraint use and over all compliance to the Selwyn Foundation Group philosophy. Definitions of restraint and enablers are congruent with the definition in NZS 8134. All residents have an assessment on entry, which includes the need for a restraint of enabler. The restraint co-ordinator interviewed was able to describe clearly the minimisation strategies used. |

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

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

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Only staff who have completed training are permitted to apply restraints. There are responsibilities and accountabilities determined in the restraint policy that includes responsibilities for key staff. Interviews with the restraint coordinator and review of his signed job descriptions identified understanding of the role. |

##### 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.

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

#### Standard 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A restraint assessment that includes strategies tried, risks, cultural needs and any issues is completed as part of the consent and assessment form in use. This assessment is present in three of three resident files for residents using restraint. Interventions and risks identified through the assessment process are transferred into care plans. Restraint documentation identifies the involvement of family.  Assessments are undertaken by the restraint coordinator or another registered nurse and the GP with input from the family. |

##### 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.

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

#### Standard 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. There are approved restraints documented in the policy.  The restraint co-ordinator is responsible for completing the documentation with input from registered nurses. The approval process includes ensuring the environment is appropriate and safe, that alternatives have been considered and attempted and restraint is used as a last resort. The service has an up to date restraint/enabler register.  Restraint monitoring forms include type of restraint used times restraint on/off, visual checks time, care given and comments/effectiveness of restraint. Three of three restraint-monitoring forms sighted show that restraint is not always monitored within stated timeframes. This is an area requiring improvement. |

##### 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.

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

##### Criterion 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Restraint monitoring forms include type of restraint used times restraint on/off, visual checks time, care given and comments/effectiveness of restraint. |
| **Finding:** |
| Three of three restraint-monitoring forms sighted show that restraint is not always monitored within stated timeframes. |
| **Corrective Action:** |
| Ensure all restraints are monitored within stated timeframes. |
| **Timeframe (days):** 90 *(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.

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

#### Standard 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The restraint evaluation includes the areas identified around future options to avoid the use of restraint, review of frequency of use and effectiveness as part of the care plan and restraint review and the impact the restraint has had on the resident. Family have participated in the evaluation for the use of restraint where evaluation has occurred. Three of three files sampled for residents using restraint have a documented three monthly evaluation. |

##### 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.

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

##### Criterion 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.

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

#### Standard 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Individuals approved restraint is reviewed at least three monthly through the restraint meeting and as part of the facility approval team review with family involvement. Restraint usage throughout the facility is analysed and information fed back to staff via hospital unit, staff and registered nurse meetings. |

##### 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.

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an established and implemented infection control (IC) programme and its content and detail is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme is available. The service uses the Bug Control manual. There is a job description for the infection control coordinator and clearly defined guidelines. The infection control programme is linked into the risk management system.  The Selwyn organisation is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the G.P's, labs, the infection control and public health departments at the local DHB and Bug Control. There are monthly infection control meetings that are part of the monthly staff /quality meeting. Minutes are available for staff.  The organisation is a member of Bug Control and accesses their resources for providing education to the infection control coordinators and for advice if required. Selwyn have a six monthly infection control coordinators meeting at head office chaired by the director of nursing. Data trending and analysis are discussed at the meeting The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health SOP.  The service had a gastric outbreak in February 2014 (not norovirus) and another in March 2014 (results not yet back to confirm norovirus). Public Health was notified of each outbreak in a timely manner. The facility was 'locked down' and families and visitors advised not to visit (confirmed in interviewed with nine family members). |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An RN is the infection control coordinator (IC) she has worked in this role for four months. IC matters are taken to the monthly unit/ staff / quality meetings and registered nurses meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. She is responsible for reviewing the IC facility programme annually in conjunction with the IFC coordinators from the other facilities. The RN complies with the objectives of the infection control standard operations procedures and works with all staff to facilitate the programme. She has attended IC training provided by an external specialist in a previous role in March 2014. The infection control coordinator has access to all relevant resident information to undertake surveillance, audits and investigations. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D 19.2a: The Bug Control infection control manual outlines a comprehensive range of procedures, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.  IC standard operations procedures included (but not limited to) a) infection control programme description, b) notifiable diseases, c) standard precautions, d) transmission based precautions, e) isolation procedure, f) hand hygiene procedures, g) managing infectious diseases table, and h) blood and body fluid exposure. Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service procedures contained within the infection control manual.  The IC programme defines roles and responsibilities of the IC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator. The facility IC programme is reviewed annually by the IC coordinator in conjunction with the IFC coordinators from the other facilities. D 19.2a: Infection control procedures include outbreak management, antimicrobial usage, prevention and management of infections. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control coordinator is responsible for coordinating/providing education and training to staff. All new staff receive infection control education at orientation including hand washing and preventative measures. Annual infection control education was delivered last in March 2014. All IC training is mandatory and evaluated by staff who attend. Records of the evaluations were sighted. The training folder records the staff education and attendance. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection monitoring is the responsibility of the IC coordinator who is an RN. The infection control programme SOP describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Selwyn Park are appropriate to the acuity, risk and needs of the residents.  The IC coordinator collates IC data. The data is entered into the Selwyn database and the quality and education manager generates a monthly quality improvement report for each facility. Infection control data is benchmarked. The analysis is reported to the monthly staff / quality meetings (minutes viewed). The IC coordinator uses the information obtained through the surveillance of data to determine any extra infection control education needs within the facility Internal audit of infection control is included three monthly in the annual programme and was last conducted in March 2014. Definitions of infections are described in the infection control manual. Infection control SOP's are in placing appropriate to the complexity of service provided. The surveillance SOP describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting. |

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

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

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

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

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

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