

Level Fifty-Two Limited

Current Status: 6 May 2014

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

General overview

Level Fifty-Two Ltd, trading as Camellia Rest Home, continues to provide care for a maximum of 30 rest home level care residents. The home is operating at maximum occupancy.

There have been no significant issues related to service delivery, changes in personnel or other matters requiring notification.

There is evidence that the ten improvements identified during the certification audit have been rectified.

This audit revealed no areas requiring improvement.

Audit Summary as at 6 May 2014

Standards have been assessed and summarised below:

Key

| Indicator | Description | Definition |
|-----------|---|---|
| Blue | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
| Green | No short falls | Standards applicable to this service fully attained |
| Yellow | 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 |
| Yellow | 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 |
| Red | 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 6 May 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. | | Standards applicable to this service fully attained. |
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Organisational Management as at 6 May 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. | | Standards applicable to this service fully attained. |
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Continuum of Service Delivery as at 6 May 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. |
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Safe and Appropriate Environment as at 6 May 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. |
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Restraint Minimisation and Safe Practice as at 6 May 2014

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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Infection Prevention and Control as at 6 May 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. |
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

| | | |
|---|--|-----------------------------|
| Legal entity name: | Level Fifty-Two Limited | |
| Certificate name: | Level Fifty-Two Limited | |
| Designated Auditing Agency: | The DAA Group Limited | |
| Types of audit: | Surveillance Audit | |
| Premises audited: | Camellia Resthome | |
| Services audited: | Rest home care (excluding dementia care) | |
| Dates of audit: | Start date: 6 May 2014 | End date: 6 May 2014 |
| Proposed changes to current services (if any): | | |
| | | |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 30 | |

Audit Team

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|--------------------------|-------|----------------------------|---|-----------------------------|---|
| Lead Auditor | XXXXX | Hours on site | 8 | Hours off site | 4 |
| Other Auditors | XXXXX | Total hours on site | 8 | Total hours off site | 4 |
| Technical Experts | | Total hours on site | | Total hours off site | |
| Consumer Auditors | | Total hours on site | | Total hours off site | |
| Peer Reviewer | XXXXX | | | Hours | 2 |

Sample Totals

| | | | | | |
|--|----|-----------------------------------|----|--------------------------------------|----|
| Total audit hours on site | 16 | Total audit hours off site | 10 | Total audit hours | 26 |
| Number of residents interviewed | 5 | Number of staff interviewed | 7 | Number of managers interviewed | 1 |
| Number of residents' records reviewed | 4 | Number of staff records reviewed | 3 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 8 | Total number of staff (headcount) | 20 | Number of relatives interviewed | |
| Number of residents' records reviewed using tracer methodology | 1 | | | Number of GPs interviewed | |

Declaration

I, XXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group 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 The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | The DAA Group Limited has provided all the information that is relevant to the audit | Yes |
| h) | The DAA Group Limited has finished editing the document. | Yes |

Dated Thursday, 15 May 2014

Executive Summary of Audit

General Overview

Level Fifty-Two Ltd, trading as Camellia Rest Home, continues to provide care for a maximum of 30 rest home level care residents. The addition of ten new rooms to increase bed numbers in 2012 is working well and the home is operating at maximum occupancy.

There have been no significant issues related to service delivery, changes in personnel or other matters requiring notification apart from a well contained infection event.

This audit revealed no areas requiring improvement. There is evidence that the ten improvements identified during the 2012 certification audit have been rectified.

Outcome 1.1: Consumer Rights

Staff demonstrate appropriate transparency and openness in the ways they communicate with resident, relatives and other parties involved in the services. The service adheres to the principles of open disclosure and notifies residents and their families where necessary and appropriate, of any matters that may impact on them.

Complaints are managed efficiently and effectively by the nurse manager. There have been a small number of minor complaints received since the previous audit and these show evidence of being quickly resolved.

Outcome 1.2: Organisational Management

There are no changes to governance or the service performance monitoring systems. All staff and the owners are involved in monitoring the quality of services delivered. Adverse events are recorded and reported appropriately. There have been no serious adverse events since the previous audit.

Recruitment of new staff and management of existing staff adheres to good employment practices. The three areas requiring improvement from the previous audit which were related to position descriptions, chemical handling training and management of consumer records are now resolved.

There are good levels of skilled and experienced staff on each shift 24 hours a day seven days a week.

Outcome 1.3: Continuum of Service Delivery

The provision of services is delivered by suitably qualified and experienced staff. The registered nurse conducts the initial assessment and initial care plan on the resident's admission to the service. The provision of care is based on the assessed needs of the resident, for residents at rest home level of care. Since the previous certification audit the service has made improvements in ensuring that records of daily monitoring are maintained and monitoring occurs as

required on the care plan.

The activities are planned to meet the needs and strengths of the residents.

A safe medicine management system is observed on the day of audit. Staff who are responsible for medicine management are assessed as competent to perform the role. The previous area for improvement related to ensuring the medication recording system (medication chart and standing orders) comply with legislation and guidelines and ensuring staff are assessed as competent are areas of improvement implemented from the previous certification and provisional audits.

The menu is reviewed by a dietitian as suitable for the older person living in a care facility. The service has a well-established and implemented registered food safety plan.

Outcome 1.4: Safe and Appropriate Environment

The interior and exterior of the facility and chattels are being well maintained. The building has a current warrant of fitness. New carpet has been installed in the main living areas. The previous area requiring improvement related to labelling of chemical containers has been rectified.

Outcome 2: Restraint Minimisation and Safe Practice

The service has a policy of no restraint. There are no enablers in use nor have there been any restraint events. Staff demonstrate awareness and knowledge of the service policy and protocols and there is ongoing staff training in restraint minimisation.

Outcome 3: Infection Prevention and Control

The service has an appropriate system for the surveillance of infections, which reflects the size and scope of the service. Where the infection rates are higher than expected the service implements a risk management plan to address any shortfalls identified. The areas that required improvements related to the roles and responsibilities of the infection control co-ordination, guidelines for seeking advice, and responsibility for updating policies, are now addressed and improvements implemented since the last audit.

Summary of Attainment

| | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|-----------|----|----|---------------|--------|-------------|---------|-------------|
| Standards | 0 | 21 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 41 | 0 | 0 | 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 | 29 |
| Criteria | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|------|------|-------------|------------|---------|-------------------|------------------|
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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 1.1.9: Communication (HDS(C)S.2008:1.1.9)

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

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

Attainment and Risk: FA

Evidence:

The service is adhering to its open disclosure policy and procedures. Staff are maintaining open, transparent communication. There is evidence of this in review of incidents and from interviews with residents. Residents are able to identify staff involved in their care. Access to interpreter services is available. There is a fully described residential agreement that describes funded and unfunded services. Interview with five residents reveals that their care interventions are discussed, documented and shared with their family members as appropriate. New residents and their families are fully oriented to the facility confirmed by five resident interviews). The nurse manager confirms that relatives are advised immediately there is a change in the resident's health status, and that residents are advised and supported to undergo a review of their needs assessment, if indicated.

The service complies with 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.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| The service has clearly described complaint policies and procedures that comply with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code), these are included in the admission agreement. The sighted complaints register and records of the six complaints submitted since the certification audit in 2012 show that processes and timeframes are correctly adhered to. Copies of complaint forms and the complaint process are readily accessible in the residents' information booklet which is given to each resident. Five residents interviewed confirm their awareness of the complaint process. All stated that they have been provided with information on how to make a complaint. |

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

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

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

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

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

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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 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

The service is effectively and efficiently managed by a NZ registered nurse who is maintaining her practising certificate (sighted APC as current) and her professional portfolio. The same manager has been in the role for three and half years and she is well supported by the long term owner who is on site at least weekly. There are regular reviews of service delivery goals and organisational performance. Service delivery is monitored by monthly analysis of quality data and feedback from residents and their families (confirmed by review of staff meeting minutes, quality reports and interview with the Nurse Manager (NM) and the administrator).

The quality system is aligned to the annual business plan and describes systems for service monitoring and review, risks and how these are mitigated, and the range of goals and activities which monitor organisation performance and improve service delivery.

An organisational chart shows lines of responsibility and reporting. The nurse manager reports to the owners. The part time registered nurse, an administrator, caregivers, enrolled nurses (ENs) and allied health professionals report to the manager. The nurse manager's job description accurately describes her authority, accountability and responsibility.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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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 1.2.3: 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: |
| There is a well-established quality and risk system which is known and understood by staff, as confirmed by interview with caregivers, a cleaner and the cook. Quality data is shared at monthly staff meetings. (Sighted meeting minutes for 2013 and 2014). These include statistics and analysis of accidents and incidents, the results of internal audits and resident and relative feedback. Policies are reviewed annually (as sighted in the amendment logs and from interview with nurse manager and the administrator). The manager reviews these against known standards, legislation and current best practice. Care staff confirm that they are kept informed about changes in policy at weekly staff meetings or via the daily communications book. Where service monitoring or feedback reveals areas requiring an improvement, these are documented in either an incident / accident report, a quality improvement report and in audit action sheets. These records and the minutes of staff meetings demonstrate that corrective actions are monitored for progress and completion. Organisational risk is well defined in the business plan and documented across a range of policies (eg, the health and safety manual, the accidents and incidents policy and in the fire and emergency manual). Health and safety is discussed at monthly staff meetings. Environmental audits for safety are conducted regularly and reactive facility maintenance occurs (as observed on the day of audit and confirmed by staff interview). Chemical safety data sheets are kept updated and onsite. The new staff orientation/induction and the education programme includes information on health and safety. Specific risk assessment tools are utilised in service delivery plans to identify and manage clinical risk. All known and newly identified hazards are reported and documented in the hazard register (sighted). |
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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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

Criterion 1.2.3.3 (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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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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 1.2.3.5 (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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

Criterion 1.2.3.6 (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: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

Criterion 1.2.3.7 (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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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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 1.2.3.9 (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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| The adverse event reporting system is a planned and co-ordinated process. The system for documenting, analysing, tracking and trending incidents/accidents and adverse events is well understood by staff (three caregivers, the activities co-ordinator, a cleaner, the cook and the administrator interviewed). The records are clearly and appropriately written and there is evidence these are investigated, and where necessary, follow up action is taken (report forms for 2013 and 2014 reviewed minutes of staff meetings, communications book and staff interviews). A new system for analysing individual falls is implemented since October 2013. Staff say this has increased their awareness of preventable falls. The nurse manager informs family/whanau of adverse events when necessary. The service complies with ARC D19.3a.vi.; D19.3b; D19.3c |

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has implemented human resource processes that are compliant with legislation and good employment practice. The previous areas related to position descriptions are now resolved. All job descriptions have been reviewed and updated as necessary. (Sighted individual job descriptions for nurse manager, registered nurse (RN), enrolled nurse (EN) and caregivers and activities co-ordinator). Each job description includes who the role reports to, overall objectives, and responsibilities.

Professional qualifications are validated as part of the employment process. Copies of professional practising certificates are sighted for the Nurse Manager/RN and the other RN and the EN

Three new staff files reviewed contain evidence of recruitment and employment processes (eg, reference checking and interview questions) and evidence that a full orientation and induction to the role has occurred. Orientation and induction includes learning about the services essential emergency procedures.

Ongoing in-service education is provided to staff by the Nurse Manager, the part time RN and external educators at least monthly. The Nurse Manager is now an accredited ACE assessor. Six of 15 caregivers have completed the ACE core competencies and three more have commenced the programme since the previous audit. All the training provided is in subject areas appropriate to care of older people and staff attendance records are maintained.

The Nurse Manager is attending at least eight hours of regular ongoing education and forums related to the role of Manager (evidence of attendance at DHB manager's forums and provider network meetings).

The previous area for improvement related to staff education on the safe handling of cleaning products and chemicals is now resolved. There is evidence of chemical training provided by the supply contractor in September 2012 and February 2014. All staff engage in performance appraisals at least once a year and these are up to date.

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

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

Attainment and Risk: FA

Evidence:

Finding:

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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 1.2.7.3 (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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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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 1.2.7.5 (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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

Standard 1.2.8: 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 staffing rationale which accurately reflects the needs of the resident group. The number of staff rostered on each shift and their skills and experience are appropriate for rest home level care. There have been no changes to the level of care staff allocated to each shift since the previous certification audit. Staff numbers had already been increased to accommodate the additional six beds in 2012. All staff interviewed stated that there is enough staff on each shift to provide for residents needs and comfortably complete the work tasks allocated to them. There is a new role - a part time (six hours a week) administrator who supports the manager. The service meets the requirements of ARC D17.1; D173a; D173b; D173e; D173f; D174a; D174c; and D174d. |

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: |
| 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.) |

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 previous required improvement which was related to the level of detail to manage consumer records policy is now resolved. The policy has been reviewed and updated and management of consumer records is clearly described. |

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has commenced the use of the electronic interRAI assessment. The current paper based initial assessments include personal support needs, communication, diet, fluids, culture, spirituality, sexuality, mobility, pain relief, cognition, continence, skin and wound. The initial assessments also include pressure area risk, body chart for skin integrity, separate pain assessment, mini nutritional assessment, falls risk, geriatric assessment scale, manual handling assessment and a bladder chart. There is an initial care plan used for up to three weeks until the long term care plan is developed. The service utilises a standardised long term care plan which is individualised to the resident's needs. Acute care plans are used for temporary changes to the resident's condition or needs. The long term care plans identify the problem, aim, and staff interventions. The evaluation of the care plan is conducted on a separate form. The care plans cover the physical, psychosocial, cultural and spiritual needs for the resident. The long term care plans record those who are consulted to contribute to the care planning and are signed by the RN, resident or resident representative (when applicable). The four of four residents' files reviewed have the appropriate assessments, care plans and desired goals identified.

Interview with the nurse manager (RN) confirms that the initial assessment and initial care plan are developed on the day of admission, the long term care plan is developed within three weeks and reviewed and evaluated at least six monthly. The residents are reviewed by a general practitioner (GP) at least three monthly, when the resident is assessed as stable. The residents continue to see their own GPs in the community, with the nurse manager or RN accompanying the resident to the GP visit. The five of five residents interviewed report a satisfaction with the care at Camellia Rest Home.

Each resident has one file which includes the multidisciplinary team input into care. A daily record of care records interventions each shift. There is verbal handover between each shift, with changes also recorded on a handover sheet. A communication book is also maintained to record appointments. The nurse manager (RN) and three caregivers report that there is an adequate handover to provide information for the continuity of care and report an excellent team approach to care. The five of five residents interviewed report high satisfaction with the care provided at the service.

Tracer example

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

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

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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 1.3.3.3 (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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a previous area of required improvement at 1.3.5.2 to ensure records of daily monitoring requirements are maintained and monitoring occurs as required on the care plan. The progress notes sighted in the four of four residents' files have at least daily progress note entries, and more frequently if there are changes that occur on other sifts. The, at least monthly, observations (eg, weight, blood pressure) are recorded in the four of four residents' files reviewed. The four of four care plans sighted describe the required intervention to achieve the desired outcomes identified by the ongoing assessment process. This previous issues is now addressed and an area of improvement implemented and embedded into practice since the last audit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has adequate dressing and continence supplies to meet the needs of the residents. The four of four care plans reviewed record interventions that are consistent with the residents' assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with the

residents' needs. The file of the resident reviewed records changed intervention to meet the resident's temporary change in mobility and dependence. The five of five residents interviewed have high praise for the interventions at the service.

The ARC requirements are met.

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

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

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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 1.3.7: 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: |
| The activities co-ordinator reports activities plans are individualised to the resident's needs. The activities are developed in conjunction with the resident and where appropriate their family. The activities assessments and plans as sighted in the four of four residents' files reviewed, shows they are up to date and reflect individualised needs of the residents. The activities are based on the resident's needs, interests, skill and strengths. The activities cover cognitive, physical and social needs. Community events (such as ANZAC Day) that are occurring locally included in the programme. |
| The four off four residents' files reviewed have activities and social assessments. The goals are updated and evaluated in each resident's file at least six monthly with care plan reviews and multidisciplinary reviews. The activities co-ordinator reports that where residents have a specific need, the service endeavours to provide the resources for this. |

Where possible residents' independence is encouraged to maintain links with family and community groups. Residents are provided with outings on a routine basis. One to one and group activities are planned to meet the resident's interests. The five of five residents interviewed report they enjoy the range and variety of planned activities.

The ARC requirements are met.

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

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

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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 1.3.8: 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: |
| The four of four care plans reviewed evidence evaluations are recorded at least six monthly by the nurse manager or RN with input from the GP, the resident, the family and the activities coordinator. Most of the documented evaluations indicate the resident's progress in meeting goals, and care plans are updated to reflect progress towards meeting goals. Some of the care plan issues/problem, interventions and progress towards meeting the goals have evaluations that are less detailed than the others (eg, state no change or goals met), though this does not represent a systemic issue. Where progress is different from expected the service either updates the long term care plan or uses an acute care plans for temporary changes. The four of four residents' files reviewed indicate they are updated to reflect changing needs of the resident. One resident reviewed has an acute care plan for their changed mobility. The five of five residents interviewed report involvement in the evaluation process and are satisfied with the care provided. |
| The ARC requirements are met. |

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

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

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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 1.3.8.3 (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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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

Attainment and Risk: FA

Evidence:

There were previous corrective action requests at 1.3.12.1 and 1.3.12.3. Criteria 1.3.12.1 required the organisation to review and amend the process of standing orders to ensure medications are approved per person. GPs are required to sign for each medication prescription individually. Criterion 1.3.12.3 required the nurse manager to complete a medication competency assessment. These are now addressed and improvements implemented since the last audit.

Medicines for residents are received from the pharmacy in a pre-packed delivery system. The signing sheet that records the sachets are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or hospital admission. A safe system for medicine management is observed on the day of audit.

Medicines are stored in locked medicine trolleys and in the locked treatment room. There is a monthly stock rotation recorded for the medicines that are not packed in the sachets. The controlled drugs are stored in a locked safe, two staff sign the register at each administration and a weekly stock count is undertaken. The service's medicine fridge is monitored at least weekly and temperatures are within recommended guidelines.

The eight of eight medicine charts reviewed are reviewed by the GP in the last three months, and this is recorded on the medicine charts. All prescriptions sighted contain the date, medicine name, dose, time of administration with any allergies highlighted in red ink. All medicine charts reviewed have each medicine individually prescribed. All signing sheets are fully completed on the administration of medicines.

There are documented competencies sighted for the staff designated as responsible for medicine management; this includes the nurse manager and the RN. This is an improvement implement since the last audit.

At the time of audit there is one resident assessed as competent by their GP to self-administer one of their medications (sighted on medication chart).

The ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

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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 1.3.12.3 (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: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

Standard 1.3.13: 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 two week rotating menu, with seasonal variations, is approved by a registered dietitian in March 2014 as suitable for aged care residents. The menu review is based on the dietitian scoring system, with a score rating of 43 out of 48, which is a satisfactory rating. A nutritional profile is completed for each resident upon entry to the service and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. For example, the service provides diabetic and specialised diets to meet specific residents' needs. The care staff manages the additional food supplements for the residents (eg, Fortisip). The five of five residents report satisfaction with the kitchen services. The service has an established food safety plan. All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer are in their original packaging or labelled and dated if not in the original packaging. The kitchen staff have undertaken food safety management education appropriate to service delivery. |

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: |
| 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: |

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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.) |

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

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| Attainment and Risk: FA |
| Evidence: |
| The previous area requiring improvement related to clear labelling of chemicals is now resolved. Visual inspection of the environment and cleaning product storage areas reveals that all containers are clearly labelled. |

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| The sighted BWOF is current and expires on 27 June 2014. |

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: |
| 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: |
| The service has a philosophy and practice of no restraint. There is currently no restraint or enabler use at the facility. There are adequately documented guidelines should the need for a restraint or enabler occur. All staff engage in training related to the safe use of restraints, enablers and de-escalation techniques and the nurse manager conducts an annual audit which considers the relevance of restraint policies and frequency and content of staff education. The ARC requirements are met. |

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

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

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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.) |

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

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

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

ARC D5.4e ARHSS D5.4e

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| Attainment and Risk: FA |
| Evidence: |
| The previous audit identified an area for improvement at criterion 3.1.7 to ensure there are clearly defined roles and responsibilities of the infection control team/personnel and committee. The nurse manager is the infection control coordinator, with the roles and responsibilities documented in their job description (updated 30 November 2012). This is now addressed and an area of improvement implemented since the last audit. The previous audit identified an area for improvement at criterion 3.1.8 to amend the infection control policies to contain clear processes for early consultation and feedback when significant changes are proposed. The infection control policies and procedures are updated (last reviewed and updated November 2013) and contain clear processes for early consultation and feedback when significant changes are proposed. |

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

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

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

Attainment and Risk: FA

Evidence:

The previous audit identified an area for improvement at criterion 3.3.3 to amend the infection control policies to clearly identify who is responsible for policy development. The infection prevention and control policies and procedures are developed by an aged care consultant. The nurse manager who is the infection control coordinator has the responsibility for the review of the policies to ensure they are relevant to the service. The responsibilities are clearly documented in the job description and the infection control policies.

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

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

Attainment and Risk: FA

Evidence:

Infection control data is collected on urinary tract infections, chest infections, wound infections, eye and ear infections and multi-resistant organisms. The surveillance data is gathered for the rest home and hospital level of care residents. The monthly report of collected data is provided at the staff meetings (in which the owner also attends). The senior manager is the infection control coordinator. The surveillance data collected is based on guidelines from an aged care consultant. Infection control data is included in the quality audit programme.

All care staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The data sighted for 2013 and to date in 2014 record an increase of chest infections in July and August 2013, in which the analysis concludes this is seasonal changes reflective of community norms.

The annual review of the infection for 2013 records that there have been two infection outbreaks that were effectively contained. One related to scabies and the other gastroenteritis (negative result for norovirus). The analysis records that the services procedures were followed.

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

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

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

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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.) |