# CHT Healthcare Trust - Peacehaven Resthome & Hospital

## Current Status: 23 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

Peacehaven is a purpose built rest home and hospital facility. The service provides care for up to 45 rest home and hospital residents. The current occupancy is seven rest home residents and 35 hospital residents. Peacehaven was purchased by CHT in June 2013 and is now part of the CHT organisation. The CHT group has strong board and effective governance practices. The manager is a registered nurse who has been in the role since July 2013 and has a background in aged care and management. Resident and family feedback during the audit was very positive.

This audit has identified areas for improvement around meeting minutes, clarification of the role of the senior coordinator and first aid training for staff.

## Audit Summary as at 23 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 23 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. |  | Standards applicable to this service fully attained. |

### Organisational Management as at 23 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 23 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 23 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Restraint Minimisation and Safe Practice as at 23 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. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 23 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 23 April 2014

### Consumer Rights

Peacehaven provides resident centred care. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ('the code') is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents’ rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan and a Tikanga best practice policy to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time.

### Organisational Management

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

Quality information is reported to monthly combined staff and quality meetings. There is an improvement required around staff/quality meeting minutes. Residents and relatives are provided the opportunity to feedback on service delivery issues at six weekly resident meetings, at residents focus groups and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Peacehaven has job descriptions positions that include the role and responsibilities of the position. There is an improvement required around clarifying the role of the senior coordinator. There is an annual in-service training programme that has been implemented for the year and staff are supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing and caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

### Continuum of Service Delivery

The service has admission policies. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed with the resident and/or family/whanau input. Care plans are developed in VCare (client information management system) and demonstrate service integration and guide all staff in cares. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. Residents are assessed within set timeframes and receive well planned and co-ordinated services. There is an activities programme that operates over seven days, which offers a variety of activities suited to the needs of the residents.

Medicines are managed via the robotic system and policies reflect legislative requirements. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. Education and medicines competencies are completed annually by all staff responsible for administration of medicines. Staff that dispense medicines have been assessed as competent.

The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged and van outings are arranged on a regular basis.

All food is cooked on site by the cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented, homely and the menu plans have been reviewed by a dietitian. The service is awarded a continuous improvement rating around meeting the nutritional needs of residents.

### Safe and Appropriate Environment

There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme.

The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Visual inspection evidences buildings, plant and equipment comply with legislation, with documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family/whanau members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

Documented systems are in place for essential, emergency and security services. Staff interviews and files evidence current training in relevant areas. Visual inspection evidences alternative energy and utility sources are maintained, an appropriate call bell system is available and security systems are in place. There is an improvement required around having a staff member on duty with a first aid certificate at all times.

### Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently six residents requiring restraints and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

### Infection Prevention and Control

The infection control coordinator is a registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | CHT Healthcare Trust |
| **Certificate name:** | CHT Healthcare Trust - Peacehaven Resthome & Hospital |

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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:** | Peacehaven Resthome & Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 23 April 2014 | **End date:** | 24 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:** | 42 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 6 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 14 | Total audit hours | 38 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 9 | Number of staff interviewed | 9 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 30 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | 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 Thursday, 15 May 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Peacehaven is a purpose built rest home and hospital facility. The service provides care for up to 45 rest home and hospital residents. The current occupancy is seven rest home residents and 35 hospital residents. Peacehaven was purchased by CHT in June 2013 and is now part of the CHT organisation. The CHT group has strong board and effective governance practices. The manager is a registered nurse who has been in the role since July 2013 and has a background in aged care and management. Resident and family feedback during the audit was very positive.  This audit has identified areas for improvement around meeting minutes, clarification of the role of the senior coordinator and first aid training for staff. |

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| **Outcome 1.1: Consumer Rights** |
| Peacehaven provides resident centred care. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ('the code') is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents’ rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan and a Tikanga best practice policy to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. |

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

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has admission policies. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provides evidence that the provider has systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed with the resident and/or family/whanau input. Care plans are developed in VCare (client information management system) and demonstrate service integration and guide all staff in cares. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. Residents are assessed within set timeframes and receive well planned and co-ordinated services. There is an activities programme that operates over seven days, which offers a variety of activities suited to the needs of the residents.   Medicines are managed via the robotic system and policies reflect legislative requirements. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. Education and medicines competencies are completed annually by all staff responsible for administration of medicines. Staff that dispense medicines have been assessed as competent.  The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged and van outings are arranged on a regular basis. All food is cooked on site by the cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented, homely and the menu plans have been reviewed by a dietitian. The service is awarded a continuous improvement rating around meeting the nutritional needs of residents. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Visual inspection evidences buildings, plant and equipment comply with legislation, with documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family/whanau members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.  Documented systems are in place for essential, emergency and security services. Staff interviews and files evidence current training in relevant areas. Visual inspection evidences alternative energy and utility sources are maintained, an appropriate call bell system is available and security systems are in place. There is an improvement required around having a staff member on duty with a first aid certificate at all times. |

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

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

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 47 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 1 | 97 | 0 | 3 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 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 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Meeting minutes of the staff/quality meeting do not contain evidence of analysis of quality data and discussion of trends and outcomes from the analysis of quality data. | Ensure that the quality data is analysed and that quality/health and safety meetings include discussion of the outcomes of the analysis so that all staff are informed of the results of quality improvement data. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.2 | Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low | The senior coordinator is a registered nurse in her home country but does not have a New Zealand registration. She is employed in a management role and her offer of employment states she has been employed as a temporary registered nurse, but does acknowledge the need for her to gain New Zealand registration. Families and residents identify her as a registered nurse and she wears a registered nurse uniform and her name badge states she is a registered nurse (noting that the words ‘registered nurse’ on her uniform and name badge were covered during the audit). It is noted that some of the role confusion was generated by the previous owners and that clinically she is not working outside her scope – for example any care plan entries are countersigned by a registered nurse. There is a New Zealand registered nurse on duty 24 hours per day. There is however some confusion around her role. | Ensure the role of the senior coordinator is clarified. | 90 |
| HDS(C)S.2008 | Standard 1.4.7: Essential, Emergency, And Security Systems | Consumers receive an appropriate and timely response during emergency and security situations. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | A review of the roster for the past two weeks shows there are nine shifts when there is no staff member on duty with a first aid certificate. | Ensure there is a staff member on duty at all times with a current first aid certificate. | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Criterion 1.3.13.1 | Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | The service commenced using a Replenish Energy and Protein (REAP) programme in October 2013. REAP puts a focus on nutrition and 'nutrition alerts' and is an agenda item at nursing and caregiver meetings. The documented programme has been developed by the dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. There are four levels. The emphasis is on food first rather than commercial supplements for managing unintended weight loss. At Peacehaven there are currently residents on REAP level two and level three. These residents are clearly documented on the whiteboard in the kitchen. When a resident is identified as having unintended weight loss a weight loss report is completed. This includes checking the mouth and teeth, reviewing diet type, monitoring food intake, consulting with the cook, consulting the dietitian, referring to the GP, referring to family/whanau and reviewing medication. One file was sampled for a resident who has been on REAP level three. He was assessed by a dietitian prior to commencement on REAP. The dietitian for the organisation (who is not the dietitian who developed REAP) was unavailable for interview. Her clinical notes evidenced the programme as a very positive initiative with positive outcomes for residents. The resident on REAP whose file was sampled has had weight gain. On interview the resident was able to discuss his REAP plan and was pleased that he was gaining weight. He stated he was having extra snacks and the staff was monitoring his weight. All staff were provided with training around REAP by the dietitian in October 2013 with the kitchen staff receiving more detailed training. Six of six health care assistants, one registered nurse and the senior coordinator interviewed are all familiar with REAP and report the benefits to residents. The cook is aware of all residents on REAP and works closely with the registered nurses to monitor residents progress. The cook interviewed reports the ways in which she implements REAP include fortifying food wherever possible for those on the programme. Examples include cream and brown sugar on cereals, extra margarine on vegetables, fortifying mashed potato, sauces and purees, cream on desserts in the evening (for level three), fortifying soup, providing fortified milk and fortified drinks, fortified custard for supper for those on REAP level three and sandwiches for supper on REAP level two (of which there are currently no residents). The service continues to evaluate and improve the REAP programme and initial results show a marked decrease in weight loss for those using the programme. |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy that describes the code of rights. On interview all staff (six health care assistants (who work throughout the facility), one registered nurse (RN), one senior coordinator and one manager), were aware of consumers rights and were able to describe how they incorporated consumer rights within their service delivery. Code of rights is discussed at resident and combined staff/quality meetings. Nine of nine residents (four rest home and five hospital) and six family members (one rest home and five hospital) interviewed spoke highly of the staff’s respect of all aspects of the Code of rights.  Code of rights and elderly abuse training was last carried out in February 2014. |

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

Consumers are informed of their rights.

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of personal property. All nine residents and six 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 February 2014. The resident’s initial assessments and care plans detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. All nine residents interviewed stated their needs were met. All seven resident files reviewed have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this. There is a policy that describes spiritual care. There are various churches locally and residents are encouraged to attend these. Church services are conducted in the facility at least once every two weeks with denominations who run the service rotating. There is also a weekly Catholic communion. All residents and family members interviewed indicated that resident’s spiritual needs are being met when required. On interview nine of nine residents (four rest home and five hospital),stated staff respect their rights. There are currently two married couples resident in the facility. Couples have appropriate information in their care plans regarding the residents preferences around time spent together and privacy. 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. On interview all nine residents stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview all six health care assistants (who work throughout the facility) could described how they encouraged residents to engage in activities in the facility and to link with community activities including school and church groups and the RSA. There is a policy that describes abuse and neglect and the topic is covered at orientation and has been addressed at staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Abuse and neglect training last occurred in May 2013. Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. Nine residents and six family members were complementary of the care provided and stated staff were very approachable and friendly.  D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. D4.1a: Resident files reviewed identified that cultural, spiritual values and individual preferences are identified. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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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:** |
| The service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan, a Tikanga best practice policy and a cultural appropriateness policy. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policies/procedures. Staff training includes cultural safety at orientation. There are present there are no residents who identify as Maori. Peacehaven identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health plan and policies.  Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by an RN, with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual’s service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with one registered nurse (RN), one senior coordinator and six health care assistants (who work throughout the facility) confirm that they are aware of the need to respond to cultural differences. On interview all staff were able to identify how to obtain support so that they could respond appropriately.  A3.2: There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e). D20.1i: The service has developed a link with the Treaty Advisory Board to obtain Maori advisory services and advocacy should this be required. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes covers harassment and exploitation. All residents interviewed reported that the staff respected them. Elderly abuse prevention training occurs at orientation and as part of the in-service training schedule and includes professionalism and standards of conduct. The RN's supervise staff to ensure professional practice is maintained in the service.  Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies to guide practice that align with the health and disability services standards. There is a quality framework that is being implemented that supports an internal audit programme. The caregivers are encouraged to complete ACE NZQA level training and an internal in-service training programme is implemented. The manager attends external training sessions appropriate for her position.   A2.2: Services are provided at Peacehaven 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 the registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Eleven incidents/accidents forms were viewed for March 2014. The forms includes a section to record family notification. All 11 forms indicated family were informed or if family did not wish to be informed. On interview nine of nine residents (four rest home and five hospital), six family members (one rest home and five hospital) and six health care assistants (who work throughout the facility) all stated that family are informed following changes in the residents’ health status.  The registered nurse interviewed stated that they record contact with family/whanau. Contact records were documented in all files reviewed.  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 meeting occurs six weekly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan.  There is a policy that describes the availability of interpreter services when required.  D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b: Six family members stated that they are always informed when their family members health status changes. D11.3:The information pack is available in large print and advised that this can be read to residents. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures (and associated processes) clearly direct the service in relation to the gathering of informed consent. The service states its commitment to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Seven of seven resident files reviewed (two from the rest home and five from the hospital) included completed informed consent forms.  Interviews with six health care assistants, one registered nurse and the manager indicate all are familiar with informed consent and what information to provide relatives/residents. The informed choice and consent procedure that includes advance directives and resuscitation. It states "The competent resident may use an advance directive in accordance with common law. The competent resident is to sign the CPR consent form to indicate their resuscitation decision. The resident’s GP is to circle the resident’s level of competency on the CPR consent form and circle whether CPR is clinically indicated or not. Where a resident is not competent, no person - not their legal representative nor their GP can make an advance choice about resuscitation for the incompetent resident. A GP cannot make an advance directive. However a GP can give advice about the clinical appropriateness of resuscitating the resident". Seven resident files reviewed had appropriately signed advanced directive forms.  D13.1. All admission forms sighted in seven residents files sampled (two from the rest home and five from the hospital) were signed. D3.1.d Discussion with six family members (one rest home and five hospital) identified that the service actively involves them in decisions that affect their relative’s lives. |

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

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

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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 a policy that describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with six caregivers, nine residents and six family members informed they are aware of advocacy and how to access an advocate. D4.1d; Discussion with six family members (one rest home and five hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions.  ARC D4.1e: The resident file includes information on resident’s family/whānau and chosen social networks. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview all staff (six caregivers, an RN and one senior coordinator) stated that residents are encouraged to build and maintain relationships. On interview all residents and family members confirmed this. D3.1h; Discussion with six family members (one rest home and five hospital), stated that they are encouraged to be involved with the service and care. D3.1.e: Discussion with all staff (six health care assistants (who work throughout the facility) and six family members (one rest home and five hospital), confirm that they are supported and encouraged to remain involved in the community and external groups such as church and RSA visits. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with nine of nine residents (four rest home and five hospital) inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints There is a complaints register. Complaints for 2013 since CHT purchased Peacehaven and 2014 to date were reviewed. Verbal and written complaints are documented. There was one complaint to the Health and Disability Commission prior to CHT purchasing Peacehaven. This related to the quality of palliative care provided to a resident and since this time the registered nurses are now trained in the Liverpool Care Pathway and there is a palliative care resource nurse employed. A second complaint to the Health and Disability Commission in November 2013 was withdrawn by the complainant following staisfactory resolution of the complaint at a facility level. There have been three further complaints in 2013/2014 to date plus two complaints from an associate of a resident where the family have documented that they do not wish this associate to complain on behalf of the resident.  All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants.  Discussions with nine residents and six family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with six health care assistants stated that concerns/complaints were discussed at monthly staff /quality meetings.  D13.3h: A complaints procedure is provided to residents within the information pack at entry. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Peacehaven is a purpose built rest home and hospital facility. The service provides care for up to 45 rest home and hospital residents. The current occupancy is seven rest home residents and 35 hospital residents. Peacehaven is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care. Peacehaven was purchased by CHT in July 2013 and is now part of the CHT organisation. Peacehaven has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year and aligns with the CHT operational strategic goals and business plan for 2014. The quality process being implemented includes regularly review of policies, an internal spot audits and a health and safety programme that includes hazard management. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The service has policies and procedures 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. Monthly combined staff /quality / health and safety / restraint and Infection control meetings and monthly registered nurse meetings discuss key components of the quality system and any issues are reported (link 1.2.3.6). There is an internal spot audit schedule that is completed six monthly by the area manager and corrective action plans used to manage shortfalls.  The manager is a registered nurse who has been in the role since August 2013 and has a background in aged care and management . The manager covers all on-call. The job description for the manager outlines her authority, accountability and responsibility. The manager has completed on-going training appropriate to their positions. There is RN cover in the facility 24/7. ARC,D17.3di (rest home), D17.4b (hospital): The manager has maintained at least eight hours annually of professional development activities related to managing a hospital and rest home. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the absence of the manager the senior coordinator oversees the management of Peacehaven with support from the regional manager (who is a registered nurse) and senior registered nurses.  D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies and quality improvement programme includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Peacehaven has a quality framework that is being implemented. The manager is directly involved in operations at the facility and the senior coordinator supports her in this role. There is a current business plan that includes goals and a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (six health care assistants (who work throughout the facility, the senior coordinator, one registered nurse and the diversional therapist), inform an understanding of the quality activities undertaken at Peacehaven. Resident meetings occur six weekly (minutes viewed). Nine of nine residents interviewed are aware meetings are held. Annual surveys are conducted of residents and relatives by Press Gayney. The survey conducted in November 2013 compared Peacehaven with 72 similar facilities in Australia and New Zealand. Peacehaven rated in the 72nd percentile. All residents and relatives interviewed stated they are asked for feedback regarding the service. The results have been discussed in a staff meeting and the survey data is currently being sturdied by the organisation so corrective action plans can be developed from the results.   D5.4 The service has appropriatepolicies/ procedures to support service delivery; Policies and procedures align with the client care plans. D10.1: Care of the deceased resident procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary  certifications and documentation is completed in a timely manner. D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. D19.2g: Falls prevention strategies such as physiotherapy reviews and instruction around prevention in care plans.  Policies and procedures are in place with evidence of review. The manager manages quality systems. There is a quality team which includes all staff. The quality programme is reviewed annually and is being implemented. Information is reported through the monthly staff /quality meetings. Meetings standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. There is an improvement required around meeting minutes. Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility. Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. Peacehaven has six residents who have restraints and no residents with enablers. The area manager completes a six monthly internal spot audit covering all areas of the service. All issues found in the 2013 audits have identified corrective action plans and resolutions. Results of audits are discussed in quality and staff meetings.  Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits is not always reported through to quality and staff meetings (link 1.2.3.6). Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. Quality improvements have been regularly completed and documented in the quality/staff meeting minutes. All staff interviewed could describe the corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme. Peacehaven has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be utilised. Five caregivers interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The manager manages quality systems. There is a quality team which includes all staff. The quality programme is reviewed annually and is being implemented. Information is reported through the monthly staff /quality meetings. Meetings standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. |
| **Finding:** |
| Meeting minutes of the staff/quality meeting do not contain evidence of analysis of quality data and discussion of trends and outcomes from the analysis of quality data. |
| **Corrective Action:** |
| Ensure that the quality data is analysed and that quality/health and safety meetings include discussion of the outcomes of the analysis so that all staff are informed of the results of quality improvement data. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy that describes accident/incident management. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the manager who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and raw data is reported to the staff/quality meetings (link 1.2.3.6).  Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. There was a norovirus outbreak in March 2014 and public health were promptly informed. Incidents/accidents for April 2014 to date were viewed and 11 forms were viewed from this time. Incidents are collated monthly onto a reporting sheet to monitor issues and trends. Preventative and corrective actions are documented as required. Actions are reflected in residents long term care plans (LTCP). If risks are identified these are also processed as hazards. Neuorlogical observations have been completed when a resident has had a knock to the head.  D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are job descriptions available for positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of RN’s are current. The service also maintains copies of other visiting practitioner’s certification including GP, pharmacist and physiotherapist. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, reference checks and training. There is an annual appraisal process in place and appraisals are current in all files reviewed. There is confusion around the role of the servcie coordinator and this is an area requiring improvement. There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with six healthcare assistants described the orientation programme that includes a period of supervision. The healthcare assistants reported that supervision can be extended if needed. This was verified by the manager. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Interview with six healthcare assistants inform there is access to sufficient training. Medication competencies are completed for all RN’s and senior healthcare assistants who administer medication.   D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication. |

##### **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:** PA Low |
| **Evidence:** |
| There are job descriptions available for positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of RN’s are current. The service also maintains copies of other visiting practitioner’s certification including GP, pharmacist and physiotherapist. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, reference checks and training. There is an annual appraisal process in place and appraisals are current in all files reviewed. |
| **Finding:** |
| The senior coordinator is a registered nurse in her home country but does not have a New Zealand registration. She is employed in a management role and her offer of employment states she has been employed as a temporary registered nurse, but does acknowledge the need for her to gain New Zealand registration. Families and residents identify her as a registered nurse and she wears a registered nurse uniform and her name badge states she is a registered nurse (noting that the words ‘registered nurse’ on her uniform and name badge were covered during the audit). It is noted that some of the role confusion was generated by the previous owners and that clinically she is not working outside her scope – for example any care plan entries are countersigned by a registered nurse. There is a New Zealand registered nurse on duty 24 hours per day. There is however some confusion around her role. |
| **Corrective Action:** |
| Ensure the role of the senior coordinator is clarified. |
| **Timeframe (days):** 90 *(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. All residents and family members interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the manager will be on-call at all times, 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 24/7 RN cover. A contracted physio attends the facility for eight hours a week and the CHT OT works 12 hours a week (although currently this position is vacant). |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate).  All resident files are in V-care and hard copy files are available. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident’s files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home and hospital setting. The service keeps a resident register.   Peacehaven has a control of documents and records process that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. V-care is password protected. Hard copy resident files are stored securely and protected from unauthorised access by being held at the nurses’ station in a secured cabinet. Old files are individually archived and locked in a secure area.  Resident records are up to date and reflect residents’ current overall health and care status. Records can be accessed only by relevant personnel. Care plans and progress notes are legible, signed and dated by the RN's. Medical notes and allied health input are signed and dated appropriately.  D13.3: The admission agreements reviewed align with a) – K) of the ARC contract. 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:** |
| There is an admission procedure. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and referrer. This process is documented on the CHT enquiry for admission form  The manager states that in the event of a potential resident being declined entry to the service, the service would work with the potential resident and their family, informing them of the reason the service is unable to accept the resident and offering alternative suggestions where possible. The service has not had any residents declined entry to the service. |

##### **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:** |
| There is a care plan policy states the care plans will be written by the registered nurses who are part of the multidisciplinary team.  Discussions with one registered nurse confirmed attendance at regular DHB education sessions. Assessment, planning, evaluation, review and exit are undertaken by the registered nurses with input from allied health professionals and health care assistants as sighted in seven resident’s files sampled (two from the rest home and five from the hospital). Service delivery is primarily undertaken by health care assistants under the guidance of the registered nurses as evidenced in resident progress notes. Health care assistants have had comprehensive in-service education and enrolment in the ACE programme is mandatory. All have annual performance appraisals to ensure they are competent to provide care as required. Residents have access to a GP and the manager has checked that the GP used has a current practising certificate. Residents are able to access their own GP providing the requirements of the service are met. The six health care assistants, one registered nurse and the senior coordinator interviewed expressed confidence in their own ability and that of their colleagues to provide a competent service and the nine residents (four hospital, five rest home) and six family/whanau members (five hospital, one rest home) interviewed expressed confidence in the skills of staff. D16.2, 3, 4: Seven files were reviewed (two from the rest home and five from the hospital), seven of seven files identified that an assessment and initial care plan were completed within 24 hours and a long term care plan completed within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes.  D16.5e: All seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly or more frequently where this is the case.  An admission checklist is completed. The organisation clearly identifies and communicates the level of detail within policies, to meet current accepted good practice and meet legislative requirements. Residents are assessed initially for a) risk of falls, b) risk of pressure areas, c) continence, d) pain (where appropriate), e) MNA depression scale. Reviews had occurred within the six month time frame in seven of the eight files sampled. One rest home file was not for review as the resident was a new admission. Fourteen of the 14 resident medicine records sampled show that the medicines have been reviewed three monthly.  Doctors’ visits and allied health notes (physiotherapist, dietitian, podiatrist etc.) are included in resident files. Assessment/monitoring forms such as continence monitoring, risk of falls, risk of pressure areas and pain management are available also wound management and monitoring.   The service has a variety of ways in which they ensure that the service is co-ordinated. Residents' progress notes are updated daily for hospital residents and at least weekly for rest home level resident and these are readily available for all staff and allied health professionals to see. Staff also have a verbal handover between each shift. Six health care assistants, one registered nurse and the senior coordinator interviewed could describe 'hand over' which occurs at the change of each shift. Staff meetings provide further opportunities for service co-ordination. The GP interviewed expresses a high level of confidence in the service and reports that the registered nurses contact him by telephone or fax at appropriate times.   Tracer Methodology rest home:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology hospital:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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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:** |
| Seven residents files sampled (two from the rest home and five from the hospital) included needs assessments. The initial nursing assessment is comprehensive and completed on all seven files reviewed. The following personal needs information is gathered during admission (but not limited to): a) personal and identification and next of kin b) ethnicity and religion, c) current and previous health and/or disability conditions, d) medication and allergies, e) activities of daily living, f) equipment needs, g) family/whānau support, h) activities preferences, i) food & nutrition information and j) mental function. An initial diet profile is also completed and evidenced on all eight files. The assessments contain information relating to the all areas relating to the resident. There is also a falls risk assessment, a Water low pressure sore risk assessment, a dependency rating, a dietary requirements form, an Abbey pain assessment (if appropriate), a mini nutritional assessment, a resident depression scale, and a continence assessment. Observation/weight charts are completed at least monthly.  The registered nurse interviewed reports that information is obtained from residents and their families/whanau, needs assessments, hospital discharge summaries, previous GP notes and other specialist assessments where these are available. The nine residents (five from the rest home and four from the hospital) and six family (one from the rest home and five from the hospital) interviewed report that they had provided information during the assessment process.  The needs assessment agency provide a comprehensive needs assessment prior to admission which helps to form the basis of the plan of care. |

##### **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:** |
| Residents' files include; initial assessment, BP and weight recordings, short term care plans, long term care plans, risk assessments/nutrition, regular evaluations, GP initial assessment and visits, lab results, NASC assessment, allied health reports, activities, consents, advance directives, letters, referrals and archived notes. Care plans are individually developed with the resident and family/whānau involvement is included where appropriate. All seven care plans reviewed were evidenced to be up to date. The care plan is developed in consultation with the resident and, if appropriate, their family/whānau. Goals and outcomes are identified and agreed and how care is to be delivered is explained. All residents have an individualised long-term care plan that covers all areas of need identified. Areas covered in the seven resident files (two rest home and five hospital), sampled include (but are not limited to): behaviour, social and emotional needs, cultural needs, falls risk, ADL's, nutrition and social needs. Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health including physiotherapy and secondary care specialists including cardiology, mental health services of the older person, ophthalmology and retinal screening, podiatry and nurse specialists. There is evidence that residents are seen by their GP at least three monthly and within 48 hours of admission. The care plan format is comprehensive and goal oriented. Notes are well maintained. Significant events and communication with families/whanau are well documented.  D16.3k: Short-term care plans are in use for changes in health status including infections, UTIs and skin tears. D16.3f: All resident files reviewed identified that family/whanau were involved. |

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

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

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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:** |
| Peacehaven provides services for residents requiring rest home and hospital level care. Care plans are completed comprehensively.  Seven resident care plans (two rest home and five hospital), were reviewed for this audit:  Wound plans, infection control plans for ESBL, diabetes specific plans and comprehensive challenging behaviour plans are evident. Six care plans evidenced six monthly care plan reviews. One rest home care plan was not due for review. The use of short-term care plans is evident. The care being provided is consistent with the needs of residents; this is evidenced by discussions with six health care assistants who work across rest home and hospital, six family/whanau members, one RN, the senior coordinator, the manager and the area manager. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident’s primary care either changes to the GP who covers the service or they retain the services of their own doctor depending on their preference.  There is evidence of referrals to specialist services such as podiatry, retinal screening, cardiology, wound care specialist nurse and the gerontology nurse specialist. There is also evidence of community contact. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided by external providers. Wound assessment and wound management plans are in place for 12 wounds and one pressure area (grade one sacral pressure area). On interview, the RN and the senior coordinator stated that they could access or make a referral to a wound or continence specialist nurse if they assessed that this was required. The GP assesses wounds regularly (documentation viewed). |

##### **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:** |
| The diversional therapist employed by the service has worked at Peacehaven for seven years and works fifty-seven hours a fortnight (over three days each week). The service is currently advertising for an activities coordinator to cover the other days plus weekends. All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the lounge. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family. Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. The programme includes green prescription group exercises, Tai Chi, bingo, newspaper reading, word games and bus trips. There are also visits from community groups.  All six family/whanau members interviewed stated that activities are appropriate and varied enough for the residents. All nine residents interviewed stated they were happy with the activities available and are given a choice regarding attendance. D16.5d: Six of seven resident files reviewed identified that the individual activity plan is reviewed when at care plan review. One resident had not been in the facility long enough for a review. |

##### **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:** |
| The care plan policy includes the evaluation requirements. Records of regular reviews with the GP have been maintained...:  D16.4a: Care plans are evaluated six monthly or more frequently when clinically indicated in the form of a new assessment and new care plan. The care plan, which is re written every six months, includes evaluation against all goals.  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:** |
| D16.4c; The service provided examples of where a residents condition had changed and the resident was reassessed for a higher level of care. D 20.1: Discussions with one registered nurse identified that the service has access to the mental health team, gerontology nurse, wound care specialists, dietitian, Medlab, radiological services, hospital specialists, cultural organisations, social workers, clinical nurse specialists and a range of other allied providers. The nine residents (five from the rest home and four from the hospital) interviewed and six family/whanau (one from the rest home and five from the hospital) interviewed are aware of their options to access other health and disability services and are supported through this process. All confirm advice has been provided by the facility. When a resident requires a referral to another service, the GP takes responsibility for this task. An explanation is given to the resident and their family/whanau are informed as appropriate. Documentation relating to referrals and completed referral forms were sighted in five of seven resident files sampled. The registered nurse reported that the other two residents had not required referral to outside services. |

##### **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:** |
| A transfer/discharge checklist accompanies residents to receiving facilities. In the case of death, clinical care is provided which meets the wishes of the resident and family/whanau and their instructions are observed regarding the treatment of the body. In the case of death, communication with the family is made. Policy and procedures guide staff through the process of discharge, exit or transfer. All relevant forms are utilised. Risks are identified and minimized. The specific forms used for transfer and discharge from the service, identify any known risks or concerns. Family/whanau are kept informed as appropriate as evidenced in interviews with family/whanau. |

##### **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:** |
| A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in line with accepted guidelines. The service has blister packs, which are delivered every two weeks.  The day RN checks the medication on arrival from the pharmacy. There are weekly checks of the controlled drug register. Medication errors are reported and managed through the incident reporting process. All opened eye drops are labelled. A pharmacy contract is in place and the pharmacy is available for advice and support, as and when required. Unused or expired medicines are taken back to the pharmacy for appropriate disposal. Staff responsible for medicine management are competent to perform this function. All those deemed competent have completed documented medication competencies. Staff competencies are completed. There is a sample list of signatures and the registered nurse interviewed described their responsibilities in regard to medication administration. The medications systems procedure includes a section "where residents are responsible for their own medication". This states a) "Store the medicines, including Controlled Drugs, in the resident’s room in a locked cupboard or drawer that is accessible to the resident and staff and b) Medicines should be checked every week. Appropriate senior staff and the doctor must assess a resident’s ability to take their own medicine at least every three months using SM172.Frm Self-Medication Checklist. Alerts are to be entered for all residents who are self-medicating. These alerts will be printed on the duty report. The service currently have no residents self-medicating. All documents and signing sheets are completed in ink and legible. Fourteen resident medication charts and signing sheets reviewed identified all charts had photo identification and allergies//adverse reactions and duplicate names noted. The signing sheets for prn, oral medications and controlled drugs are correctly signed.  D16.5.e.i.2; Medications are reviewed three monthly or as required by the G.P in 14 of 14 medication files sampled. Medicines are only prescribed by GPs and paid for by the service when medicine is subsidised by Pharmac and includes packaging charges. The service encourages GPs to prescribe medicines that are funded. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The CHT food service procedure provides information to staff about the food service procedure. Food services are contracted out and cooked on site by Medirest services. Policies on food service are developed and implemented. These policies and practices meet the requirements of the food hygiene regulations act 1974. There is a summer and winter menu approved by the Medirest dietitian. Four-week menus for summer and winter are appropriate and varied. The contracted food services dietitian makes changes to the menu. D19.2: Medirest employs an area manager (who oversees nutritional services), a week cook, a weekend cook and three kitchen hands, all of which have completed the Medirest food safety programme.  A mini nutritional assessment is completed on admission for each resident and this is reviewed six monthly. Nutritional needs for each resident are entered on the care plan. Special diets are available and catered for as are resident preferences. Dietary information forms are completed on admission and a copy given to the kitchen for their information. The dietary preferences of each resident are displayed on a whiteboard in the kitchen. The food service procedure states "Residents upon admission will have their individual preferences (likes/dislikes), religious and/or cultural requirements assessed by the care staff using SM190.Frm- Dietary Information. Form. This assessment may include input from the family/ whanau where appropriate. There are copies of resident’s food preferences/ dietary needs in the kitchen and the cook was able to identify which residents required special meals (such as diabetic).  Meals supplied include as routine, breakfast, lunch, dinner, morning tea, afternoon tea and supper. These meals are served at times that reflect community norms. Outside of regular meal times, staff will provide a nutritious snack or drink if residents are hungry or thirsty. Extra snacks are provided when needed. Residents' weight is recorded on admission and monthly thereafter and were stable in five out of seven resident files sampled. The other two: - one resident had been assessed by a dietitian, was on REAP level three and gradually gaining weight, the other was a new admission and not due for a monthly weigh.  There is a comprehensive quality assurance programme implemented in the kitchen. The following is included monthly; a) food safety audit, b) food temperature monitoring, c) fridge, freezer and dishwasher temps daily, and d) incoming food temps. Medirest operates a 'balanced score card' monitoring process to ensure compliance with the quality processes. The kitchen is clean and well maintained.  The main grocery shop occurs weekly according to the menu. Food is stored in the pantry, the fridge and the freezer and temperatures are recorded daily. Food sighted in the fridge, freezer and pantry was covered and dated and raw food was stored below cooked food. Different coloured chopping boards are used for different food types and there is a roster for kitchen cleaning. The kitchen was clean on the day of the audit. The nine residents (five from the rest home and four from the hospital) interviewed and six family (one from the rest home and five from the hospital) interviewed state they are happy with food temperatures and meals provided.  The service commenced using a Replenish Energy and Protein (REAP) programme in October 2013. REAP puts a focus on nutrition and 'nutrition alerts' and is an agenda item at nursing and caregiver meetings. The documented programme has been developed by the Medirest dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. The REAP programme is an area of continuous improvement. |

##### **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:** CI |
| **Evidence:** |
| The CHT food service procedure provides information to staff about the food service procedure. Food services are contracted out and cooked on site by Medirest services. There is a summer and winter menu approved by the Medirest dietitian. Policies on food service are developed and implemented. These policies and practices meet the requirements of the food hygiene regulations act 1974. Four-week menus for summer and winter are appropriate and varied. Dietary information forms are completed on admission and a copy given to the kitchen for their information. There is a comprehensive quality assurance programme implemented in the kitchen and the following happens on a monthly basis a) food safety audit, b) food temperature monitoring, c) fridge, freezer and dishwasher temps daily, and d) incoming food temps. Medirest operates a 'balanced score card' monitoring process to ensure compliance with the quality processes. |
| **Finding:** |
| The service commenced using a Replenish Energy and Protein (REAP) programme in October 2013. REAP puts a focus on nutrition and 'nutrition alerts' and is an agenda item at nursing and caregiver meetings. The documented programme has been developed by the Medirest dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. There are four levels. The emphasis is on food first rather than commercial supplements for managing unintended weight loss. At Peacehaven there are currently residents on REAP level two and level three. These residents are clearly documented on the whiteboard in the kitchen. When a resident is identified as having unintended weight loss a weight loss report is completed. This includes checking the mouth and teeth, reviewing diet type, monitoring food intake, consulting with the cook, consulting the dietitian, referring to the GP, referring to family/whanau and reviewing medication. One file was sampled for a resident who has been on REAP level three. He was assessed by a dietitian prior to commencement on REAP. The dietitian for the organisation (who is not the dietitian who developed REAP from Medirest) was unavailable for interview. Her clinical notes evidenced the programme as a very positive initiative with positive outcomes for residents. The resident on REAP whose file was sampled has had weight gain. On interview the resident was able to discuss his REAP plan and was pleased that he was gaining weight. He stated he was having extra snacks and the staff was monitoring his weight. All staff were provided with training around REAP by the Medirest dietitian in October 2013 with the kitchen staff receiving more detailed training. Six of six health care assistants, one registered nurse and the senior coordinator interviewed are all familiar with REAP and report the benefits to residents. The cook is aware of all residents on REAP and works closely with the registered nurses to monitor residents progress. The cook interviewed reports the ways in which she implements REAP include fortifying food wherever possible for those on the programme. Examples include cream and brown sugar on cereals, extra margarine on vegetables, fortifying mashed potato, sauces and purees, cream on desserts in the evening (for level three), fortifying soup, providing fortified milk and fortified drinks, fortified custard for supper for those on REAP level three and sandwiches for supper on REAP level two (of which there are currently no residents). The service continues to evaluate and improve the REAP programme and initial results show a marked decrease in weight loss for those using the programme. |
| **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:** |
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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 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has waste management policies and procedures for the safe disposal of waste and hazardous substances such as decontamination procedure; blood and body fluid spill management procedure; blood accident procedure.  Chemicals are labelled and there is appropriate protective equipment and clothing for staff. There is an incident reporting system that includes investigation of these types of incidents. The service has a health and safety management system. There is a hazard register and on-going hazard control plans.  Management of waste and hazardous substances is covered during orientation of new staff. In-service education in management of chemicals, waste and hazardous substances was last delivered by in 2013. Six health care assistants, one registered nurse, the senior coordinator and the manager interviewed are familiar with policies and the appropriate practices. Material Safety Data Sheets are available to staff (sighted). General waste is removed by the council and sharps are removed in an approved container by the pharmacy. Staff were observed to use appropriate personal protective equipment (PPE). Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. PPE was observed in use. The staff working on the day of audit demonstrate good knowledge of the appropriate use of protective equipment and clothing. The staff interviewed including six health care assistants, one registered nurse and the senior coordinator interviewed are knowledgeable about the reasons for use of protective equipment and clothing and utilise this. |

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

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

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

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The building holds a current warrant of fitness, which expires on 1 June 2013. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed one of the owner/managers contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. The maintenance person is available on an on call basis. External contractors are engaged to complete work as required. The facility's amenities, fixtures, equipment and furniture are appropriate for rest home and hospital residents. There is sufficient space so that residents are able to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. Resident’s bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level pathways to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained. D15.3d: The lounge area is designed so that space and seating arrangements provide for individual and group activities. D 15.e: The following equipment is available, pressure relieving mattresses and cushions, shower chairs, hoist, chair scales, transfer belts, slipper sams, wheelchairs. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There are 42 rooms, three double rooms have ensuites, 18 single rooms have ensuites, and 18 rooms have a toilet and hand basin and three rooms without a toilet. There are four combined communal showers and toilets and two separate communal toilets. All have adequate signage. Visitor/staff toilets are well signed. Shower rooms have shower curtains to maintain privacy and all communal toilets and showers have locks. Hand basins are located in all service areas. All toilets have access to hand basins and adequate hand drying facilities. Hand sanitizer gel is provided throughout the facility. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. The floor coverings are carpet and vinyl. The facility was clean and well presented. Residents and health care assistants interviewed report sufficient toilets and showers. |

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

#### Standard 1.4.4: 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 space in all bedrooms for residents and staff. Six health care assistants were asked if there was sufficient room and they confirmed they were able to move freely to provide cares. Doorways into residents' rooms and communal areas are wide enough for wheelchair and trolley access. Residents interviewed (nine) confirm their bedrooms are spacious and they can personalise them as desired. Relatives/whanau (six) states they are happy with their family/whanau member’s room. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a main lounge and a separate dining area. There are small sitting areas within the facility. Residents were seen to be moving freely throughout facility in wheel chairs and walking frames. Residents are able to move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements and give wheelchair access. Activities occur in the main lounge and residents are able to access their rooms for privacy when required. D 15.3d: Seating and space is arranged to allow both individual and group activities to occur. |

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

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

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

#### Standard 1.4.6: Cleaning And Laundry Services **(**HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a cleaning policy and a cleaning quality management plan. Cleaning audits occur. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer’s labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. The laundry is currently being decommissioned and laundry will be conducted off site and the manager reports that she will have contact with the contractor at least monthly to provide feedback. The ISS services manager was interviewed and reports appropriate practices are being implemented. There is a documented laundry audit, which is completed monthly for the service. ISS services audits laundry and cleaning processes monthly and standards of laundry. Issues are followed up with staff by the supervisor or regional manager. Resident satisfaction with cleaning and laundry services is monitored through the annual satisfaction survey with a high level of satisfaction being reported.  All bulk chemicals and chemicals used by the cleaner are kept in locked cupboards that cannot be accessed by residents. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **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:** PA Low |
| **Evidence:** |
| Civil defence is covered in the risk management procedure. This details aspects of civil defence including emergency supplies. There is a fire safety and evacuation procedure. Fire training and security situations are part of orientation of new staff - orientation checklist sighted. Staff training in emergency management including fire safety and evacuation, also emergency response for healthcare facilities, this occurred in December 2013. Fire evacuation also occurred on 1 December 2013. Sighted policy and procedure on emergency and security situations including how services will be provided in health, civil defence or other emergencies according to the needs of the residents in the service, how the service will manage in a worst case scenario pandemic event. These policies have been reviewed within the last two years. Interviews with six health care assistants, one registered nurse and the manager showed they are aware of emergency and security procedures. Fire equipment includes fire hose reels, fire extinguishers, smoke detectors and sprinklers - sighted. A fire services company conduct monthly checks. There is an improvement required around having staff on duty with a first aid certificate at all times. An approved evacuation scheme was signed off by the New Zealand Fire Service on 29 June 2006. A review of the roster for the past two weeks shows there are nine shifts when there is no staff member on duty with a first aid certificate. Extra blankets are available. There is emergency lighting at the facility and torches and batteries are stored (sighted). The facility has emergency lighting and a gas BBQ is available for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. A store of emergency water is kept. The facility has Civil Defence kits. Staff are aware of how to find this equipment as confirmed at interviews with six health care assistants, one registered nurse and the manager. Call bells are evident in resident’s rooms, lounge, dining, and toilets/bathrooms. There is a call bell system in place. Call bells are tested by the maintenance man and repaired in a timely fashion. Call bells were randomly tested during the audit and were all in working order. Nine of nine residents (four rest home and five hospital) interviewed commented that staff respond promptly to the call bell. The service has a health and safety management system.  Visitors and contractors are required to sign in and out.  Exits are physically locked by afternoon staff at approximately 6pm each night. This is double checked by night staff when they come on duty at 11pm.  There is security lighting for after dark. All staff interviewed are familiar with security measures. 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:** PA Low |
| **Evidence:** |
| Civil defence is covered in the risk management procedure. This details aspects of civil defence including emergency supplies. There is a fire safety and evacuation procedure. Fire training and security situations are part of orientation of new staff - orientation checklist sighted. Staff training in emergency management including fire safety and evacuation, also emergency response for healthcare facilities, this occurred in December 2013. Fire evacuation also occurred on 1 December 2013. Sighted policy and procedure on emergency and security situations including how services will be provided in health, civil defence or other emergencies according to the needs of the residents in the service, how the service will manage in a worst case scenario pandemic event. These policies have been reviewed within the last two years. Interviews with six health care assistants, one registered nurse and the manager showed they are aware of emergency and security procedures. Fire equipment includes fire hose reels, fire extinguishers, smoke detectors and sprinklers - sighted. A fire services company conduct monthly checks |
| **Finding:** |
| A review of the roster for the past two weeks shows there are nine shifts when there is no staff member on duty with a first aid certificate. |
| **Corrective Action:** |
| Ensure there is a staff member on duty at all times with a current first aid certificate. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| General living areas and resident rooms are appropriately heated and ventilated. The facility has central heating. All bedrooms and communal areas have at least one external window. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a restraint manual applicable to the type and size of the service. The restraint manual includes a section on training that covers policies, procedures, challenging behaviours management, de-escalation techniques, emergency / acute restraint and appropriate use of safety enablers. Restraint training occurs yearly. Challenging behaviour training has been provided. Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers. The restraint manual determines that enablers are voluntary and the least restrictive option. There are no enablers in use in the facility and six residents with restraints (three lap belts and five bed sides).  Prior to the purchase of the facility environmental restraint was practiced in the form of barriers to stop residents leaving their rooms, a locked automatic gate at the entrance and covering the exit button to the front door to make it difficult to locate. The use of barriers has ceased and the key code to the gate, including an easy to read ‘shape’ is visible on both sides of the gate. The exit button is in the reception area and no longer covered. |

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

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

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

## **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:** |
| The restraint coordinator is an RN experienced in aged care. She is supported by the clinical coordinator. Assessment and approval process for a restraint intervention includes the RN, resident/or representative and medical practitioner. |

##### **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:** |
| The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. A registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In restraint files reviewed, assessments and consents were fully completed. Consent for the use of restraint is completed with family involvement and a specific Consent for enabler / restraint form is used to document approval. These were sighted in the four restraint files reviewed. |

##### **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:** FA |
| **Evidence:** |
| The restraint manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. The four files reviewed had a completed assessment form and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the four files reviewed. All files reviewed have a consent form detailing the reason for restraint and the restraint to be used. In resident files reviewed, monitoring forms had been completed. Assessments are completed. A sixmonthly evaluation of restraint is completed that reviews the restraint episode. The service has a restraint and enablers register for the facility that is up dated each month. |

##### **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:** 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 2.2.3.5 (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 in 2.2.4.1 (a) – (k). In the four restraint files reviewed, evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every monthly by the facility restraint co-ordinator and through restraint committee meetings. A restraint evaluation is completed for each individual month. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner. |

##### **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 six monthly through the restraint (staff/quality) meeting and as part of six monthly facility approval team review with whanau involvement. Restraint usage throughout the facility is analysed and information fed back to staff via all facility 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:** |
| The infection control (IC) coordinator is an RN and has been in the post for one month. The infection control coordinator can access external specialist advice from GP's, laboratories and DHB infection control specialists when required. The infection control programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the coordinator and external expertise when required. Infection control is a standing agenda item at the monthly staff/quality meetings and monthly RN meetings (link 1.2.3.6). Staff are informed about infection control practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the infection control coordinator and entered into the infection register.  There are job description for the infection control coordinator including the role and responsibilities of the infection control coordinator. IC is part of the audit schedule and is undertaken monthly. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine. In March 2014 the facility had a Norovirus outbreak. Records show this was managed well and all staff and residents have now recovered. |

##### **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:** |
| Infection control matters are taken to all staff/quality meetings (minutes reviewed). The infection control coordinator can access external DHB, infection control nurse specialist, laboratories, and GP's specialist advice when required. They are responsible for reviewing the infection control programme annually at the organisational IC meeting. The coordinator complies with the objectives of the infection control policy and work with all staff to facilitate the programme. The coordinator has completed on line infection control training through the Ministry of Health. Staff complete annual infection control education. Access to specialists from the DHB, laboratories and GP’s is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations. |

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

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control coordinator has completed on lione Ministry oif Health training. All new staff receive infection control education at orientation including hand washing and preventative measures. Annual infection control education has not yet occurred as CHT have not yet owned the facility for one year. This is booked for the week following the audit (email confirmation sighted) and will use the CHT IC training resource. The training folder records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Peacehaven are appropriate to the acuity, risk and needs of the residents.  The infection control coordinator enters infections on to the infection register and carry out a monthly analysis of the data. The analysis is intended to be reported to the monthly staff,/ quality meeting and the monthly RN meeting (link 1.2.3.6). The infection control coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of 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.)* |