

Orongo Lifecare Limited

Current Status: 27 February 2014

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

General overview

Orongo Rest Home has 46 beds and provides care to residents requiring rest home level or dementia level care. The facility is fully occupied at audit.

There have been no significant changes to the land or buildings since the previous audit. The facility manager and the registered nurse (RN) have been working in this rest home for nine and eleven years respectively.

At the last audit there were two areas identified as requiring improvement. These have been fully addressed. At this audit there are eleven areas identified as requiring improvement. These relate to: open disclosure; documentation of complaints; facility manager's education; reporting incidents/adverse events; documentation in resident records; and human resource processes. Care planning; ensuring interventions meets the resident's needs; having individualised activities plans for residents in the rest home require improvements. A number of medication management practices require improvement. This includes ensuring staff have current medication competencies.

Audit Summary as at 27 February 2014

Standards have been assessed and summarised below:

Key

| Indicator | Description | Definition |
|-----------|---|--|
| | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
| | No short falls | Standards applicable to this service fully attained |
| | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |

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

Consumer Rights as at 27 February 2014

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

Organisational Management as at 27 February 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 medium or high risk and/or unattained and of low risk. |
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Continuum of Service Delivery as at 27 February 2014

| | | |
|--|--|--|
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
|--|--|--|

Safe and Appropriate Environment as at 27 February 2014

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

Restraint Minimisation and Safe Practice as at 27 February 2014

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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Infection Prevention and Control as at 27 February 2014

| | | |
|--|--|---|
| <p>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.</p> | | <p>Standards applicable to this service fully attained.</p> |
|--|--|---|

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

| | |
|---|--|
| Legal entity name: | Orongo Lifecare Limited |
| Certificate name: | Orongo Lifecare Limited |
| Designated Auditing Agency: | Health Audit (NZ) Limited |
| Types of audit: | Surveillance Audit |
| Premises audited: | Orongo Rest Home |
| Services audited: | Rest home care (excluding dementia care); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 27 February 2014 End date: 27 February 2014 |
| Proposed changes to current services (if any): | |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 46 |

Audit Team

| | | | | | |
|--------------------------|-------|----------------------------|-----|-----------------------------|---|
| Lead Auditor | XXXXX | Hours on site | 9.5 | Hours off site | 7 |
| Other Auditors | XXXXX | Total hours on site | 9 | Total hours off site | 4 |
| Technical Experts | | Total hours on site | | Total hours off site | |
| Consumer Auditors | | Total hours on site | | Total hours off site | |
| Peer Reviewer | | | | Hours | |

Sample Totals

| | | | | | |
|--|------|-----------------------------------|----|--------------------------------------|------|
| Total audit hours on site | 18.5 | Total audit hours off site | 11 | Total audit hours | 29.5 |
| Number of residents interviewed | 3 | Number of staff interviewed | 7 | Number of managers interviewed | 3 |
| Number of residents' records reviewed | 8 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 15 | Total number of staff (headcount) | 22 | Number of relatives interviewed | 2 |
| Number of residents' records reviewed using tracer methodology | 3 | | | Number of GPs interviewed | 1 |

Declaration

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

I confirm that:

| | | |
|----|---|-----|
| a) | I am a delegated authority of Health Audit (NZ) Limited | Yes |
| b) | Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health Audit (NZ) Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | Health Audit (NZ) Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health Audit (NZ) Limited has finished editing the document. | Yes |

Dated Monday, 10 March 2014

Executive Summary of Audit

General Overview

Orongo Rest Home has 46 beds and provides care to residents requiring rest home level or dementia level care. The facility is fully occupied at audit.

There have been no significant changes to the land or buildings since the previous audit. The facility manager and the registered nurse (RN) have been working in this rest home for nine and eleven years respectively.

At the last audit there were two areas identified as requiring improvement. These have been fully addressed. At this audit there are eleven areas identified as requiring improvement. These relate to: open disclosure; documentation of complaints; facility manager's education; reporting incidents/adverse events; documentation in resident records; and human resource processes. Care planning; ensuring interventions meets the resident's needs; having individualised activities plans for residents in the rest home require improvements. A number of medication management practices require improvement. This includes ensuring staff have current medication competencies.

Outcome 1.1: Consumer Rights

Policies and procedures are available to guide staff practice on open disclosure. Family and residents confirmed they are happy with communication processes and feel well informed. Evidence of open disclosure occurring following reported incidents/adverse events is not consistently available and this is an area requiring improvement.

Policies and procedures provide guidance to staff on the complaints process. There have been no written complaints received since the last audit. While staff can identify the process for managing minor complaints or concerns (verbal complaints) these are not being recorded in the minor complaints/concerns register and this is an area requiring improvement.

Outcome 1.2: Organisational Management

The facility manager is an enrolled nurse (with a current practising certificate) who has been employed as the facility manager since January 2006. The facility manager is attending relevant ongoing education, however, has not completed the eight hours related to managing a service in the last year as required to meet the providers contract with the Waitemata District Health Board. This is an area requiring improvement.

The organisation's quality and risk systems includes: compliments management; internal audits; resident satisfaction surveys; resident meetings; audits; incident reporting and benchmarking of quality data with another facility. Staff are reporting a range of incident/adverse events with the exception of medication events or omissions. This is an area requiring improvement.

Policies and procedures are being reviewed and updated at least every two years. Document control processes are in place.

There is a process for the reporting and management of new hazards. A hazard register is maintained. A process to identify and manage organisational risk is in place.

Staff interviewed report being informed of quality and risk issues, including adverse events, use of restraint, infections and audit results, via staff meetings, the staff notice board and/or shift handovers.

Recruitment and human resource processes are detailed. Records evidencing reference checks and interviews are not available in all staff files. Police checks are not being conducted despite new employees providing written consent for this to occur. Whilst performance appraisals are noted to be current; a number of appraisals cannot be located during audit. These are areas requiring improvement. Signed employment agreements and copies of staff job descriptions are present in staff files.

The annual practising certificates are available for all applicable health professionals (including contractors) and now meet the requirements of the standard.

There is a registered nurse on duty Monday to Thursday each week. The facility manager or registered nurse share being on call. Staffing is adjusted where required for changes in resident care needs. There is at least one staff member with a current resuscitation certificate on duty at all times. Staff who have been working in the dementia service for more than six months have completed an industry approved qualification.

Documentation in resident files is not always sufficiently detailed or timely. This is an area requiring improvement.

Outcome 1.3: Continuum of Service Delivery

Each stage of service provision is undertaken by suitably qualified and/or experienced service providers. The facility manager and registered nurse (RN) have been working in the facility for nine and 11 years respectively, with current annual practising certificates.

Residents are assessed on admission by the RN using various risk assessment tools. The activities coordinator conducts the activities assessment. An individualised activities plan is not created for the rest home residents. This is an area for improvement. There is a 24-hour activity plan in the dementia unit. Care plans are created in a timely manner but are insufficiently detailed to address the changing needs of the resident. None of the residents reviewed have short term care plans in place. The resident's response to treatment is not consistently documented in the care notes of the eight resident's file reviewed. These are areas requiring improvement.

The RN's uses written records during handover and the content of hand-over is comprehensive. The hand over included the new/acute problems like infections and other issues that require further monitoring and evaluation.

A documented medication management policy is in place. Improvements are required to ensure that the policy includes checking processes for medications when delivered, medication prescribing, administration and documentation practices met standards. Ensuring caregiver's complete annual medication competency assessments also requires improvement. The medication self-administration policy and procedure is implemented in practice.

Food, fluid and nutritional needs of the residents are provided in line with the recognised nutritional guidelines. Special diets are provided e.g. vegetarian, puree, diabetic as well as food dislikes and allergies. Residents are weighed monthly and have stable weights. Residents verbalise that they enjoy the meals served in the facility. Served meals are attractively presented. The summer and winter menus have been reviewed by the dietitian in May 2013. Policies in the food service are implemented. The cook and kitchen assistants prepare meals wearing disposable hats and kitchen gloves.

Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--|--|-------------|---|---|------------------|
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Moderate | Open disclosure is not able to be evidenced in the resident files for five of nine applicable incident reports reviewed at random during audit. | Ensure open disclosure occurs in a timely manner for all applicable events and records are available to demonstrate this. | 90 |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | <p>Whilst there is a separate register for the recording of concerns and minor complaints this is not being completed. A concern or minor complaint is noted to be a 'complaint that can be remedied to the complainant's satisfaction at the time the complaint is received and the complainant advises the issue does not need to be pursued further'.</p> <p>Four of six respondents in the resident satisfaction survey (July 2013) identified their concerns 'could have been managed better'.</p> | Ensure minor complaints and concerns are documented as per the organisations policy. | 180 |
| HDS(C)S.2008 | Standard 1.2.1: Governance | The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | | | |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|---|-------------------|---|---|-------------------------|
| HDS(C)S.2008 | Criterion 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. | PA Low | The facility manager is attending education/in-service. However, is unable to demonstrate she has completed eight hours of education in the last twelve months relevant to the management of an aged care facility (as required by the ARRC Contract). | Ensure the facility manager participates in at least eight hours of relevant educations as identified in the ARRC Contract. | 180 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Medication related incident or adverse event reports are not being documented by staff. This includes where medications are not signed as being given as prescribed (or noted a with-held or refused).The Medication policy notes 'it is mandatory for staff to report any discrepancies, errors or omissions'. | Ensure all types of incidents are being reported investigated and followed up in a timely manner as per the organisations policies. | 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 Moderate | | | |
| HDS(C)S.2008 | Criterion 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | Records evidencing reference checks or interview process are not available in two of five staff files sampled where the staff member has been employed between December | Ensure all human resource practices comply with the organisations policies. | 90 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|---|----------------|---|--|------------------|
| | | | | <p>2010 and July 2013.</p> <p>Police checks are not being undertaken despite new employees providing written consent for this to occur as a component of the employment process. Police checks are noted as being required in the organisations policies.</p> <p>The master list identifies when staff performance appraisals are due. Three of six staff files sampled did not contain a performance appraisal completed in the last twelve months. The master register identifies these have been done and are unable to be located during audit.</p> | | |
| HDS(C)S.2008 | Standard 1.2.9: Consumer Information Management Systems | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | <p>Staff are not documenting the time entries are made in clinical notes. Rather only the date of entry is being recorded. Documentation in clinical records is not always complete or timely. As an example:</p> <ul style="list-style-type: none"> - when a urine sample has been collected this is documented. However, additional assessment including signs and symptoms the resident is demonstrating is | <p>All staff must ensure that time of entries are documented in the clinical notes.</p> <p>Staff must ensure that assessments need to be documented in the clinical notes that prompts them to collect specimens like urine.</p> <p>Ensure that all adverse events are documented in the clinical notes.</p> | 90 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--|---|------------|---|--|------------------|
| | | | | not documented. - where an incident report has been completed following an adverse event, this is not always documented in the resident notes sampled. Eg one resident has three falls which are not documented in the clinical notes but are reported on incident reports. | | |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA High | | | |
| HDS(C)S.2008 | Criterion 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. | PA High | Interventions in the care plans are not being consistently provided to meet the resident's needs/desired outcomes. As an example a resident who has had fourteen falls since the care plan was last updated in August 2013. Ways to minimise falls like the use of sensor mats are not included in the care plan. Routine medication reviews are occurring (three monthly). While the physiotherapist has reviewed the resident, the physiotherapist stated being 'unaware of the number of falls the resident has been having' and a plan aimed/ focused on reducing falls has not been developed. The falls risk assessment remains unchanged despite the numerous falls. | Ensure care plans are sufficiently detailed to guide staff in the provision of care. Ensure the care plans are updated in a timely manner to include alternative interventions to minimise resident falls. | 30 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|------------------------------------|--|------------|---|--|------------------|
| | | | | Another resident had four falls in one month. The care plan sighted has not been reviewed or updated to include further interventions to mitigate falls risk. | | |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | 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. | PA Low | | | |
| HDS(C)S.2008 | Criterion 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. | PA Low | There are no individualised activities plans in place for residents receiving rest home level care. | The activities coordinator must ensure that individualised activities plan will be created for all residents in the rest home. | 180 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA High | | | |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA High | The long term care plans are not sufficiently detailed to reflect the current needs of residents including where the care needs of residents have changed e.g. as a result of falls or development of infections. Short term care plans are not sighted in any of the files sampled. As an example a resident who has had fourteen falls since the care plan was last updated in August 2013. The interventions are insufficient in order to prevent further episodes of falls or | Ensure that long term care plans are sufficiently detailed that reflects the current needs of the residents. Ensure that short term care plans are created to address the acute needs of the residents. | 30 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--------------------------------------|---|------------|---|---|------------------|
| | | | | possible injury to the resident. Sensor mats or the use of hip protectors are not included in the planned interventions. | | |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA High | | | |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA High | <p>The documented medication management is insufficiently detailed and does not meet all the requirements of the current medicines regulations. The requirements of the current medication policies and procedures are not implemented in practice.</p> <ul style="list-style-type: none"> •A lunchtime medication round was observed in the dementia unit. The caregiver is sighted administering all lunchtime medications from memory (no medication records were being used by the staff member) and signing sheets not signed at the time of administration. •14/15 medication records sampled have a 'ditto' symbol or arrow symbol to identify the date medication was prescribed by the GP. •Where medications are prescribed for daily administration, the time which the medication is to be | Ensure medication records are sighted when medications are given and that these are signed as administered. Ensure that all medication management practices comply with the current accepted practice and legislative requirements. | 7 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--------------------|---|------------|---|---|------------------|
| | | | | <p>administered is not always clearly prescribed. E.g. Risperidone, Digoxin and Furosemide daily.</p> <ul style="list-style-type: none"> •Medication signing sheets do not evidence that all medications have been administered as prescribed including oral medications, inhalers and topical products. •The RN has removed from the robotic rolls all medications to be administered by the caregivers for the period Thursday 1700 hours to Sunday 2100 hours. •Medications for some residents are being crushed. Whilst there are some guidelines available from the pharmacy, the organisation is unable to evidence that these guidelines have been considered for residents who are having medications crushed. • There is currently no process in place to check that medications delivered for the next cycle are congruent with medications prescribed by the GP in medication records. | | |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are | PA High | Seven of seven caregivers who administer medication have | Ensure that all caregivers who administer | 7 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|------|------|---|------------|---|---|------------------|
| | | competent to perform the function for each stage they manage. | | medication competency assessments which have been completed more than twelve months ago. The competencies sighted are dated 2009 to 2012. The RN and FM have medication competency assessments completed in the last twelve months. | medication will have a medication competency assessment completed annually. | |

Continuous Improvement (CI) Report

| Code | Name | Description | Attainment | Finding |
|------|------|-------------|------------|---------|
| | | | | |

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

While residents and family advise there is open communication with staff; documentation evidencing open disclosure is not present for all applicable incident reports sampled during audit. This is an area requiring improvement.

The registered nurse (RN) and facility manager interviewed confirm all current residents can speak and understand English. If translators are required; this is reported to be organised via with the DHB.

The aged related residential care (ARRC) contract requirements are met.

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

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

Attainment and Risk: PA Moderate

Evidence:

There is an open disclosure policy dated May 2014. This identifies that residents and their support persons have the right to open disclosure. The process of disclosure is included in the policy and the policy notes the disclosure intended time frame is within 24 hours of the event happening.

There is evidence of open disclosure occurring however this is not always consistent or at times timely. Nine incident reports selected at random. A review of the progress notes of the applicable residents does not contain documentation evidencing the family were informed in relation to five of these nine incidents. This is an area requiring improvement.

The registered nurse (RN) and four of four caregivers interviewed advise the RN or the senior caregiver is responsible for ensuring open communication occurs with family in a timely manner.

The three residents and both family interviewed confirm they are happy that staff are communicating in an open manner with them.

Finding:

Open disclosure is not able to be evidenced in the resident files for five of nine applicable incident reports reviewed at random during audit.

Corrective Action:

Ensure open disclosure occurs in a timely manner for all applicable events and records are available to demonstrate this.

Timeframe (days):90(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

Attainment and Risk: PA Low

Evidence:

There is a 'concerns and complaints' policy dated October 2013. The policy notes that right of residents, significant family or others to make a complaint. The process of documenting, acknowledging and responding to complaints are detailed and align with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

All four caregivers interviewed are able to verbalise their responsibilities in relation to the complaints process where the resident or family members makes a written complaint. Concerns or minor complaints (as defined in the organisations policy) are being managed but are not being documented in the concerns/minor complaints register. This is an area requiring improvement.

All three residents and two family members interviewed confirm they are aware of the complaints process and are happy with services being provided.

ARRC contract requirements are not fully met.

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

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

Attainment and Risk: A

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The complaints register is sighted. There have been no complaints documented since 13 September 2010. The facility manager advises there have been no written complaints received from residents, family members, the District Health Board, the Ministry of Health or the Health and Disability Commission since the last audit.

Whilst there is a separate register for the recording of concerns and minor complaints this is not being completed. A concern or minor complaint is noted to be a 'complaint that can be remedied to the complainants satisfaction at the time the complaint is received and the complainant advises the issue does not need to be pursued further'. Staff interviewed advise these may relate to residents personal laundry and food related concerns. The care givers advise they document these in the residents progress notes Where the concern/complaint has not been able to fully addressed at the time a note is made in the communication book. The staff advise these complaints are not otherwise documented. This is verified during interview with the facility manager.

Four of six respondents in the resident satisfaction survey (July 2013) identified their concerns 'could have been managed better' as identified in the summary of survey results sighted.

Finding:

Whilst there is a separate register for the recording of concerns and minor complaints this is not being completed. A concern or minor complaint is noted to be a 'complaint that can be remedied to the complainants satisfaction at the time the complaint is received and the complainant advises the issue does not need to be pursued further'.

Four of six respondents in the resident satisfaction survey (July 2013) identified their concerns 'could have been managed better'.

Corrective Action:

Ensure minor complaints and concerns are documented as per the organisations policy.

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The vision, values or principals of the organisation are documented and dated March 2013. The quality manager advises there are reviewed with the director regularly. An annual quality and risk review is utilised to help inform the review. The 2013 quality and risk review sighted for 2013. This was undertaken in early 2014. There is a focus on quality improvement processes and providing a positive living environment for residents in a home environment. Family involvement, compassion, respect/privacy and quality of life are some (but not all) of the organisations values/principals that guide care.

The facility provides rest home and dementia level care.

The facility manager (FM) has been in the role since January 2006. The education records sighted details the FM has participated in six hours of education in the last year in variance to the Aged Related Residential Care (ARRC) contract. This is an area requiring improvement.

ARRC contract requirements are met excluding D 17.3 d.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The facility manager (FM) has been in the role since January 2006. The FM is an enrolled nurse with a current annual practising certificate (APC) which is sighted. The job description details the roles and responsibilities. The FM participates in ongoing education. The education records sighted details the FM has participated in six hours of education in the last year- most of this is clinically focused. The FM is unable to demonstrate she has participated in eight hours of education annually of professional development activities related to managing a Rest Home. This is an area identified as requiring improvement.

Finding:

The facility manager is attending education/in-service. However, is unable to demonstrate she has completed eight hours of education in the last twelve months relevant to the management of an aged care facility (as required by the ARRC Contract).

Corrective Action:

Ensure the facility manager participates in at least eight hours of relevant educations as identified in the ARRC Contract.

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

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

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

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

Attainment and Risk:FA

Evidence:

Orongo Rest Home has a quality and risk programme which includes (but is not limited to):

- complaints / compliments
- resident satisfaction surveys
- resident meetings
- internal audits
- incident reporting (including near miss events)
- benchmarking quality data
- monitoring residents for infections
- monitoring the use of restraints and enablers
- policy and procedure review
- staff education
- hazard reporting
- undertaking a comprehensive annual review of quality outcomes/results.

There is a documented quality plan which notes a quality improvement philosophy. The roles and responsibilities of key staff are noted.

Compliments are reported and discussed with staff at least monthly as verified in the minutes of the quality committee and staff meetings sighted. There ranges between one and five compliments reported each month received from residents, family members, visiting health professionals or community agencies/services.

Four of four caregivers interviewed confirm they are advised of relevant quality and risk issues and adverse events during shift handovers or at staff meetings. The minutes of the three most recent monthly staff meetings are sighted. Minutes includes discussions on infection rates, care issues for individual residents, incidents and accidents, compliments, health and safety issues, the menu (including change to summer menu) and staff training opportunities. There is a notice board in the staff office that contains details of each resident's names. The quality manager updates this board to identify each resident who has had a fall, skin tear, infection or other type of event. The events are colour coded and provide a clear visual prompt to staff on the residents who have increased falls or infections. The staff advise this communication process works very well to keep adverse event data with an individual resident focus. The information reported via the incident reporting process is included in a benchmarking programme with the other residential care facility owned by the director. The benchmarking data is reported to be per 1000 resident days and compares rest home and dementia services with rest home and dementia service data from the other facility. There is evidence of analysis of the benchmarking data on at least a monthly basis and overall analysis of 2013 year is noted in the '2013 evaluation of services and performance' document. The benchmarking data reflects Orongo has a higher rate of falls in comparison with the other facility. Corrective action plans are being developed following internal audits and in relation to the weekly clinical meeting. The corrective action planning process following adverse events is not clearly verifiable in relation to resident adverse events. This is raised as an area for improvement in 1.3.6.1 and 1.3.8.3. Medication related adverse events are not being reported by staff. This is raised as an area for improvement in 1.2.4.3.

The minutes of the three most recent quality meetings sighted. These include more specific discussions on adverse events, complaints, restraints in use, and staff education. Data related to residents with infections is also discussed. The meeting minutes have to do list which includes actions to be undertaken and by whom.

A family satisfaction survey was undertaken in July 2013 and includes at least 12 different questions. Seven responses received and the summarised findings reviewed at audit. Overall the feedback is positive.

Resident meetings occur monthly. The minutes of the four meetings held between August 2013 and December 2013 sighted verify a range of topics discussed.

Policies and procedures are reviewed at least two yearly. There is a review schedule noted (and sighted). All policies sighted during audit have been reviewed within the last two years. Since the last audit a specific folder is kept in the staff office of all policies scheduled for review each month during the year. Staff are encouraged to review and provided comment or feedback on these policies for consideration during the review process. Newly updated policies are now placed in a separate folder and staff are asked to review and sign they have read the updated policies. Two hardcopies of the full manuals containing all current policies and procedures are available on site. One is held by the facility manager and the other is located in the staff office. The quality manager is responsible for initiating and undertaking the review of all policy/procedure documents and for document control processes.

An internal audit schedule is maintained and includes audits related to service delivery, documentation, environment and equipment. All required audits are noted to have been undertaken for the last three months sampled. Audit reports selected at random and reviewed including clinical records audits (December 2013 and February 2014), controlled drug audit (February 2014), Security checklist audit, food services audit (each month) and chemical safety audit (January 2014). The audits are evaluated and identified improvements required are noted and corrective action plans developed. A review of the corrective action plan for three audits verifies the majority of corrective actions have been fully implemented. The remainder are in process with contracted health professionals.

There are processes in place for staff to report new hazards. New hazards are being reported and managed. The organisations hazard register is reviewed at least every two years. Organisation risks are included in a variety of policies and procedures and well as the business plan and the hazard, risk and emergency response plan (May 2012). Actions to minimise risk are included in these documents.

ARRC contract requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| Attainment and Risk: PA Moderate |
| Evidence: <p>A number of policies provides guidance for staff on the type of events that are required to be reported and the process. Medication related adverse events are not being reported. This is an area requiring improvement. The number of incidents occurring are being categorised and reported each month and incorporated in a benchmarking programme with the other residential care facility owned by the Orongo rest home director.</p> <p>The FM and QM are able to identify the type of events that are required to be essentially notified and who notifications are to be made to. There have been no essential notifications made since the last audit.</p> <p>ARRC contract requirements are not fully met.</p> |

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

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

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

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

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

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| Attainment and Risk: PA Moderate |
| <p>Evidence:</p> <p>Policies detail the requirement for staff to report adverse events and the associated processes. Four caregivers interviewed are able to identify the type of events that are required to be reported including falls, skin tears/bruises, swelling, episodes of challenging behaviour and medication errors. Incident reports are sighted completed for relevant events in the resident files sampled excluding medication related events. During audit a number of resident medication records have gaps in documentation to verify the administration for oral, topical and inhaled medications. These omissions in documentation have not been reported via the incident reporting system. The FM advises there have been no medication related incidents reported during 2013 and year to date in 2014. This is an area requiring improvement.</p> <p>The four caregivers interviewed confirm whoever initially identifies the adverse event is responsible for reporting the event. Incident reports are provided to the registered nurse (RN) for review and then processed by the FM and quality manager. A detailed monthly analysis of reported events is occurring and incident rates included in the facility benchmarking programme/</p> <p>The four caregivers interviewed advises they are informed of reported events in a timely manner via shift handover, monthly staff meetings and via the visual board on the wall in the staff office. This is verified in minutes of staff meetings sighted and observation of this board.</p> |
| <p>Finding:</p> <p>Medication related incident or adverse event reports are not being documented by staff. This includes where medications are not signed as being given as prescribed (or noted a with-held or refused).The Medication policy notes 'it is mandatory for staff to report any discrepancies, errors or omissions'.</p> |

Corrective Action:

Ensure all types of incidents are being reported investigated and followed up in a timely manner as per the organisations policies.

Timeframe (days):90(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Policy documents provide the framework for recruitment/human resources and ongoing staff education requirements. A review of six staff files (the sample size is expanded at audit) identifies that staff are required to complete an application. Policy notes interviews are to be conducted and reference checks obtained for the successful candidate obtained. Interview and reference check records are not present in all staff members files sampled. Police checks are not being conducted despite new employees providing written consent for this to occur. Whilst staff are noted to have current performance appraisals; records to evidence these are not available for sighting. These are areas identified as requiring improvement.

Copies of current annual practising certificates are available for the FM, QM, RN, ten pharmacists, two general practitioners' (GP), one podiatrist, one occupational therapist, one dietitian and one physiotherapist. The area identified as requiring improvement at the last audit now meets the standard.

Four of four staff interviewed detailed the orientation programme that staff are required to complete. This includes an orientation to the facility, safety systems/processes, staff, individual resident needs, shift responsibilities, the Code, policies and procedures, care processes, and communication. The staff advise the orientation sufficiently prepares them for their role and responsibilities. Records evidencing staff have completed the organisations orientation requirements are sighted in the staff files sampled.

An ongoing education programme is planned and implemented. There is a documented training plan for 2013 and 2014 which are sighted. A review of education provided in 2013 is also summarised in the annual quality review. Records of attendance are maintained and includes: infection prevention and control; delirium; fire evacuation; head to toe assessment; depression, first aid; pain management, the Code and person centred care. Staff working in the dementia unit are required to complete an industry approved qualification. Records sighted verify all seven of ten staff on the roster in the dementia unit have completed an industry approved qualification. Three staff have been working in the dementia unit for less than six months. Whilst the FM and RN have current annual medication competency assessments undertaken; the caregivers are not included. This is raised as an area for improvement in 1.3.12.3.

ARRC contract requirements are not fully met.

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

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

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

Criterion 1.2.7.3 (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: PA Moderate |
| <p>Evidence:</p> <p>Six staff files reviewed at audit. Applications are present in the files, along with copies of signed employment agreements and job descriptions. Records evidencing reference checks or interview process are not available in two of five staff files sampled. The staff member's were employed between December 2010 and July 2013.</p> <p>Police checks are not being undertaken (present in no files sampled) despite new employees providing written consent for this to occur as a component of the employment process. Police checks are noted as being required in the organisations policies.</p> <p>The master list identifies when staff performance appraisals are due. Three of six staff files sampled did not contain a performance appraisal completed in the last twelve months. The master register identifies these have been done and are unable to be located in staff files or by the FM during audit. These are areas requiring improvement.</p> |
| <p>Finding:</p> <p>Records evidencing reference checks or interview process are not available in two of five staff files sampled where the staff member has been employed between December 2010 and July 2013.</p> <p>Police checks are not being undertaken despite new employees providing written consent for this to occur as a component of the employment process. Police checks are noted as being required in the organisations policies.</p> <p>The master list identifies when staff performance appraisals are due. Three of six staff files sampled did not contain a performance appraisal completed in the last</p> |

twelve months. The master register identifies these have been done and are unable to be located during audit.

Corrective Action:

Ensure all human resource practices comply with the organisations policies.

Timeframe (days):90(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are a number of policies which refer to safe staffing and skill mix including the 'duty schedule and staff allocation' policy (October 2012). A review of the current roster and interview with four caregivers, the RN, and the facility manager identifies:

- the RN works 32 hours per week (Monday to Thursday)
- the facility manager is on call week nights and shares the weekend on call duties with the RN. The name of who is on call is communicated to staff.
- care givers are allocated to specific wings each duty
- there is a designated senior caregiver rostered on the weekends, afternoon shifts and night shifts.
- there is a minimum of three staff rostered on duty at all times. On the morning and afternoon shifts there are additional caregiver hours rostered. Between 7 and 8.30 pm there are at least two caregivers working in the dementia unit.
- staffing is adjusted based on resident needs. A resident has recently been assessed as requiring a higher level of care and is being transferred later in the week. The activities coordinator is coming on site an hour earlier to help serve the breakfasts in one of the wings due to increase care needs of this resident. This change in hours was arranged prior to the audit and confirmed during staff interview
- a staff member with a current cardiopulmonary resuscitation (CPR) certificate is on duty every shift
- staff working in the dementia unit have completed an industry approved qualification or are working towards this as per the timeframes specified in the ARRC contract
- there are designated hours and staff who are responsible for catering services, laundry services, household services and the activities programme.

ARRC contract requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk:PA Moderate

Evidence:

Documentation in clinical records is noted in ink, The date of entry is noted. The time of entry is inconsistently noted. Documentation is not always sufficiently detailed or timely. This is an area requiring improvement.

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

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

Attainment and Risk:PA Moderate

Evidence:

Staff are not documenting the time entries are made in clinical notes. Rather only the date of entry is being recorded.

Documentation in clinical records is not always timely. As an example :

- when a urine sample has been collected this is documented. However, additional assessment including signs and symptoms the resident is demonstrating is not documented.

- where an incident report has been completed following an adverse event, this is not always documented in the resident notes sampled. Eg one resident has three falls which are not documented in the clinical notes.

Staff are not documenting the time entries are made in clinical notes. Rather only the date of entry is being recorded.

The entries in the files sampled are legible..

Finding:

Staff are not documenting the time entries are made in clinical notes. Rather only the date of entry is being recorded.

Documentation in clinical records is not always complete or timely. As an example :

- when a urine sample has been collected this is documented. However, additional assessment including signs and symptoms the resident is demonstrating is not documented.

- where an incident report has been completed following an adverse event, this is not always documented in the resident notes sampled. Eg one resident has three falls which are not documented in the clinical notes but are reported on incident reports.

Corrective Action:

All staff must ensure that time of entries are documented in the clinical notes.

Staff must ensure that assessments need to be documented in the clinical notes that prompts them to collect specimens like urine.

Ensure that all adverse events are documented in the clinical notes.

Timeframe (days):90(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk:FA

Evidence:

The facility manager and the RN have been working in the facility for nine and eleven years respectively. The RN works four days a week. All residents are assessed by the RN on admission. Admission risk assessment tools include Norton's, mini-mental, continence, pain, skin, sensory, falls risk and nutrition. The activities coordinator conducts the activity assessments. A 24-hour dementia unit activities plan is sighted.

The GP admits the new resident within 24-48 hours and three monthly routine reviews are sighted in the files reviewed.

Seven out of eight care plans are created in a timely manner however the care plan of a frequent faller does not reflect the resident's current status and needs. All residents reviewed have no short term care plans in place. There is an inadequate documentation in the care notes regarding infections for example; the rationale for urine collection and the signs and symptoms experienced by residents. The resident's response to treatment is not consistently documented in the care notes of the eight reviewed files. These are raised as areas for improvement in 1.2.9.1, 1.3.6.1. and 1.3.8.3.

Caregivers and afternoon shift RN receive comprehensive hand-over from the morning RN as witnessed during the afternoon hand-over.

Tracer Methodology 1 (rest home level of care)

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

Tracer Methodology 2 (dementia level of care)

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

ARC requirements D3.1c, D16.5ii and D16.3l are not met.

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

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

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

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

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

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

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

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

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

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

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

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

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| Attainment and Risk: PA High |
| Evidence: Interventions in the care plans are not being consistently provided to meet the resident's needs/desired outcomes. As an example a resident who has had fourteen falls since the care plan was last updated in August 2013. Other members of the health team are involved for example; the GP, physiotherapist but the needs of the resident remain unmet. Care plans are not updated in a timely manner and this an area requiring improvement. ARC requirement D16.3d is not met. |

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

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

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| Attainment and Risk: PA High |
| Evidence: Eight of eight reviewed resident's file have care plans in place with interventions but not all are sufficiently detailed to meet the resident's needs/desired outcomes. As an example a resident who has had fourteen falls since the care plan was last updated in August 2013. Ways to minimise falls like the use of sensor mats, or developing a falls clock are not included in the care plan. Routine medication reviews are occurring (three monthly). While the physiotherapist has reviewed the resident, |

the physiotherapist stated being 'unaware of the number of falls the resident has been having' and a plan aimed/ focused on reducing falls has not been developed. The falls risk assessment remains unchanged despite the numerous falls.

Another resident had four falls in one month. The care plan sighted has not been reviewed or updated to include further interventions to mitigate falls risk. The care plan falls risk rating has been increased but no other changes noted.

Although there are no short term care plan in place for a resident with urinary tract infection, an intervention is in place to address the problem e.g. commencing a three-day fluid input, obtaining urine sample for sensitivity and commencing the resident with antibiotics.

Finding:

Interventions in the care plans are not being consistently provided to meet the resident's needs/desired outcomes. As an example a resident who has had fourteen falls since the care plan was last updated in August 2013. Ways to minimise falls like the use of sensor mats are not included in the care plan. Routine medication reviews are occurring (three monthly). While the physiotherapist has reviewed the resident, the physiotherapist stated being 'unaware of the number of falls the resident has been having' and a plan aimed/ focused on reducing falls has not been developed. The falls risk assessment remains unchanged despite the numerous falls.

Another resident had four falls in one month. The care plan sighted has not been reviewed or updated to include further interventions to mitigate falls risk.

Corrective Action:

Ensure care plans are sufficiently detailed to guide staff in the provision of care. Ensure the care plans are updated in a timely manner to include alternative interventions to minimise resident falls.

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

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

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

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

Attainment and Risk:PA Low

Evidence:

Assessments are undertaken of resident's activity preferences and abilities. A 24-hour activity plan is in place for the residents in the dementia unit. Activities provided for the residents are appropriate to their needs, age, culture and their level of needs. There are no individualised activities plans for residents in the rest home. This is an area for improvement in 1.3.7.1.

ARC requirement D16.5ciii is not met.

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

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

Attainment and Risk:PA Low

Evidence:

The activities coordinator creates an annual activities plan for all the residents. The dementia unit has a 24-hour activity plan in place and sighted which include folding of washings, scrap books, outings and baby clothes/dolls. Crafts, dolls and other materials are accessible in the lounge as sighted. The daily activities are updated in the board by the activities coordinator which include outings, outdoor bowls, walk in the beach or road, going for coffee, attending concerts, socialising with other rest home residents, attending 'communicare', picnics, church and bingo on Fridays. An attendance book is sighted to monitor each resident's participation in activities.

The activities coordinator in this role for almost four years and supported by an occupational therapist for trainings and guidance. All reviewed rest home files have six-monthly reviews but there are no individualised resident activities plans is created.

Finding:

There are no individualised activities plans in place for residents receiving rest home level care.

Corrective Action:

The activities coordinator must ensure that individualised activities plan will be created for all residents in the rest home.

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

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

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

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

Attainment and Risk:PA High

Evidence:

Eight of eight resident's file reviewed have care plans in place but none has short term care plans for acute needs of the residents for example; urinary tract infections. Care plans are insufficiently detailed to reflect the current needs of the residents.

ARC requirement D16.3d is not met.

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

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

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

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

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

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| Attainment and Risk: PA High |
| Evidence: Eight of eight resident's file reviewed have care plans in place but none has short term care plans for acute needs of the residents e.g. urinary tract infection. Care plans are insufficiently detailed to reflect the current needs of the residents. |
| Finding: The long term care plans are not sufficiently detailed to reflect the current needs of residents including where the care needs of residents have changed e.g. as a result of falls or development of infections. Short term care plans are not sighted in any of the files sampled. As an example a resident who has had fourteen falls since the care plan was last updated in August 2013. The interventions are insufficient in order to prevent further episodes of falls or possible injury to the resident. Sensormats or the use of hip protectors are not included in the planned interventions. |
| Corrective Action: Ensure that long term care plans are sufficiently detailed that reflects the current needs of the residents. Ensure that short term care plans are created to address the acute needs of the residents. |
| Timeframe (days): 30 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

Attainment and Risk:PA High

Evidence:

While there is a policy available for staff on medication management practices, it is observed at audit there are a number of practices which require improvement. This includes relating to the prescribers documentation, checking, administration and documentation of medications administered.

The RN and FM have current medication competency assessments. The caregivers are all overdue. This is an area requiring improvement.

There is one resident in the facility that self-administer medicines. i.e. inhaler. Policies and procedures for self-administration is implemented.

ARC requirements D1.1g and D19.2d are not met.

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

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

Attainment and Risk:PA High

Evidence:

A documented medication management policies and procedures in place but are not consistently implemented in practice. Improvement is required to ensure that the policy addresses all the areas required for medicines regulations, in particular to medication administration, competencies, dispensing, prescribing, medication reconciliation and disposal.

Orongo Rest Home uses the robotics system for both rest home and dementia units. Fifteen of 15 medication charts sighted are reviewed by the GP every three months. The allergy and sensitivity status of residents are noted. Discontinued medications are dated, signed and legible. There are two lockable medication cupboards, one in the rest home and one in the dementia unit but all robotics medications are kept in the rest home drug room. Creams and inhalers are kept in an open cupboards inside the rest home drug room. There are two sets of keys to open the drug room. Medicines are only prescribed by the GP who visits the facility on a weekly basis. There are no expired /unwanted medications. All expired medications are locked in the cupboard in a brown bag for return to the pharmacy when a pharmacy staff delivers medications in any day of the week. A secure sharps bin is sighted in the drug room. The temperature of the medication fridge is monitored and maintained within 2-8C.

The caregiver is sighted administering all lunchtime medications from memory (no medication records were being used by the staff member) and signing sheets not signed at the time of administration. Medication signing sheets do not evidence that all medications have been administered as prescribed including oral medications, inhalers and topical products.

Fourteen out of 15 medication records sampled have a 'ditto' symbol or arrow symbol to identify the date medication was prescribed by the GP. Where medications are prescribed for daily administration, the time the medication is to be administered is not always prescribed, e.g. Risperidone, Digoxin and Furosemide daily.

The RN has removed from the robotic rolls all medications to be administered by the caregivers for the period Thursday 1700 hours to Sunday 2100 hours. As staff are not always referring to medication records or signing as soon as medications are administered there is the potential medications will be missed/ not administered.

Medications for some residents are being crushed. Whilst there are some guidelines available from the pharmacy, the organisation is unable to evidence that these guidelines have been considered for residents who are having medications crushed.

There is currently no process in place to check that medications delivered for the next cycle are congruent with medications prescribed by the GP in medication records

The pharmacist is available for advice when needed.

There are no controlled drugs on site except morphine elixir which is kept inside a lockable cupboard. The controlled drugs register is sighted and is current.

Finding:

The documented medication management is insufficiently detailed and does not meet all the requirements of the current medicines regulations. The requirements of the current medication policies and procedures are not implemented in practice.

- A lunchtime medication round was observed in the dementia unit. The caregiver is sighted administering all lunchtime medications from memory (no medication records were being used by the staff member) and signing sheets not signed at the time of administration.

- 14/15 medication records sampled have a 'ditto' symbol or arrow symbol to identify the date medication was prescribed by the GP.

- Where medications are prescribed for daily administration, the time which the medication is to be administered is not always clearly prescribed. E.g. Risperidone, Digoxin and Furosemide daily.

- Medication signing sheets do not evidence that all medications have been administered as prescribed including oral medications, inhalers and topical products.

- The RN has removed from the robotic rolls all medications to be administered by the caregivers for the period Thursday 1700 hours to Sunday 2100 hours.

- Medications for some residents are being crushed. Whilst there are some guidelines available from the pharmacy, the organisation is unable to evidence that these guidelines have been considered for residents who are having medications crushed.

- There is currently no process in place to check that medications delivered for the next cycle are congruent with medications prescribed by the GP in medication records.

Corrective Action:

Ensure medication records are sighted when medications are given and that these are signed as administered.

Ensure that all medication management practices comply with the current accepted practice and legislative requirements..

Timeframe (days):7 (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: PA High |
| Evidence: There are seven caregivers administering medications covering rest home and dementia units, the RN and the facility manager. |
| Finding: Seven of seven caregivers who administer medication have medication competency assessments which have been completed more than twelve months ago. The competencies sighted are dated 2009 to 2012. The RN and FM have medication competency assessments completed in the last twelve months. |
| Corrective Action: Ensure that all caregivers who administer medication will have a medication competency assessment completed annually. |
| Timeframe (days): <i>7 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk:FA

Evidence:

Food, fluid and nutritional needs of the residents are provided in line with the recognised nutritional guidelines. On admission, the RN, facility manager or cook writes the dietary requirements of the resident on the kitchen board while the dietary form is kept in a folder in the rest home and dementia unit's pantries. The kitchen board is updated regularly by the RN, facility manager or cook. Special diets are provided e.g. vegetarian, puree, diabetic as well as food preferences and allergies. Thickeners are available for residents with choking issues as per recommendation by the speech language therapist. Residents are weighed monthly as verified in the residents' files. Five of eight reviewed have stable weights. Food charts are commenced for residents with unstable weights and are weighed weekly. No dietician review is required because the residents' weights are starting to be stable. Residents verbalise that they enjoy the meals served in the facility. Observation of their lunch meal indicates the food is attractively presented.

The summer and winter menus have been reviewed by the dietitian in May 2013. Meals are served at times that reflect community norms although the dementia unit is provided half an hour earlier than in the rest home during lunch time. Policies in the food service are implemented. The cook and kitchen assistants prepare meals wearing disposable hats and kitchen gloves.

Food procurement, transportation, delivery, and disposal comply with current legislation and guidelines. There is a fridge, a chiller and a freezer in the facility. The temperatures are monitored twice daily by the kitchen hand and are within the acceptable temperatures. There is a temperature monitoring record sighted. The cook daily monitors temperatures of the served meals for the residents. The cook rotates the canned goods upon delivery. A first in-first out system is in place as verified during the interview with the cook and one kitchen hand. There are no opened canned goods during kitchen inspection. The cook places orders to the suppliers in a weekly basis. Cooked foods in the chiller are labelled and dated. The cook and the kitchen hand reported that they have enough equipment to prepare the meals for the residents and their supplies can last for a week in the event of an emergency. All four of four staff working in the kitchen have current food handling certificates as sighted

The kitchen is clean and there are no supplies or stock that touches the floor inside the pantry.

ARC requirements are met.

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

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

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

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.2: 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: <p>The building has a current building warrant of fitness with an expiry date of 9 July 2014. The facility manager confirms the ongoing requirements to maintain the building warrant of fitness are maintained. Electrical safety test and tags are present on four pieces of electrical equipment sighted at random during audit. Three pieces of clinical equipment checked at random (the hoist, scales and nebuliser) have labels identifying performance monitoring checks have been undertaken in the last twelve months.</p> <p>ARRC contract requirements are met for criteria audited.</p> |

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| Attainment and Risk: FA |
| Evidence: One resident who suffered from XXXXXXXX uses a bed loop to maintain independence and safety. The bed loop (a device designed for a resident to move in and out of the bed independently) is provided for the resident as requested. Enabler assessment/evaluation form is in place as verified in the resident's care plan. ARC requirements are met. |

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

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

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

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

Standard 3.4: 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: Previous PA (raised in 3.4.3) on education has been addressed. March 2013 infection control training shows that attendees evaluate the contents of the in-service training. Written evaluations of 20 staff members are sighted in the infection control folder. |

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

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

Attainment and Risk:FA

Evidence:

Orongo Rest Home's infection control programme is appropriate for the size and complexity of the facility. The RN is the infection control coordinator and monitors cases of infections i.e. urinary tract, skin/soft tissue, respiratory tract, gastro-intestinal, scabies, systemic (MRSA, ESBL, VRE), eyes, ear, nose, mouth. The use of antimicrobials are monitored as sighted. The Quality Manager acts as the infection control expert and provides vital informations and guidance to the infection control coordinator. Monthly summaries from the laboratory regarding specimen testing are kept in the infection control folder. Surveillance for infection is carried out in accordance with the infection control programme of the facility. The programme for this facility is appropriate to the size and complexity of the service. Results of the surveillance is communicated to the staff during monthly staff and quality meetings. Appropriate interventions are commenced to address the need of the residents.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

Timeframe (days):*(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.

Attainment and Risk:FA

Evidence:

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