# Elsdon Enterprises Limited - Annaliese Haven

## Current Status: 1 April 2014

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

## General overview

Annaliese Haven is certified to provide rest home level and dementia care for up to 63 residents. On the day of the audit, there were 20 residents at rest home level care and 36 residents receiving dementia care across the two secure units. The service is privately-owned and was purchased by the new owners, who own three other aged care facilities in June 2013.

The manager has many years management experience in the service sector and has been in the role since September 2013. He is supported by a nurse manager who has seven years aged care experience including two and a half years at Annaliese Haven. She has been in the nurse manager role since September 2013. Family and residents interviewed all spoke positively about the care and support provided.

This audit identified improvements required by the service in the following areas; corrective action planning, aspects of training, documenting staff designation, information provided to dementia families, progress notes, assessments, care plans, wound documentation, aspects of medication management, serving practices for food, and calibration of equipment.

## Audit Summary as at 1 April 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 1 April 2014

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

### Organisational Management as at 1 April 2014

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

### Continuum of Service Delivery as at 1 April 2014

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | 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 1 April 2014

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

### Restraint Minimisation and Safe Practice as at 1 April 2014

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

### Infection Prevention and Control as at 1 April 2014

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

## Audit Results as at 1 April 2014

### Consumer Rights

The support provided to residents at Annaliese Haven is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance. Residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Residents and their families are kept informed. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent and advanced directives are appropriately documented. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

### Organisational Management

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

The facility is one of four aged care facilities owned and operated by Elsdon Enterprises Ltd. The day to day running of the home is provided by a facility manager with support from a nurse manager. The facility is guided by a comprehensive set of policies and procedures. An internal audit programme monitors service performance. Improvements are required whereby corrective actions are developed and followed through where performance has been identified as less than expected. Health and safety policies, systems and processes are implemented to manage risk.

Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction programmes for the staff ensure staff are competent to provide care. Improvements are required around provision of all education all requirements. Staffing levels are safe and appropriate. Improvements are also required in relation to documenting staff designation in progress notes.

### Continuum of Service Delivery

Resident files reviewed include service coordination centre assessment forms. Care plans are developed in consultation with relevant people including residents and where appropriate family / Whanau or Enduring Power of Attorney. A registered nurse assessment, including a variety of risk assessments are completed on admission and reviewed six monthly following admissions.

Residents and/or family have input into the development of care plans. There are improvements required around information provided to dementia families, progress notes, assessments, care plans and wound documentation.

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long term care plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly and there is a separate programme for the rest home and the dementia units.

Policies and procedures around medication detail service provider's responsibilities. Unit supervisors (senior caregivers) and caregivers are responsible for medicine management have attended in-service education for medication management and complete a medication competency annually. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are improvements required around dating open eye drops, disposing of expired medicines, as required medication prescribing, medication administration, review of competencies for residents who self-administer medicines and medication competency assessments for registered nurses.

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

A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and the chef and the cook have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services. There are improvements required around serving hot food to residents who require a puree diet and food safety training for kitchen hands.

### Safe and Appropriate Environment

The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. The building holds a current warrant of fitness.

Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate.

There are large spacious lounges and dining areas with a number of smaller lounges throughout the facility. There are adequate toilets and showers. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning.

Cleaning services are well monitored through the internal auditing system. Laundry is completed on site. Appropriate training, information and equipment for responding to emergencies is provided. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident’s rooms to suit individual resident preference. There is an improvement required around calibration of medical equipment.

### Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint is required. There are no residents using enablers. Staff received training around the management of behaviours that challenge in March 2014.

### Infection Prevention and Control

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

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Elsdon Enterprises Limited |
| **Certificate name:** | Elsdon Enterprises Limited - Annaliese Haven |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Annaliese Haven Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 1 April 2014 | **End date:** | 2 April 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 56 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 6 |
| **Other Auditors** | XXXX & XXXX | **Total hours on site** | 24 | **Total hours off site** | 6 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 36 | Total audit hours off site | 15 | Total audit hours | 51 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 13 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 8 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 16 | Total number of staff (headcount) | 61 | Number of relatives interviewed | 9 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Friday, 2 May 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Annaliese Haven is certified to provide rest home level and dementia care for up to 63 residents. On the day of the audit, there were 20 residents at rest home level care and 36 residents receiving dementia care across the two secure units. The service is privately-owned and was purchased by the new owners, who own three other aged care facilities in June 2013.  The manager has many years management experience in the service sector and has been in the role since September 2013. He is supported by a nurse manager who has seven years aged care experience including 2 ½ years at Annaliese Haven. She has been in the nurse manager role since September 2013. Family and residents interviewed all spoke positively about the care and support provided.  This audit identified improvements required by the service in the following areas; corrective action planning, aspects of training, documenting staff designation, information provided to dementia families, progress notes, assessments, care plans, wound documentation, aspects of medication management, serving practices for food, and calibration of equipment. |

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| **Outcome 1.1: Consumer Rights** |
| The support provided to residents at Annaliese Haven is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance. Residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Residents and their families are kept informed. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent and advanced directives are appropriately documented. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner. |

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| **Outcome 1.2: Organisational Management** |
| Annaliese Haven has an organisational philosophy, which includes a vision, mission statement and strategic objectives.  The facility is one of four aged care facilities owned and operated by Elsdon Enterprises Ltd. The day to day running of the home is provided by a facility manager with support from a nurse manager. The facility is guided by a comprehensive set of policies and procedures. An internal audit programme monitors service performance. Improvements are required whereby corrective actions are developed and followed through where performance has been identified as less than expected. Health and safety policies, systems and processes are implemented to manage risk.  Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction programmes for the staff ensure staff are competent to provide care. Improvements are required around provision of all education all requirements. Staffing levels are safe and appropriate. Improvements are also required in relation to documenting staff designation in progress notes. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Resident files reviewed include service coordination centre assessment forms. Care plans are developed in consultation with relevant people including residents and where appropriate family / Whanau or Enduring Power of Attorney. A registered nurse assessment, including a variety of risk assessments are completed on admission and reviewed six monthly following admissions.  Residents and/or family have input into the development of care plans. There are improvements required around information provided to dementia families, progress notes, assessments, care plans and wound documentation. Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long term care plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly and there is a separate programme for the rest home and the dementia units.  Policies and procedures around medication detail service provider's responsibilities. Unit supervisors (senior caregivers) and caregivers are responsible for medicine management have attended in-service education for medication management and complete a medication competency annually. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are improvements required around dating open eye drops, disposing of expired medicines, as required medication prescribing, medication administration, review of competencies for residents who self-administer medicines and medication competency assessments for registered nurses. The service has transfer and discharge procedures The staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital.  A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and the chef and the cook have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services. There are improvements required around serving hot food to residents who require a puree diet and food safety training for kitchen hands. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. The building holds a current warrant of fitness.  Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate.  There are large spacious lounges and dining areas with a number of smaller lounges throughout the facility. There are adequate toilets and showers. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning.  Cleaning services are well monitored through the internal auditing system. Laundry is completed on site. Appropriate training, information and equipment for responding to emergencies is provided. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident’s rooms to suit individual resident preference. There is an improvement required around calibration of medical equipment. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint is required. There are no residents using enablers. Staff received training around the management of behaviours that challenge in March 2014. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 35 | 0 | 4 | 6 | 0 | 0 |
| **Criteria** | 0 | 82 | 0 | 5 | 6 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective actions are not consistently developed following quality activities. Some internal audits evidence corrective actions recorded (food service, medical treatment, medication procedure) and some do not (safety audit, resident care plan, resident hygiene and grooming). Where there are corrective actions recorded there, is no evidence other than verbal discussion at quality meetings, that actions have been completed, evaluated and signed off. | Ensure that a) corrective actions are developed for all identified issues, and b) ensure that all corrective actions are completed, evaluated and signed off. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Restraint and cultural safety/awareness training has not been provided in the past two years. | Ensure all educational requirements are provided for staff. | 90 |
| 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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.9.9 | All records are legible and the name and designation of the service provider is identifiable. | PA Low | Staff member designation is not always recorded as evidenced in resident files reviewed. | Ensure that all staff record their name and designation when making entries in to resident’s records. | 90 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.4 | The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Moderate | Registered nursing management/assessment and input have not been documented in the progress notes for the past two months in two of three rest home files. A further four files (from the dementia unit) have issues/changes of health status identified that require RN follow up but no RN documentation in the progress notes around the issue. Examples include (but not limited to); a) resident returned from hospital (in two dementia files), and b) one where a caregiver had documented a toe nail lifting and b) another where the resident had a toe that was painful enough to prevent her sleeping. | Ensure that all residents have regular RN input that this is documented, and that RN’s follow up all appropriate issues and document this in the progress notes. | 60 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | (i)The resident on respite care in the dementia unit had a nursing assessment completed during her last admission in October 2013. No new assessment has been completed during this admission (March 2014). (ii) One other file in the dementia unit does not have a date on the initial nursing assessment. (iii) One of five files sampled from the dementia unit is for residents who have behaviours that challenge but there is no documented behaviour assessment. (iv) While challenging behaviours assessments are completed in four of five files sampled from the dementia unit. The assessments do not identify triggers for the behaviours. | (i) And (ii) Ensure that a new assessment is completed every time a resident is admitted and that all assessments are dated. (iii) Ensure that all resident who exhibit behaviours that challenge have a behaviour assessment completed and that triggers for behaviours are identified. | 90 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.x | PA Moderate | (i) D16.2, 3, 4: There is no care plan completed within 24 hours in any of the eight files sampled that describe interventions to guide caregivers in providing care to residents. As a result, the respite admission (dementia) and the new admission (dementia) do not have a care plan. (ii) One of three files sampled in the rest home does not include interventions that relate to XXXXX (ii) One of five files sampled in the dementia unit is for a resident who displays XXXXXX but there are no interventions for managing this in the care plan. (iv) One dementia resident did not have additions made to the long term care plan (behaviours) and (v) one dementia resident did not have a short term care plan for skin tears and bruising. | (i) D16.2, 3, 4: Ensure every resident has an initial care plan developed with interventions to guide caregivers within 48 hours of admission. (ii) – (v) Ensure care plans have interventions that relate to all identified areas of need. | 60 |
| 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 Moderate |  |  |  |
| 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 Moderate | None of the seven wounds including one pressure area have a comprehensive assessment or document when the wound should next be reviewed. | Ensure all wounds have a comprehensive assessment and document when the wound should next be reviewed. | 90 |
| 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i)Ten open eye drops (seven in the dementia unit and three in the rest home) have not been dated when opened. (ii) In ‘Forget Me Not’ dementia unit, there is one bottle of eye drops in use that are expired and in the rest home fridge there is a box of expired flu vaccines (these were all disposed of during the audit and a review of resident notes show the expired flu vaccine had not been given). (iii) Seven of 16 medication charts (two from the rest home, five from the dementia units) sampled have PRN medications prescribed with no documented indication for use. (iv) Four of 16 medication chart (from dementia unit) have PRN medications charted with no daily maximum dose or doses recorded. (v) Five of 16 (one from the rest home, four dementia unit) medication charts have regular non-packaged medications that have not been signed as administered. | (i)Ensure eye drops are dated when opened. (ii) Ensure medications are disposed of when they expire. (iii) Ensure PRN medications document an indication for use. (iv) Ensure PRN medications document a maximum dose. (v) Ensure medications are administered as prescribed. | 60 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | The registered nurses have not completed medication competency assessments. | Ensure registered nurses complete medication competency assessments. | 180 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Moderate | (i)During the lunch service across the two dementia units at lunch on the first day of the audit the kitchen hand was sighted to be serving 17 puree meals at once. E.g. meat onto each of the 17 plates, the potato onto each of the 17 plates. All meals were delivered to residents once they were all served. There was no system to keep the meals hot. (ii) The three evening kitchen hands who serve evening meals have not completed food safety training. | (i)Ensure all meals are served at a suitable temperature. (ii) Ensure all kitchen staff have food safety training. | 90 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | Medical equipment is calibrated against other equipment (for example a known weight for scales). It is not professionally calibrated. | Ensure all medical equipment is professionally calibrated annually. | 90 |

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

Consumers receive services in accordance with consumer rights legislation.

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (six caregivers, two activities coordinators, one registered nurse, and one nurse manager) and the facility manager confirm their familiarity with the Code. Interviews with five rest home residents and nine relatives (three rest home and six dementia) confirm the services being provided are in line with the Code of rights.  Code of rights and advocacy training is provided as a regular in-service education and training topic (last provided by local advocate in July 2013). |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with five residents and nine relatives identify they are well-informed about the code of rights. The service provides an open-door policy for concerns or complaints. Monthly rest home resident meetings (minutes sighted for March 2014) are held providing the opportunity to raise concerns in a group setting. The most recent annual satisfaction survey (February 2014) includes questions relating to privacy, dignity, complaints process, and residents rights with 93% of respondents reporting they were overall satisfied or very satisfied.  Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines. D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a Code of rights pamphlet, and advocacy and Health and Disability Commissioner information. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.  Discussions with five residents and nine relatives confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.  D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. D14.4 There are clear written instructions provided to residents and family on entry regarding responsibilities of personal belongings. Personal belongings are documented and included in residents’ files. Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. All five residents and nine relatives confirm the service is respectful. A resident satisfaction survey is carried out annually to gain feedback. Survey questions relating to privacy, respect, and satisfaction with care reflect residents are 93% satisfied or very satisfied. D4.1a: Residents’ files include their cultural and /or spiritual values when identified by the resident and/or family. The information pack, provided to residents and their families, includes the home's philosophy of care. Discussions with five residents confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Eight care plans reviewed identify specific individual likes and dislikes. The abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training on abuse and neglect is a mandatory requirement and last provided in November 2013.  Discussions with the facility manager, nurse manager and registered nurse report there have been no identified incidents of abuse or neglect. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a cultural safety policy. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.  There are no permanent residents at Annaliese Haven who identify as Maori, and one respite dementia resident at the time of the audit does identify as Maori. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori healthcare providers. The respite resident has not had an assessment conducted for this admission (link #1.3.4.2) – however, staff were aware of his ethnicity and could describe how they cared for him in a culturally sensitive manner. D20.1 I: The service utilises a local Maori consultant on an as-needed basis for consultation. This individual is identified in policy. Interviews with six caregivers, one registered nurse, one nurse manager and one facility manager confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Cultural safety and awareness training last provided in 2011 (link #1.2.7.5). A3.2 There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Care planning includes consideration of spiritual, psychological and social needs. Five residents indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Nine relatives report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions. The service holds a family function twice a year. D3.1g The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the nurse manager and registered nurse. D4.1c Seven of eight care plans reviewed include the residents’ social, spiritual, cultural and recreational needs (one dementia resident is on respite care). |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The staff induction programme includes a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with the facility manager. Interviews with six caregivers, one registered nurse and one nurse manager acknowledge their understanding of professional boundaries. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The quality programme is designed to monitor contractual, standards compliance, and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. Resident satisfaction surveys reflect high levels of satisfaction with the services that are received. A quality coordinator (retired RN) is in charge of the internal audit programme and a senior caregiver is in charge of organising the education programme (certified ACE assessor). There is access to computer and Internet resources. There are monthly staff meetings and monthly rest home resident meetings.  Five residents and nine relatives interviewed spoke very positively about the care and support provided. Six caregivers, one registered nurse, two activities coordinators, and the nurse manager have a sound understanding of principles of aged care and state that they feel supported by the facility manager. A2.2: Services are provided at Annaliese Haven that adheres to the Heath & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring (with exceptions link #1.2.3.8)  D1.3 All approved service standards are adhered to. D17.7c.There are implemented competencies for caregivers. Registered nurses are required to undergo medication competencies (link 13.12.3). There are clear ethical and professional standards and boundaries within job descriptions. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies are in place relating to open disclosure. Five residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.  A sample of incident reports reviewed, and associated resident files, evidenced recording of family notification. Nine relatives interviewed confirm they are notified of any changes in their family member’s health status. The facility manager and nurse manager can identify the processes that are in place to support family being kept informed. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.  D11.3 The information pack is available in large print and is read to sight-impaired residents. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Written informed consent is gained for do not resuscitate or resuscitation orders appropriately for eight of eight files sampled (three from the rest home and five from the dementia units). The eight files reviewed all had valid consents. It was stated by the registered nurse and nurse manager that family involvement occurs with the consent of the resident.  Other forms of written consent included consent to share information, consent for photographs and consent for transportation. A review of eight files found all consents were present and signed by the resident or their EPOA. EPOA documents are kept on the resident's secondary file. Five residents interviewed (from the rest home) confirm that they are given good information to be able to make informed choices.  Six caregivers (one unit supervisor from the rest home, one caregiver from the rest home and four from the dementia units), the registered nurse and the clinical manager interviewed conform information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.  D13.1: There were seven of seven admission agreements sighted (one resident is on respite care). D3.1.d: Discussion with nine families (three from the rest home and six from the dementia unit) identified that the service actively involves them in decisions that affect their relative’s lives. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents’ meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items.  D4.1e; The residents’ files include information on residents family/whanau and chosen social networks. Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.  D4.1d; Discussions with nine relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The client information pack informs visiting can occur at any reasonable time. Interviews with five residents and nine relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident’s life are documented in the care plans.  D3.1.e Discussions with five residents and nine relatives verify that they are supported and encouraged to remain involved in the community. Annaliese Haven support on-going access to community services (e.g. church, general practitioner visits, and library). Entertainers are invited to perform at the facility.  D3.1h: Discussions with nine families verify that they are encouraged to be involved with the service and care. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.  Information on the complaint’s forms includes the contact details for the Health and Disability Advocacy Service.  Interviews with five residents and nine relatives are familiar with the complaints procedure and state any concerns or issues are addressed.  The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been no lodged complaints in 2013 or 2014 to date. Advised by the facility manager that a full investigation and resolution including communication with complainants would be documented for any lodged complaint.  D13.3h. A complaints procedure is provided to residents within the information pack at entry. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Annaliese Haven provides rest home and dementia level care for up to 63 residents in a 20 bed rest home wing and in two dementia specific units – 21 beds and 22 beds. On the day of audit, there were 56 residents - 20 rest home residents, and 36 dementia residents. The philosophy of care includes a mission statement and vision. The mission statement “is to produce a caring, loving family home for our residents, with excellent care, delivered in a loving individual and practical manner”. The mission statement is included in the information booklet, which is given to each resident and family on admission. The business is privately owned and is one of four facilities owned and operated by Elsdon Enterprises. The facility was purchased in July 2013 with the appointment of the current facility manager and nurse manager occurring in September 2013. The nurse manager was previously employed as the registered nurse (past two years) and has worked in aged care as an RN for seven years and as a caregiver prior to this. The facility manager has experience in management and quality systems. The facility manager reports to the owners on an informal basis and receives financial and payroll support from the head office.  Improvement note: The facility manager has not attended professional development since commencing his role and is encouraged to do so.   An organisational chart visually describes reporting relationships for the organisation. The service has a business/quality plan for 2014. This plan lists goals, which relate to clinical excellence, community and service links, safety and risk management, financial viability, and buildings and maintenance. Dates for completion are documented with evidence of on-going monitoring. The internal audit programme regularly assesses service performance. The facility manager is responsible for the quality management system at Annaliese Haven with support from a part time quality coordinator (non-practising registered nurse). |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the facility manager’s absence, the nurse manager is in charge with support from another part time registered nurse. The facility manager is responsible for the day to day functions of the organisation, including oversight of the quality and risk management programme. Both the facility manager and the nurse manager work full time and are available after hours.  D19.1a; A review of the documentation, policies and procedures and from discussions with staff, identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The quality and risk management system is understood and implemented by the nurse manager, facility manager and staff.  A comprehensive set of policies and procedures are in place. The nurse manager and facility manager report new and/or revised policies are developed with input from staff. The facility manager signs off on all new policies. They are available for staff to read and to sign after reading.  Policies and procedures are stored in hard copy files at the facility. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed two-yearly unless changes occur more frequently. As a face sheet in each manual, and lists of policies and procedures that have been either recently developed or revised are documented.  Key components of service delivery are linked to the quality and risk management programmes. The service has a business/quality plan in place for 2014. This plan lists general goals, which relate to clinical excellence, community and service links, safety and risk management, financial viability, and buildings and maintenance. Further specific goals have been developed around InterRAI training for registered nurses, infection prevention and control programme, health and safety, marketing, upgrades and maintenance and satisfaction surveys. Dates for completion are documented with evidence of on-going monitoring. The internal audit programme regularly assesses service performance and this is also discussed at quality management meetings.   Annual review of the 2013 quality plan was conducted in December 2013. The resident/family survey conducted in February 2014 attracted 25 of a possible 52 respondents. Comments were very positive. Questions related to food services, cleaning, activities, laundry, safety and security, and gardens and surrounds. Overall, responses rated 93% in all areas as either satisfied or very satisfied.  The internal audit programme involves monitoring areas of quality and risk including food service, medical treatment, medications, safety, restraint, privacy of information, resident care plans, laundry, building compliance, infection control, resident cares and hygiene, manual handling and controlled drug medications.  The quality coordinator is responsible for ensuring all internal audits are completed. Tasks are delegated to the registered nurse and to staff where appropriate. On review of the completed audits for 2013 and 2014 year-to-date, it is noted that the actual audits are being completed as per the audit schedule.  Data that is collected is analysed, evaluated and communicated to staff. Corrective actions have been developed for some audits reviewed but not all. Where corrective actions have been developed there is little evidence to confirm that these have been completed, evaluated and signed off. Verbal discussion is held at the monthly staff meetings and monthly quality management meetings of quality activities as evidenced in meeting minutes. These are areas requiring improvement.   Opportunities for improvement are identified through the various quality activities, however, improvements are required whereby corrective actions are recorded and completed. Results of the internal audits are discussed in the monthly staff meetings (last held 20 March 2014), and monthly quality management meetings (6 March 2014). Results of the resident/family satisfaction survey are discussed with the residents in the monthly residents/family meetings (4 March 2014). Meeting minutes for all meetings are posted in the staff room.  Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register. The register is updated as new hazards are identified. Risks and hazards are monitored through the internal audit programme (sighted).  D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner. D19.3: there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management D19.2g: Falls prevention strategies include sensor mats and closely observing residents who are at risk of falling, use of mobility aids, correct footwear and exercise and walking groups. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The internal audit programme involves monitoring areas of quality and risk including food service, medical treatment, medications, safety, restraint, privacy of information, resident care plans, laundry, building compliance, infection control, resident cares and hygiene, manual handling and controlled drug medications.  The quality coordinator is responsible for ensuring all internal audits are completed. Tasks are delegated to the registered nurse and to staff where appropriate. On review of the completed audits for 2013 and 2014 year-to-date, it is noted that the actual audits are being completed as per the audit schedule.  Data that is collected is analysed, evaluated and communicated to staff. Corrective actions have been developed for some audits reviewed. Verbal discussion is held at the monthly staff meetings and monthly quality management meetings of quality activities as evidenced in meeting minutes. Opportunities for improvement are identified through the various quality activities. Results of the internal audits are discussed in the monthly staff meetings (last held 20 March 2014), and monthly quality management meetings (6 March 2014). |
| **Finding:** |
| Corrective actions are not consistently developed following quality activities. Some internal audits evidence corrective actions recorded (food service, medical treatment, medication procedure) and some do not (safety audit, resident care plan, resident hygiene and grooming). Where there are corrective actions recorded there, is no evidence other than verbal discussion at quality meetings, that actions have been completed, evaluated and signed off. |
| **Corrective Action:** |
| Ensure that a) corrective actions are developed for all identified issues, and b) ensure that all corrective actions are completed, evaluated and signed off. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Adverse events (including but not limited to: falls, skin tears, infections, medicine errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by a registered nurse. Data is collected and collated on a monthly basis. Results are communicated to staff at the staff meetings (meeting minutes sighted).  A sample of incident forms (35) were reviewed for February 2014 and involved three rest home residents, and five dementia residents. Incidents reviewed included falls, medication error, behaviours, a missing item, skin tears and a bruise. Staff advised that they document family being contacted and write a description of the event in the resident’s progress notes (viewed for all eight residents with related incidents). Adverse events include an investigation. Follow up is conducted by the registered nurses and GP is notified if required. The nurse manager investigates the event with further follow up by the facility manager if required. The adverse events form documents the follow-up actions taken - including wound management and progress notes for two residents with wounds and skin tears, falls risk assessment completed and reviewed for seven residents, additions to the long term care plan, and behaviour assessments completed. One dementia resident did not have additions made to the long term care plan (behaviours) and one dementia resident did not have a short term care plan for skin tears and bruising (link #1.3.5.2). Monthly incident/accident analysis is conducted and results discussed at staff meetings. Statutory and regulatory obligations are understood by the facility manager and nurse manager. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner. D19.3b; There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are 61 staff employed by Annaliese Haven which includes a facility manager, a nurse manager, a registered nurse, caregivers, kitchen staff, cleaning and laundry staff and activities staff. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for registered nurses, general practitioners, pharmacist, and podiatrist.  Eight staff files were randomly selected for review (one diversional therapist, one rest home care giver, one nurse manager, one registered nurse, one senior care giver (unit supervisor), one chef and two dementia unit care givers). Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, evidence of a completed orientation programme including evidence of competency (medication, restraint, first aid/CPR – with exception of the RN staff who have not completed medication competency link #1.3.12.3). Police checks are conducted for all new staff as evidenced in eight of eight staff files reviewed. Staff undergo annual performance appraisals, evident in five of eight staff files – with three staff employed within the past 12 months. Annaliese Haven has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently (evidenced in the completed orientation checklists for four caregivers). Interviews with six caregivers confirm their orientation to the service was thorough. All eight staff files reviewed reflected evidence of an orientation programme that had been completed. Newly employed caregivers spend time with the diversional therapist to familiarise themselves with the activities programme in the dementia units and rest home. A system is in place to identify, plan, facilitate and record on-going education for staff. The education programme for 2013 included the following: infection control, challenging behaviours, nutrition and hydration, pain in dementia, medications, continence, advocacy and code of consumer rights, medical observations, spirituality, sexuality and intimacy, health and safety, first aid, fire and evacuation, manual handling and back care and safe chemical handling. Education is provided as either face to face sessions, self-directed reading and learning or attendance at off-site sessions. It is noted that training related to restraint and cultural safety has not been provided in the past two years. Improvements are required in this area. The registered nurse attended a three day infection control management for registered nurses course in December 2013. Attendance rates are recorded and evidence good levels of attendance by staff. The ACE caregiver training programme is provided at Annaliese Haven and is coordinated by a senior care giver. All caregivers are encouraged to complete the course. Caregivers in the dementia units are provided with the unit standards training. Of the 30 caregivers who work in the units, 19 have completed the full ACE programme including the dementia unit standards. Eight caregivers are in the process of completing and three are yet to start. The three who have not yet commenced the programme are new employees. |

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A system is in place to identify, plan, facilitate and record on-going education for staff. The education programme for 2013 included the following: infection control, challenging behaviours, nutrition and hydration, pain in dementia, medications, continence, advocacy and code of consumer rights, medical observations, spirituality, sexuality and intimacy, health and safety, first aid, fire and evacuation, manual handling and back care and safe chemical handling. Education is provided as either face to face sessions, self-directed reading and learning or attendance at off-site sessions. The registered nurse attended a three day infection control management for registered nurses course in December 2013. Attendance rates are recorded and evidence good levels of attendance by staff. The ACE caregiver training programme is provided at Annaliese Haven and is coordinated by a senior care giver. All caregivers are encouraged to complete the course. Caregivers in the dementia units are provided with the unit standards training. |
| **Finding:** |
| Restraint and cultural safety/awareness training has not been provided in the past two years. |
| **Corrective Action:** |
| Ensure all educational requirements are provided for staff. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A staffing levels and skills mix policy is in place that includes a documented rationale for staffing the service. Staffing rosters were sighted. Part time staff fill casual shifts. The nurse manager works Monday to Friday and the registered nurse works Tuesday to Saturday mainly on afternoon shift. The registered nurses provide after hours on-call. There is further support from general practitioners and St Johns ambulance service if required. Care staff interviewed advised that they are well supported by manager, and nurses. Roster includes a mixture of short and long shifts in each of the three units – rest home and two dementia units. There is a minimum of three care givers on duty overnight – with one in each unit. A chef is employed during the day as well as two kitchen hands – one morning and one in the evening. Activities are provided in by two staff – one is a diversional therapist. The activities staff work Monday through Saturday. A maintenance person/gardener is employed full time. There are designated cleaning and laundry staff.  Staff turnover is reported by the facility manager as low. Staffing levels are altered according to resident numbers and acuity. One general practitioner was interviewed who confirms that staffing is appropriate to meet the needs of residents. Five residents and nine relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The resident files are appropriate to the service type. Entries are legible, dated and signed by the relevant caregiver or registered nurse. |
| **Finding:** |
| Staff member designation is not always recorded as evidenced in resident files reviewed. |
| **Corrective Action:** |
| Ensure that all staff record their name and designation when making entries in to resident’s records. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry to Annaliese Haven potential residents, have a needs assessment, completed by the needs assessment and co-ordination service to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. E4.1.b There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others and b) how behaviours different from other residents are managed and includes the complaint policy and brief information on behaviour management. The information does not include specifically designed and flexible programmes, with emphasis on minimising restraint. This is an area requiring improvement.  D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract D14.1: Exclusions from the service are included in the admission agreement. D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement E3.1: Five resident files were reviewed from the dementia unit and all include a needs assessment as requiring specialist dementia care. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| E4.1.b There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others and b) how behaviours different from other residents are managed and includes the complaint policy and brief information on behaviour management. |
| **Finding:** |
| E4.1.b: The information provided to families in the dementia unit does not include specifically designed and flexible programmes, with emphasis on minimising restraint. |
| **Corrective Action:** |
| Ensure that families in the dementia unit are provided with all information required by the Age Related Care contract. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The admission policy describes the declined entry to services process. Annaliese Haven records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whanau back to the referral agency. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| D16.2, 3, 4: The eight resident files reviewed (three from the rest home and five from the dementia unit) identified that an initial nursing assessment was completed in six of eight files (link 1.3.4.2). There is no care plan completed within 24 hours in any of the eight files sampled that describe interventions to guide caregivers in providing care to residents (link 1.3.5.2).  Six of eight files identify that the long term care plan was completed within three weeks. Two dementia residents have not yet been at the service for three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Six of eight care plans evidenced evaluations completed at least six monthly. Two residents have not yet been at the service for six months. Activity assessments and the activities sections in care plans have been completed by the activities coordinators. Five residents interviewed (from the rest home) interviewed stated that they and/or their family were involved in planning their care plan and at evaluation.  D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. Three monthly or more frequent GP review was evidenced as occurring on review of resident’s files. Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Eight files reviewed identified integration of allied health and a team approach is evident. The GP interviewed reported that the registered nurses consult with the GP with any concerns regarding residents’ health status and he believes the service provided meets resident’s needs. The GP routinely visits weekly but frequently visits more often (he visited twice on the first day of the audit, neither of which was a routine visit) and is available at all times for urgent matters.  Tracer methodology rest home:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology dementia:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Caregivers document progress notes when issues arise and at least every 24 hours in eight of eight files sampled (three from the rest home and five from the dementia units). There are intermittent RN documented progress notes identified in some files.  D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. More frequent GP review was evidenced as occurring on review of resident’s files with acute conditions. Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Nine files reviewed identified integration of allied health and a team approach is evident. The GP interviewed reported that the registered nurses consult with the GP with any concerns regarding residents’ health status and he believes the service provided meets resident’s needs. The GP routinely visits weekly but frequently visits more often (he visited twice on the first day of the audit, neither of which was a routine visit) and is available at all times for urgent matters. |
| **Finding:** |
| Registered nursing management/assessment and input have not been documented in the progress notes for the past two months in two of three rest home files. A further four files (from the dementia unit) have issues/changes of health status identified that require RN follow up but no RN documentation in the progress notes around the issue. Examples include (but not limited to); a) resident returned from hospital (in two dementia files), and b) one where a caregiver had documented a toe nail lifting and b) another where the resident had a toe that was painful enough to prevent her sleeping. |
| **Corrective Action:** |
| Ensure that all residents have regular RN input that this is documented, and that RN’s follow up all appropriate issues and document this in the progress notes. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| In six of eight files sampled (three from the dementia unit and three from the hospital), an initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. This is an area requiring improvement.  Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes (see CAR 1.3.5.2). This includes cultural and spiritual needs, likes, and dislikes. Assessments are conducted in an appropriate and private manner. Assessments are detailed and include input from a general practitioner, support services and medical specialists as appropriate. The service has recently commenced using InterRAI and one of the files sampled in the rest home has a completed InterRAI assessment and associated care plan. The clinical manager reports a total of five residents in the facility have completed InterRAI assessments and an associated care plan. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission. Pain assessment was evidenced completed with on-going monitoring recorded for resident requiring administration of controlled medication as part of prescribed pain management plan. Nine family (three from the rest home and six from the dementia unit) and five residents interviewed (from the rest home) interviewed are very satisfied with the support provided.  ARC E4.2: Five resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements. E4.2a While challenging behaviours assessments are completed in four of five files sampled from the dementia unit. The assessments do not identify triggers for the behaviours. This is a further area requiring improvement. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| In six of eight files sampled (three from the dementia unit and three from the hospital), an initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes (see CAR 1.3.5.2). This includes cultural and spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission. Pain assessment was evidenced completed with on-going monitoring recorded for resident requiring administration of controlled medication as part of prescribed pain management plan.  ARC E4.2: Three resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements. E4, 2a While challenging behaviours assessments are completed in four of five files sampled from the dementia unit. The assessments do not identify triggers for the behaviours. |
| **Finding:** |
| (i)The resident on respite care in the dementia unit had a nursing assessment completed during her last admission in October 2013. No new assessment has been completed during this admission (March 2014). (ii) One other file in the dementia unit does not have a date on the initial nursing assessment. (iii) One of five files sampled from the dementia unit is for residents who have behaviours that challenge but there is no documented behaviour assessment. (iv) While challenging behaviours assessments are completed in four of five files sampled from the dementia unit. The assessments do not identify triggers for the behaviours. |
| **Corrective Action:** |
| (i) And (ii) Ensure that a new assessment is completed every time a resident is admitted and that all assessments are dated. (iii) Ensure that all resident who exhibit behaviours that challenge have a behaviour assessment completed and that triggers for behaviours are identified. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| A review of eight resident files identifies the use of short term and long-term care plans. These reflect variances in resident health status.  D16.2, 3, and 4: There is no care plan completed within 24 hours in any of the eight files sampled that describe interventions to guide caregivers in providing care to residents. As a result, the respite admission (dementia) and the new admission (dementia) do not have a care plan.  There are improvements required around care planning interventions. There is evidence of six monthly reviews, which is signed by a registered nurse. The long term care plan is completed within three weeks of admission by the registered nurses providing a holistic approach to care planning with resident and family input ensuring a resident focussed approach to the whole process.  E4.3 Four of five resident files reviewed from the dementia unit identified current abilities, level of independence and specific behavioural management strategies (link 1.3.5.2). D16.3f: Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations.  All eight resident files reviewed identified that family were involved. This is documented in progress notes D16.3k: Short term care plans are in use for changes in health status in the sample of eight files. However a review of incident forms (link 1.2.4) showed that one dementia resident did not have additions made to the long term care plan (behaviours) and one dementia resident did not have a short term care plan for skin tears and bruising. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The sample of files reviewed included; Dementia: one resident with behaviours that challenge, one resident with a recent hospitalisation, one respite resident, one resident who has had multiple falls and one resident with a wound infection. Rest home: one resident with weight loss, one resident who is a diabetic and one resident who has had seizures/fainting spells. A review of eight resident files identifies the use of short term and long term care plans. These reflect variances in resident health status. |
| **Finding:** |
| (i) D16.2, 3, 4: There is no care plan completed within 24 hours in any of the eight files sampled that describe interventions to guide caregivers in providing care to residents. As a result, the respite admission (dementia) and the new admission (dementia) do not have a care plan. (ii) One of three files sampled in the rest home does not include interventions that relate to XXXXXXX. (ii) One of five files sampled in the dementia unit is for a resident who displays XXXXXXXX but there are no interventions for managing this in the care plan. (iv) One dementia resident did not have additions made to the long term care plan (behaviours) and (v) one dementia resident did not have a short term care plan for skin tears and bruising. |
| **Corrective Action:** |
| (i) D16.2, 3, 4: Ensure every resident has an initial care plan developed with interventions to guide caregivers within 48 hours of admission. (ii) – (v) Ensure care plans have interventions that relate to all identified areas of need. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Eight resident files were reviewed (three from the rest home and five from the dementia unit). Six (three from the rest home and three from the dementia unit) identified that an initial nursing assessment was completed within 24 hours (link 1.3.4.2) and none had a care plan completed within 24 hours (link 1.3.5.2) and six files identify that the long term care plan was completed within three weeks (two dementia residents have not been at the service for three weeks).   There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Six of eight care plans evidenced evaluations completed at least six monthly. Two dementia residents have not yet been at the service for six months.  Activity assessments and the activities sections in care plans have been completed by the activity coordinators. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, the registered nurse and the nurse manager. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical reviews.  The nurse manager is responsible for the education programme (link 1.2.7.5) and ensures staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers at least daily (evidenced in all eight residents' progress notes sighted). (Link 1.3.3.4 regarding registered nurse progress notes). When a resident's condition alters, the registered nurse initiates a review and if required, arrange a GP visit or a specialist referral.   The six caregivers, the registered nurse, two clinical nurse leaders and the nurse manager interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, supplies of these products were sighted. Five residents interviewed (from the rest home) and nine family (three from the rest home and six from the dementia unit) interviewed were complimentary of care received at the facility. D18.3 and 4 Dressing supplies are available. There are seven wounds at the service including one pressure area. All have a rudimentary assessment but not a comprehensive assessment. All have a management plan and reviews documented, but none document timeframes for reviews. Wound documentation is an area requiring improvement. The registered nurse interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.  Continence management in-services and wound management in-service have been provided.  During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents’ rooms and ensured residents’ dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Eight resident files were reviewed (three from the rest home and five from the dementia unit). Six (three from the rest home and three from the dementia unit) identified that an initial nursing assessment was completed within 24 hours (link 1.3.4.2) and none had a care plan completed within 24 hours (link 1.3.5.2) and six files identify that the long term care plan was completed within three weeks (two dementia residents have not been at the service for three weeks). There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Six of eight care plans evidenced evaluations completed at least six monthly. Two dementia residents have not yet been at the service for six months. Activity assessments and the activities sections in care plans have been completed by the activity coordinators. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, the registered nurse and the nurse manager. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical reviews. The nurse manager is responsible for the education programme and ensures staff have the opportunity to receive updated information and follow best practice guidelines.  Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers at least daily (evidenced in all eight residents' progress notes sighted). (Link 1.3.3.4 regarding registered nurse progress notes). When a resident's condition alters, the registered nurse initiates a review and if required, arrange a GP visit or a specialist referral. The six caregivers, the registered nurse, two clinical nurse leaders and the nurse manager interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Five residents interviewed (from the rest home) and nine family (three from the rest home and six from the dementia unit) interviewed were complimentary of care received at the facility. D18.3 and 4 Dressing supplies are available. There are seven wounds at the service including one pressure area. |
| **Finding:** |
| None of the seven wounds including one pressure area have a comprehensive assessment or document when the wound should next be reviewed. |
| **Corrective Action:** |
| Ensure all wounds have a comprehensive assessment and document when the wound should next be reviewed. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are two activities coordinators at Annaliese Haven who are responsible for the planning and delivery of the activities programme. One of these people has almost completed diversional therapy training. They link with the Canterbury and South Canterbury diversional therapy groups to share ideas about programmes. There is a separate programme for the dementia units and the rest home. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident’s rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events.  The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this is added into the long term care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident’s activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary. Annaliese Haven has a van for transportation. Residents interviewed described weekly liaison with a local school, outings with the Rangiora RSA and attendance at a variety of community events. The activities coordinators have a current first aid certificate. There are a wide range of activities available for caregivers to engage with residents in the dementia unit across the 24 hour period and caregivers where observed to be engaging residents in a variety of activities during the audit. D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is at least a three monthly review by the medical practitioner.  D16.4a Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted in six LTCPs sampled (link 1.3.5.2 regarding two residents not having care plans). There are short term care plans to focus on acute and short-term issues (link 1.3.5.2). STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. One STCP reviewed evidenced transition into the long term care plan. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, weight loss and wounds. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident’s care or treatment during handover sessions which occur at the beginning of each shift. ARC D16.3c: Initial care plans are not used so cannot be evaluated by an RN within three weeks of admission (link 1.3.5.2). |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The registered nurses described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, GP and psychiatric services for the elderly. D16.4c: The service provided examples of where a resident’s condition had changed and the resident was reassessed for a higher level of care. D 20.1; Discussions with the registered nurse and nurse manager identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist and physiotherapist. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.  Progress notes document communication with family/EPOA regarding the transfer and updates on residents' condition. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked office in the rest home and each of the dementia units. Controlled drugs are stored in a locked safe in the rest home and two medication competent persons must sign controlled drugs out. The service uses four weekly blister packs medication management system. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival by the registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.  Staff sign for the administration of medications on medication signing sheet. Five of 16 (one from the rest home, four from the dementia units) medication charts have regular non-packaged medications that have not been signed as administered. Twelve of 18 medication charts had PRN medications charted with no indication for use. Seven of 16 medication charts (two from the rest home, five from the dementia units) sampled have PRN medications prescribed with no documented indication for use. Four of 16 medication charts (four from dementia units) have PRN medications charted with no maximum daily doses recorded. These are areas requiring improvements. The medication folder includes a list of specimen signatures.  Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. Education on medication management occurred 2013. Registered nurses and senior caregivers administer medicines. All senior caregivers have been assessed as competent. The registered nurses have not had a competency assessment and this is an area requiring improvement. D16.5.e.i.2; Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Ten open eye drops (seven in the dementia unit and three in the rest home) have not been dated when opened. In ‘Forget Me Not’ dementia unit, there is one bottle of eye drops in use that are expired and in the rest home fridge there is a box of expired flu vaccines (these were all disposed of during the audit and a review of resident notes show the expired flu vaccine had not been given). These are further areas requiring improvement. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked office in the rest home and each of the dementia units. Controlled drugs are stored in a locked safe in the rest home and two medication competent persons must sign controlled drugs out. The service uses four weekly blister packs medication management system. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival by the registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.  Staff sign for the administration of medications on medication signing sheet. |
| **Finding:** |
| (i)Ten open eye drops (seven in the dementia unit and three in the rest home) have not been dated when opened. (ii) In ‘Forget Me Not’ dementia unit, there is one bottle of eye drops in use that are expired and in the rest home fridge there is a box of expired flu vaccines (these were all disposed of during the audit and a review of resident notes show the expired flu vaccine had not been given). (iii) Seven of 16 medication charts (two from the rest home, five from the dementia units) sampled have PRN medications prescribed with no documented indication for use. (iv) Four of 16 medication chart (from dementia unit) have PRN medications charted with no daily maximum dose or doses recorded. (v) Five of 16 (one from the rest home, four dementia unit) medication charts have regular non-packaged medications that have not been signed as administered. |
| **Corrective Action:** |
| (i) Ensure eye drops are dated when opened. (ii) Ensure medications are disposed of when they expire. (iii) Ensure PRN medications document an indication for use. (iv) Ensure PRN medications document a maximum dose. (v) Ensure medications are administered as prescribed. |
| **Timeframe (days):** 60 *(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 Low |
| **Evidence:** |
| Education on medication management occurred 2013. Registered nurses and senior caregivers administer medicines. All senior caregivers have been assessed as competent. |
| **Finding:** |
| The registered nurses have not completed medication competency assessments. |
| **Corrective Action:** |
| Ensure registered nurses complete medication competency assessments. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Annaliese Haven has a commercial kitchen and all food is cooked on site. There are two cooks and five kitchen hands. D19.2: The two cooks and two of the kitchen hands have food safety training. This is an area requiring improvement. There is a four weekly rotating winter and summer menu. The menu was last reviewed by a dietitian in January 2013. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. However during the lunch service across the two dementia units at lunch on the first day of the audit the kitchen hand was sighted to be serving 17 puree meals at once. E.g. meat onto each of the 17 plates, the potato onto each of the 17 plates. All meals were delivered to residents once they were all served. There was no system to keep the meals hot. This is an area requiring improvement. For non mouli meals, these are served from a bain marie in both the dementia kitchenette and straight from the kitchen in the rest home and were served hot.  All food in the freezer and fridge is labelled or dated.  The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook interviewed. Letters from the clinical manager to the cook were sighted for residents requiring fortified diets. The cook reports fortified diets include extra butter, double cream, extra ice-cream and other ways to make meals high fat and high calorie. She also provides residents requiring high calorie diets with a protein drink made with complan, full fat milk and extra milk powder three times per day. Special diets are noted on the kitchen notice board, which can be viewed only by kitchen staff. Special diets being catered for include pureed diets and soft diets. Weights are recorded weekly/monthly as directed by the registered nurses. Residents report satisfaction with food choices, meals are well presented. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks.  E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours. |

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

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

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

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

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

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

##### **Criterion 1.3.13.5 (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:** PA Moderate |
| **Evidence:** |
| Annaliese Haven has a commercial kitchen and all food is cooked on site. There are two cooks and five kitchen hands. D19.2: The two cooks and two of the kitchen hands have food safety training. There is a four weekly rotating winter and summer menu. The menu was last reviewed by a dietitian in January 2013. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. For non mouli meals, these are served from a bain marie in both the dementia kitchenette and straight from the kitchen in the rest home and were served hot. |
| **Finding:** |
| (i)During the lunch service across the two dementia units at lunch on the first day of the audit the kitchen hand was sighted to be serving 17 puree meals at once. E.g. meat onto each of the 17 plates, the potato onto each of the 17 plates. All meals were delivered to residents once they were all served. There was no system to keep the meals hot. (ii) The three evening kitchen hands who serve evening meals have not completed food safety training. |
| **Corrective Action:** |
| (i)Ensure all meals are served at a suitable temperature. (ii) Ensure all kitchen staff have food safety training. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were evidenced stored securely in locked cleaning cupboards. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires 1 June 2014. Electrical equipment is checked annually and this was last completed in May 2013. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas. There are no hoists at the service. Medical equipment is calibrated against other equipment (for example a known weight for scales). It is not professionally calibrated and this is an area requiring improvement. Water temperatures are tested monthly by the maintenance person and records show they are within safe limits.  E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities. ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids.  E3.3e: There are quiet, low stimulus areas in each unit that provide privacy when required. E3.4.c: There is a safe and secure outside area that is easy to access. |

##### **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:** PA Low |
| **Evidence:** |
| Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires 1 June 2014. Electrical equipment is checked annually and this was last completed in May 2013. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. There are no hoists at the service. |
| **Finding:** |
| Medical equipment is calibrated against other equipment (for example a known weight for scales). It is not professionally calibrated. |
| **Corrective Action:** |
| Ensure all medical equipment is professionally calibrated annually. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has single rooms.  In the rest home (20 beds) 12 rooms have a full ensuite and the other eight rooms have an ensuite toilet. There is one communal shower. In ‘Forget Me Not’ (the 22 bed dementia unit) all rooms have an ensuite toilet and four rooms have a full ensuite shared between two rooms (i.e. two full ensuites). There are two communal bathrooms In ‘Memory Lane’ (21 bed dementia unit) all rooms have a full ensuite.  There are also communal toilets that are located close to dining rooms and lounges for residents' use. A visitor’s toilet is available. Caregivers interviewed report there are sufficient showering and toilet facilities. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Observation on day of audit demonstrated walking frames, shower chairs and other required equipment can be manoeuvred around the residents' personal space. This was also confirmed at interview with caregivers. Residents were observed manoeuvring walking frames in rooms safely. All residents and family members interviewed report satisfaction with their rooms. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The rest home has a large lounge and separate dining room. There is also a smaller sun room for residents to relax in. The Forget Me Not dementia wing has a large open plan dining and living room and a smaller sun room. The Memory Lane dementia wing has a large open plan lounge and dining room, a smaller ‘activities room’ which is a small lounge with windows to the lounge and a small sun room. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and residents interviewed report they can move around the facility and staff assist them if required.  E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All laundry is completed on site by staff dedicated to this task. The laundry is large with a clear clean/dirty flow. Chemicals are stored in a locked room in each area. All chemicals are labelled with manufacturer’s labels. Residents and relatives expressed satisfaction with cleaning and laundry services. On a tour of the facility, the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Cleaning and laundry audits occurred in March 2014 attaining 99%. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies and procedures and training for civil defence, other emergencies and security. The fire manual is kept in the rest home nurses’ station near the front entrance and each unit and department has flip charts for quick reference in the case of emergencies. Fire and emergency training occurred in October 2013. All shifts have a trained first-aider. The New Zealand Fire Service approved the fire evacuation scheme on the 10 November 2011. Fire evacuation drills have occurred six monthly - last conducted on 27 February 2014. Battery operated emergency lighting, extra torches and gas cooking and is available. The service is able to obtain a generator from within the community if required in an emergency. Call bells are evident in resident’s rooms, en-suites, corridors, lounges and dining rooms and toilets/bathrooms. Security policies and procedures are in place. In the dementia units the “Austco Monitoring programme” is available in each bedroom and en-suite to ensure the resident is effectively monitored with dignity and limited interruption. The system includes sensor lights in resident rooms, which illuminate depending on the location of the resident in the room. This is controlled by a timer, so can be set to meet the needs of individual residents. There is also nurse presence bell, when a nurse/carer is in the resident room a green light shows staff outside. The rest home also includes the Austco call bell system. When residents ring, a light shines outside their room, on a control panel and also goes to staff pages. There is also a certain call sound. When a staff member is in a resident room a green light shines above the resident's door. This allows for staff to know where other staff are. If the staff member with a resident rings the bell for another staff member assist, this ring is different and allows for staff to alert other staff for assistance without leaving the resident unattended. The dementia units are accessible by swipe card only, which unlocks the doors. All external doors through the facility are automatically locked at 5pm. Families interviewed advised that they ring to be let in after these hours and staff arrive promptly. The two dementia units are opened during the day via adjoining double doors. There is a civil defence kit in laundry and a first aid kit, which are checked and maintained monthly. The service has extra food and water available should the need arise. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has heat pumps in hallways and communal areas and underfloor heating throughout. The temperature can be adjusted to suit individual resident temperature preference. Temperatures are monitored monthly and adjusted when necessary (eg. during an unseasonably cold spell in March). Rooms are well ventilated and windows provide natural light. Five residents interviewed stated the temperature of the facility was comfortable. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a restraint policy, which states the home actively promotes a policy of least restraint and is currently a restraint free environment. The policies include comprehensive restraint procedures should these be required. A comprehensive checklist for safe and appropriate use of restraints is used that includes, but is not limited to, management strategies to avoid restraint use, behaviours that indicate the need for restraint, type of restraint to be used, monitoring requirements when restraint is used and evaluation of restraint use. There is a definition of enablers that states 'equipment, devices or furniture, voluntary used by a resident following appropriate assessment, that limits normal freedom of movement, with the intent of promoting independence, comfort and / or safety. The use of enablers shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining resident’s independence and safety'. There are no resident's using restraint or enablers at the time of the audit. Staff had training on managing challenging behaviour in March 2014. Training around restraint minimisation has not occurred in 2012, 2013 or 2014 to date (link 1.2.7.5). Policies and procedures are comprehensive to guide staff in the event that restraint should be needed. E4.4a: The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Annaliese Haven has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by an external provider. The registered nurse is the infection control coordinator. The quality management team incorporates the infection control committee. Discussion and reporting of infection control matters and consequent review of the programme is conducted at these meetings. Annual review was conducted in December 2013 as part of the quality plan review. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff (January 2013). Hand washing facilities are available for staff, residents and visitors throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The registered nurse is the infection control coordinator and has been in the role since November 2013 having taken over from the nurse manager. They support one another, are supported by the facility manager, and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The registered nurse attended an infection control (IC) training three day course provided by the local district health board in December 2013. The IC coordinators and staff have good external support from the local laboratory infection control team and IC nurse expert at Canterbury DHB. The infection control team is representative of the facility. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are infection control policy and procedures appropriate to for the size and complexity of the service. D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed and updated by the nurse manager and registered nurse to ensure best practice information is included. The policies and procedures were last updated and reviewed in February 2014. Annaliese Haven’s infection control policies include (but not limited to): hand hygiene, standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control coordinator. All infection control training is documented and a record of attendance is maintained. Infection control education was provided in January 2013 and is booked for 2014. The infection control coordinator attended a three day infection control management for registered nurses course in December 2013. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. All staff complete an infection control questionnaire. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. No outbreaks have been recorded in the past 18 months. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection surveillance is an integral part of the infection control programme and is described in Annaliese Haven’s infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. Resident infections are collated on a monthly reporting form, which includes signs, and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored, graphed and evaluated monthly and annually. Outcomes and actions are discussed at the quality management meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. No outbreaks were noted in the past 18 months. |

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

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

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

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

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

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