

Calvary Hospital Southland Limited

Current Status: 19 May 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

Calvary hospital is a 74 bed facility, which provides rest home and hospital level care in Invercargill. All internal and external environmental requirements that ensure the safety of the residents are being met.

There is evidence in this certification audit that every effort has been made to ensure the quality management systems are firmly embedded into the service and that care planning and service delivery is occurring with ongoing improvements.

The health and safety system within Calvary is operating at a level of continuous improvement with external recognition for two aspects.

Although Calvary hospital was founded by a religious order of sisters called the Little Company of Mary and there is a strong pastoral care team, people of all denominations are accepted.

Four areas that require improvement have been identified. These relate to shortcomings in the system for the planning and recording of staff training; the integration of residents' care plans; the use of assessments to guide care planning; and the correct use of the care plan template.

Audit Summary as at 19 May 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 19 May 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Organisational Management as at 19 May 2014

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.
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Continuum of Service Delivery as at 19 May 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 19 May 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 19 May 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 19 May 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 19 May 2014

Consumer Rights

An area of continuous improvement is the implementation of a health and safety system that is not only evidence-based with external recognition, but also links into an efficient food service and kitchen management system. Ongoing review processes are enabling new initiatives to be developed and pursued.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and brought to the attention of residents and their families on admission to the facility. All residents and family members interviewed verify that their rights are met at all times during service delivery, that staff are respectful and considerate of their needs, communication is appropriate, they all have a clear understanding of their rights and the facility's processes if these are not met.

There is confirmation from residents and family that consent forms are provided prior to admission to ensure they have time for consultation and are fully informed, and this is verified in records reviewed. Time is provided if discussions and explanation is required.

Training in the Code and the advocacy service is provided and staff demonstrate knowledge of patients and residents rights. There is evidence of consideration of residents' personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence.

A complaints policy meets requirements, residents and relatives are informed of how to make a complaint and the complaints register shows that all complaints are being followed up and signed off.

Organisational Management

A strategic plan, developed by a board of trustees, guides the management of this service towards fulfilling goals and objectives that will ensure the mission, values and philosophy of the organisation are upheld.

Key components of quality and risk management systems, that are evident in a series of meeting minutes and associated documents, include topics such as environmental issues, hazard

management, incident reporting, internal audits, corrective actions, survey results, infection control and restraint. Incident reports are being analysed and management personnel are aware of essential notification reporting requirements.

Practising certificates of health professionals are current and recruitment and staff appraisal processes are ensuring staff are able to meet the needs of the residents in a competent manner. A comprehensive orientation programme that includes demonstration of competence is in place and a staff training schedule is also in place. The planning, facilitation and recording of staff training is an area that requires improvement.

Staffing numbers and the mix of skill on each shift are adequate to ensure the residents receive good care and remain safe.

Information is entered in the integrated notes in a timely manner. All records are observed to be stored in the office area of both service areas, are legible, and the name and the designation of the provider is identifiable. Patient and residents' records are not integrated into one current or archived file and this requires improvement.

Continuum of Service Delivery

On admission to the facility a range of assessments are completed by the external needs assessment and service co-ordination (NASC) service, general practitioner (GP), and the facility's registered nurse and physiotherapist. The admitting RN develops a detailed care plan to guide staff in service provision and reviews these within recommended timeframes. Assessment tools are not always completed, and those that are, do not always have the information transferred to the patient/residents' care plans and this requires improvement.

Observation of staff, review of patient/resident notes, and patient/resident and family interviews, confirms that all staff provide individualised care that reflects desired goals and outcomes identified on the patients' and residents' care plans.

A general practitioner (GP) is interviewed during the audit and confirms the facility notifies him in a timely manner of any issues, that RNs assessments are complete and appropriate, and that his recommendations and treatments are always implemented. He is extremely complimentary of the facility and the management team. The facility physiotherapist during interview verifies the commitment to improving patients' and residents' independence and functioning.

An activities programme is planned and implemented by the diversional therapist and the activities persons, however it may not always meet the identified activities of all the residents, and individual resident's activity plans are not always developed, and are not reviewed in line with lifestyle plans; these areas need improvement.

Policies and procedures are in place for all stages of medication management. A robotic medication system is in place for the facility, although the facility is trialling the MedMAP electronic programme. The medication administration process is observed during the audit confirming safe practice occurs. Documented medication records are completed and reviewed by the residents' GPs within recommended timeframes. The local pharmacy assists in medication reconciliation.

Food, fluid and nutritional needs of all hospital residents are being managed by a dietitian, who also oversees any residents in the rest home who have special dietary needs. The procurement, preparation, storage, serving and disposal of food is safe as health and safety monitoring is occurring through the Hazards Analysis and Critical Control Points (HACCP) programme that is in place in the kitchen

Safe and Appropriate Environment

Hazards such as cleaning and laundry chemicals are being safely managed, rubbish is being disposed of in a safe manner and personal protective equipment is available for staff use.

All equipment is being maintained according to a time-framed schedule. This is overseen and implemented by a maintenance officer, who also ensures repairs are undertaken in a timely manner.

The building has a current warrant of fitness and the bathrooms, bedrooms, communal lounges and dining areas meet the needs of the hospital and rest home level residents. External garden and lawn areas are safe and well maintained.

Fire and emergency management training is being provided to staff; suitable equipment is available and is being checked by contractors within the expected timeframes. A civil defence kit is available and emergency plans are in place. Residents have access to a call bell system and their overall security is managed through physical measures, such as window latches, staff interventions, such as locking doors, and nightly visits from a security company.

The facility is warm and spacious and the windows and full length glass doors provide adequate natural light.

Restraint Minimisation and Safe Practice

Policies and procedures on restraint minimisation and safe practice, a restraint approval group and a restraint coordinator ensure there is oversight for the use of restraints and enablers. There are not currently any restraints in use; however 17 people are using an enabler. Systems in place include assessment, consent, progress reporting and review of the use of the enablers. A restraint and enabler register is in place.

Infection Prevention and Control

A documented and implemented infection control (IC) programme which meets the infection control Standards includes policies and procedures to guide staff. Records sighted, observation, and interviews with staff provides evidence that all staff have a clear understanding of what is required for prevention of infections. Patients and residents interviewed are familiar with safe hand hygiene and IC prevention measures implemented for identified infections.

The IC RN ensures the programme is implemented, collates and analyses IC data, and reports findings to the quality committee. Evidence is sighted that initial and on-going staff training is occurring for all areas of service delivery.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Calvary Hospital Southland Limited		
Certificate name:	Calvary Hospital Southland Limited		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Certification Audit		
Premises audited:	Calvary Hospital		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
Dates of audit:	Start date: 19 May 2014	End date: 20 May 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:	72		

Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXX	Total hours on site	16	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	4

Sample Totals

Total audit hours on site	32	Total audit hours off site	20	Total audit hours	52
Number of residents interviewed	8	Number of staff interviewed	25	Number of managers interviewed	2
Number of residents' records reviewed	12	Number of staff records reviewed	13	Total number of managers (headcount)	2
Number of medication records reviewed	18	Total number of staff (headcount)	89	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 The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Tuesday, 17 June 2014

Executive Summary of Audit

General Overview

Calvary hospital is a 74 bed facility, which provides rest home and hospital level care in Invercargill. All internal and external environmental requirements that ensure the safety of the residents are being met.

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Although Calvary hospital was founded by a religious order of sisters called the Little Company of Mary and there is a strong pastoral care team, people of all denominations are accepted.

Four areas that require improvement have been identified. These relate to shortcomings in the system for the planning and recording of staff training; the integration of residents' care plans; the use of assessments to guide care planning; and the correct use of the care plan template.

Outcome 1.1: Consumer Rights

An area of continuous improvement is the implementation of a health and safety system that is not only evidence-based with external recognition, but also links into an efficient food service and kitchen management system. Ongoing review processes are enabling new initiatives to be developed and pursued.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and brought to the attention of residents and their families on admission to the facility. All residents and family members interviewed verify that their rights are met at all times during service delivery, that staff are respectful and considerate of their needs, communication is appropriate, they all have a clear understanding of their rights and the facility's processes if these are not met.

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A complaints policy meets requirements, residents and relatives are informed of how to make a complaint and the complaints register shows that all complaints are being followed up and signed off.

Outcome 1.2: Organisational Management

A strategic plan, developed by a board of trustees, guides the management of this service towards fulfilling goals and objectives that will ensure the mission, values and philosophy of the organisation are upheld.

Key components of quality and risk management systems, that are evident in a series of meeting minutes and associated documents, include topics such as environmental issues, hazard management, incident reporting, internal audits, corrective actions, survey results, infection control and restraint. Incident reports are being analysed and management personnel are aware of essential notification reporting requirements.

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Staffing numbers and the mix of skill on each shift are adequate to ensure the residents receive good care and remain safe.

Information is entered in the integrated notes in a timely manner. All records are observed to be stored in the office area of both service areas, are legible, and the name and the designation of the provider is identifiable. Patient and residents' records are not integrated into one current or archived file and this requires improvement.

Outcome 1.3: Continuum of Service Delivery

On admission to the facility a range of assessments are completed by the external needs assessment and service co-ordination (NASC) service, general practitioner (GP), and the facility's registered nurse and physiotherapist. The admitting RN develops a detailed care plan to guide staff in service provision and reviews these within recommended timeframes. Assessment tools are not always completed, and those that are, do not always have the information transferred to the patient/residents' care plans and this requires improvement.

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An activities programme is planned and implemented by the diversional therapist and the activities persons, however it may not always meet the identified activities of all the residents, and individual resident's activity plans are not always developed, and are not reviewed in line with lifestyle plans; these areas need improvement.

Policies and procedures are in place for all stages of medication management. A robotic medication system is in place for the facility, although the facility is trialling the MedMAP electronic programme. The medication administration process is observed during the audit confirming safe practice occurs. Documented

medication records are completed and reviewed by the residents' GPs within recommended timeframes. The local pharmacy assists in medication reconciliation.

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Outcome 1.4: Safe and Appropriate Environment

Hazards such as cleaning and laundry chemicals are being safely managed, rubbish is being disposed of in a safe manner and personal protective equipment is available for staff use.

All equipment is being maintained according to a time-framed schedule. This is overseen and implemented by a maintenance officer, who also ensures repairs are undertaken in a timely manner.

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The facility is warm and spacious and the windows and full length glass doors provide adequate natural light.

Outcome 2: Restraint Minimisation and Safe Practice

Policies and procedures on restraint minimisation and safe practice, a restraint approval group and a restraint coordinator ensure there is oversight for the use of restraints and enablers. There are not currently any restraints in use; however 17 people are using an enabler. Systems in place include assessment, consent, progress reporting and review of the use of the enablers. A restraint and enabler register is in place.

Outcome 3: Infection Prevention and Control

A documented and implemented infection control (IC) programme which meets the infection control Standards includes policies and procedures to guide staff. Records sighted, observation, and interviews with staff provides evidence that all staff have a clear understanding of what is required for prevention of infections. Patients and residents interviewed are familiar with safe hand hygiene and IC prevention measures implemented for identified infections.

The IC RN ensures the programme is implemented, collates and analyses IC data, and reports findings to the quality committee. Evidence is sighted that initial and on-going staff training is occurring for all areas of service delivery.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	1	40	0	4	0	0	0
Criteria	1	88	0	4	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	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 1.2.7: 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	The system in place to facilitate and record on-going training for service providers is not currently demonstrating that the identified compulsory training is being attended as required and not all training undertaken is evident in the recording system.	Service providers are to complete compulsory training as required and the recording system will reflect attendance in an accurate manner.	180
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			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.2.9.10	All records pertaining to individual consumer service delivery are integrated.	PA Low	<p>Hospital and Residential: Short term care plans are developed for issues such as skin tears, wounds and urinary tract infections; however these are not integrated into the resident or patient records, but retained in a separate folder in the office of each service.</p> <p>Hospital: Multidisciplinary (MDT) meeting notes pertaining to each patient are recorded on a record sheet alongside the MDT notes of all other patients. The information is not transferred to the patient's integrated notes and is retained in the folder even following the discharge of the patient and archiving of the records.</p> <p>Residential: Notes relating to each residents activities, family support, preferences are recorded in a hardcopy record book in the diversional therapists (DT) office. When a resident is discharged there is no ability to archive these records into the resident's integrated notes.</p>	All records pertaining to patients and residents are integrated into one current or archived file.	180
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
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	PA Low	Hospital and Residential: Information gained in the initial and on-going assessment tools is not always transferred to the patients/residents	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		to serve as the basis for service delivery planning.		<p>long term care plan. For example one resident who now requires wheelchair for mobility, and a patient who requires assistive aids for transfers, does not have the information included on their long term care plan.</p> <p>The facility has developed a continence assessment form to be completed for patients and residents who have continence issues, however in the files of those with incontinence reviewed (four hospital patients and two residential residents) a continence assessment has not been completed. The CNM is interviewed and is aware of the prior required improvement and is in the process of completing the required assessments.</p> <p>There is a challenging behaviour form, however one of one resident who displays aggressive behaviour, does not have a consistent and regular behaviour assessment completed, and strategies to reduce or minimise the behaviour included on her care plan.</p>	basis for service delivery planning.	
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			
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.	PA Low	<p>Assessment information gathered during the initial and on-going assessment process for mobility (physiotherapist), nutrition (dietitian) and challenging behaviours (behaviour form) is not always transferred as interventions on the residents' or patients' care plans.</p> <p>In two of two resident files reviewed</p>	Long term care plans describe the required support and interventions to achieve the identified outcomes identified during the assessment process	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				falls are recorded in the intervention section, rather than the strategies identified during assessment process to minimise the risk of falls.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.1.8: Good Practice	Consumers receive services of an appropriate standard.	CI	
HDS(C)S.2008	Criterion 1.1.8.1	The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	<p>There are two areas of practice that collectively demonstrate that Calvary Hospital provides an environment that encourages good practice, including evidence-based practice at a level of continuous improvement. The first one specifically relates to the commitment that Calvary hospital has regarding the proactivity of the health and safety team and the achievement of tertiary status under the Accident Compensation Corporation workplace safety programme.</p> <p>A second area, which is driven from this commitment, relates to the management of food and kitchen services with the contracting of a dietitian to continually monitor the food and fluid requirements of hospital level care residents and the use of the HACCP programme to ensure the kitchen is operating at the safest and most efficient level possible.</p> <p>These areas both have their own internal monitoring and evaluation systems that enables them to maintain recognition through credible external programmes.</p>

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

Attainment and Risk: FA
Evidence: Records sighted verify staff receive training in the Code of Health and Disability Services Consumers' Rights' (the Code) initially on induction and at least annually. Care staff are observed communicating appropriately and respectfully with residents. Staff allow residents to make choices demonstrating their knowledge of residents' rights. For example one of one family member verifies staff always ensure her mother's preferences relating to clothing and accessory choices are met. Patients and residents (two hospital and six rest home) and family members (six hospital and three rest home) are able to verify that services are provided with dignity and respect at all times, privacy is maintained, and individual needs and rights are upheld. The ARRC requirements D1.1c; D3.1 are met.

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.

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

Standard 1.1.2: 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

Attainment and Risk: FA

Evidence:

Patients (hospital), residents (residential care) and family members interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service in the facility's admission package prior to the resident's admission. Those interviewed verify explanations regarding their rights occur at any time that they may have a query, and that they are aware an advocate may be appointed if needed. Those interviewed have not had any reason to access the advocacy service.

A laminated poster of the Code is visible in two communal areas in the facility. Brochures of the Code and the advocacy service are available and observed at the entrance to the facility, and are included in the admission package, as verified by patients/residents' and family interviewed.

The ARRC requirements D6.1; D6.2; D16.1b.iii are met.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.2.4 (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.

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

Standard 1.1.3: 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

Attainment and Risk: FA
Evidence:
<p>There are policy and procedure guidelines (sighted) for staff relating to privacy and dignity when supporting patients and residents. Observations during the audit verify patients and residents are encouraged and supported to maintain independence, with dignity and respect. For example residents are supported, and encouragement is heard, to mobilise with aids. The facility physiotherapist (physio) and physio aid are interviewed and confirm that all patients in the hospital wing are assessed initially on admission, and a programme to aid independence is developed (sighted). A referral to the physio occurs on a case by case basis as sighted in resident's files.</p> <p>During the audit bedroom doors are observed closed and curtains are drawn to protect resident's privacy when service delivery occurs.</p> <p>Documentation sighted includes the cultural, spiritual and ethnic values and beliefs for each resident. Three rest home resident and six hospital patient integrated files are reviewed. A Maori resident's file reviewed includes tribe, iwi, and the resident's choices relating to cultural preferences. Staff are observed ensuring these preferences are met.</p> <p>Policies and procedures relating to abuse and neglect prevention are sighted. Staff interviewed (six of six) are able to demonstrate knowledge in what abuse and neglect is, including the reporting processes. Residents and family members interviewed have not been subject to, or witnessed any abuse or neglect, and verify that they observe staff as always respectful to the residents.</p> <p>The ARRC D3.1b; D3.1d; D3.1f; D3.1i; D4.1a; are met.</p>

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.

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

Criterion 1.1.3.2 (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.

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

Criterion 1.1.3.6 (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.

Attainment and Risk: FA
Evidence:

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

Criterion 1.1.3.7 (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.

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

Standard 1.1.4: 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

Attainment and Risk: FA
Evidence:
<p>The facility has a Maori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. It describes that the holistic view of Maori health is to be incorporated into the delivery of services (whanau, hinengaro, tinana and wairua).</p> <p>There is one patient in the facility that identifies as Maori. The patient’s cultural preferences are documented and staff are observed ensuring his preferences are met, and reflect documented needs in the resident’s integrated file (sighted).</p> <p>The ARRC requirements A3.1; A3.2; D20.1i are met</p>

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.

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

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

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

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

Criterion 1.1.4.5 (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.

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

Standard 1.1.6: 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

Attainment and Risk: FA
Evidence:
<p>There are sighted policies and procedures in place that identify the inclusion of values and beliefs as part of the care planning process, and as part of service provision by all staff. Patients/residents and family interviewed verify that all staff uphold these rights.</p> <p>Staff receive regular training in supporting residents to achieve their values and beliefs and in assisting them to practice any cultural activities which they choose. For example, two family members interviewed and one resident have their preferences relating to attendance at chapel activities respected and known by staff. The facility's pastoral care person is interviewed and confirms patient/residents' cultural and spiritual needs are met according to their care plan.</p> <p>The facility is able to access interpreters if required, however there are no patients/residents for whom English is a second language.</p> <p>Residents and family members interviewed verify the facility regularly ensures their individual values and beliefs are met. They refer to their involvement in the care plan review.</p> <p>The ARRC requirements D3.1g; D4.1c are met.</p>

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.

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

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

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

ARHSS D16.5e

Attainment and Risk: FA
Evidence: <p>The facility's staff induction and orientation programme sighted includes expected behaviour in relation to discrimination, coercion, harassment, sexual, financial and other exploitation. Two of two staff interviewed confirm that they do not accept gifts or any other inducement and can describe the facility's policy in relation to discrimination, harassment and other exploitation. Patients/residents and family interviewed confirm they have not been witness to any form of discrimination.</p>

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.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Standard 1.1.8: 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

Attainment and Risk: CI

Evidence:

Calvary Hospital is demonstrating ongoing improvements in multiple areas with particular attention to ensuring quality management systems are developing in a manner that enables each aspect of the service to be delivered at the best level possible. The review of care planning systems and the improvements being made are all evidence of the encouragement of good practice.

In addition there are two linked areas in which practices are demonstrating continuous improvement in a manner that includes evidence-based practice. The health and safety programme at Calvary is aimed at ensuring staff are healthy, safe and well with the intention that this will advantage the residents and the service as a whole. Due to the proactivity of the health and safety team there is education of all of the health and safety representatives in all eight departments and to the wider staff group, ongoing attendance at forums on health and safety issues, leadership on the topic in the Southland region, organisation of a range of health and safety related initiatives for staff throughout each year, encouragement for the ongoing analysis of staff incidents and accidents and updating of hazard registers as a norm rather than an extra task, and achievement of tertiary status for the Accident Compensation Corporation (ACC) workplace safety programme for the past 14 years.

A flow on effect has been a second area of evidence-based practice for which continuous improvement is an integral aspect. This is the certification of the kitchen for the Hazard Analysis Critical Crisis Point (HACCP) programme, which includes employment of a dietitian to ensure residents receive optimal care around their nutritional needs. Each of the health and safety initiatives has a monitoring and evaluation component, including those related to staff tramps and walking group participation. The evaluations are providing guidance for the health and safety team, which is now part of the wider organisational quality management team.

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.

Attainment and Risk: CI

Evidence:

A pattern emerges throughout the audit of staff being very aware of issues relating to health and safety. Without prompting, staff spontaneously talk about issues relating to keeping themselves and the residents safe through the use of equipment, the attendance at health and safety meetings, their pride in achieving tertiary status for the Accident Compensation Corporation (ACC) workplace safety programme for the past 14 years, ongoing review of hazard registers in every department, their participation in health and safety related activities and achieving certification to the Hazard Analysis Critical Crisis Point (HACCP) programme in the kitchen.

During interview, the health and safety officer provides evidence of written documentation and verbal reports about multiple strategies intended to address health and safety. Examples include:

- attendance at study days for ACC health and safety representative training
- management of a health and safety course in Southland
- every department at Calvary Hospital has its own health and safety representative
- all departments are reviewing their hazard registers every month
- multiple initiatives to promote staff health are being arranged through the health and safety team
- the separation of staff accidents and incidents within the adverse event reporting system to enable the analysis to focus on staff safety and wellness
- education sessions on breathing to manage stress, staff tramps, walking groups and linking with Sport Southland
- achieving a place in the final after entering a competition with a health and safety initiative
- the organisation of an service wide health and safety week every two years
- having employee of the month awards that have a health and safety focus
- development of specific health and safety objectives and a workplace inspection checklist that are reviewed every year
- attendance of the health and safety team at an ACC employee well-being forum
- use of a stress hazard and controls sheet.

Each event is evaluated in its own right and the 'fishbone tool' is used to report, record, investigate and evaluate different aspects of health and safety at Calvary Hospital. Results of the evaluations guide the team for follow-up activities.

The HACCP programme that is underway in the kitchen is another initiative of the health and safety team that is ensuring all kitchen and food services are monitored and analysed to ensure quality and efficient services. This includes the employment of a dietitian that enables the residents to receive the best nutrition possible.

The manager, clinical coordinator and health and safety officer inform that the philosophy underpinning the health and safety programme is that it is advantageous to the residents and to the organisation to have happy, well and safe staff.

Finding:

There are two areas of practice that collectively demonstrate that Calvary Hospital provides an environment that encourages good practice, including evidence-based practice at a level of continuous improvement. The first one specifically relates to the commitment that Calvary hospital has regarding the proactivity of the health and safety team and the achievement of tertiary status under the Accident Compensation Corporation workplace safety programme.

A second area, which is driven from this commitment, relates to the management of food and kitchen services with the contracting of a dietitian to continually monitor the food and fluid requirements of hospital level care residents and the use of the HACCP programme to ensure the kitchen is operating at the safest and most efficient level possible.

These areas both have their own internal monitoring and evaluation systems that enables them to maintain recognition through credible external programmes.

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are procedure guidelines sighted for communicating with patients/residents, family members and visitors which sets out expected behaviours of staff, and this is observed during the audit to reflect the policy guidelines. For example, staff are heard addressing people using their title and surname unless they have indicated to use a first name. The patients'/residents' preferred name is sighted on bedroom doors and white boards in the facility's kitchen and in each wing office.

Communication by staff is observed to be appropriate and residents are given time to answer and are not rushed. Patients/residents and family members interviewed verify that staff ensure that they are understood and communication is respectful. They all state that they have never heard anything but respectful and appropriate communication.

Open disclosure occurs according to the facility's policy (sighted). Indication of this is evident on two of two incident reports reviewed that show a family member has been notified. This is also verified in the patient/resident progress notes, documenting the discussion that took place.

The clinical nurse manager (CNM) is interviewed and verifies that interpreter services have not been used for any residents in recent months, but she is able to confirm how these needs would be met, if required.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

Standard 1.1.10: 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

Attainment and Risk: FA
Evidence:
<p>The Informed Consent policy sighted includes references to the Code in relation to competence and how to assess whether a patient/resident is deemed medically unable to give informed consent themselves.</p> <p>Three residents' files and six patients' files are reviewed and include consent for photographs to be displayed, residents' name on the door and publicly displayed records to be retained, health information and care provision, advance directives, outings and flu vaccinations.</p> <p>Patients/residents and family members confirm that staff gain consent for day to day activities on a daily basis. For example, one patient has preferences for daily attendance at chapel, and staff ensure these preferences are met.</p> <p>Admission agreements are signed by the patient/resident and/or their family member on admission to the facility, and information included is aligned to the ARRC agreement requirements. This is confirmed in nine of nine patients'/residents' agreements reviewed.</p> <p>The ARRC requirements D3.1d; D11.3; D12.2 are met.</p>

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.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

Standard 1.1.11: 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

Attainment and Risk: FA
Evidence: Policies and procedures reviewed include the right for residents to have an advocate or support person of their choice at any time. The contact details for advocacy services are included in the policy document, and in the facility's information package provided on admission. Patients/residents and family interviewed verify that family and support persons are included in discussions relating to care provision initially and on-going during the review process. This is confirmed in the multidisciplinary team (MDT) meeting records (sighted) that includes input from the resident's family member. Care staff (interviewed) are aware of the residents' rights to have a support person of their choice at any time and this is supported with one of one family member who verifies this has occurred on occasions for her mother. The ARRC requirements D4.1d; D4.1e are met.

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

Standard 1.1.12: 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

Attainment and Risk: FA

Evidence:

Patients/residents and family interviewed confirm that family and visitors of their choice are able to visit residents at any time. External community links are encouraged and enabled to continue. One resident interviewed continues with meetings and speech instruction, which is supported by the facility. Progress notes and care plan content includes regular outings and appointments (records sighted).

The ARRC requirements D3.1h; D3.1e are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>A complaints policy that was sighted at stage one audit did not meet all of the requirements of Right 10 of the Code. This was amended before the day of audit and the complaints policy sighted at audit now accurately reflects all of the requirements.</p> <p>The clinical coordinator states that residents and their families are told about their right to make a complaint and how to do this when a person is admitted. Information on how to make a complaint is in an admission pack, a sample of which is sighted. During an interview with eleven caregivers, all are familiar with where complaints forms are, that there is a procedure for addressing a complaint, and all say they would take any such concern to a registered nurse or manager to deal with it. Only one of this group has had to assist a person to make a complaint.</p> <p>The complaints and compliments register is sighted. This shows seven complaints were received in 2013 and two so far this year. The manager informs that most are verbal but the issues are transferred into the complaints system to ensure they are investigated. Fifteen compliments were formally recorded in 2013 and ten so far this year. The manager informs not all compliments get recorded as they come in so many different forms. The register notes the date the complaint/compliment was received, the nature of the complaint, actions taken, who was spoken with/involved and when it was closed out. All recorded complaints have been closed out within days of the complaint being received and always within the same month.</p>

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

The mission statement has a strong Roman Catholic theme throughout it and refers to the fullness and sacredness of life; the value, culture and integrity of each person; the upholding of the moral position of the Roman Catholic church, the provision of a centre of excellence in health care and notes it will provide care for the aged, sick and dying for people in Southland regardless of religious affiliation.

A board of trustees, which has representation of a cross section of the Southland community and includes members with pastoral and professional expertise, oversees the management of Calvary hospital. The strategic plan 2012 - 2016 includes goals and objectives that cover a cross-section of the service and is linked to a quality plan that is reviewed annually and includes a quality philosophy. The scope of the service is identified as hospital, residential, and independent flats with the aim being to care for the elderly, sick and dying in Southland. The quality plan has an overview that notes one of the purposes of the management and staff of Calvary Hospital is to implement a robust quality improvement programme that meets legislative and contractual requirements. It also notes there will be systems in place for continuous improvement around the effectiveness of management systems and quality outcomes for patients and residents.

The manager is a suitably qualified and experienced person as she is a registered nurse with 38 years of experience and a post graduate certificate in critical care, research, pharmacology and heart failure. She has previously worked as a charge nurse of a critical care unit and of a medical and surgical ward and worked as a nurse specialist in heart failure. The manager informs she will have been in her current role for six years in July. Although the manager's latest appraisal is unavailable as it is held in the lawyer's office, a board member speaks highly of her skills and abilities during an interview with the auditor. In addition to receiving mentoring with two doctors, the manager attends the NZ Aged Care Conference annually and in the past year has attended sessions on medications in primary health care, restraint minimisation, a first aid update, palliative care, documentation and legal and ethical considerations in healthcare.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.2: 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

Attainment and Risk: FA

Evidence:

The clinical coordinator accepts responsibility for management of Calvary Hospital in the absence of the manager. She is a registered nurse with a current annual practising certificate who works alongside the manager on a day to day basis. She has had previous experience in district nursing, surgical nursing and neonatal care. The clinical coordinator has been in her role for five years and is maintaining her professional development. Her training records show attendance at courses on outbreak management, wound management, managing violence in the workplace, palliative care, medication management and automated external defibrillation within the last 12 to 24 months. She attends the NZ Aged Care Conference on an annual basis.

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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The quality and risk management system is underpinned by the quality and risk management plan. This plan describes fifteen processes of ways in which the service will meet their quality philosophy. Related goals cover issues around governance and management, their contractual obligations and certification requirements, quality priorities and targets, surveillance and reporting systems, internal audit systems, corrective action processes and meeting terms of references, agendas and minutes.</p> <p>Policies and procedures and other controlled documents are primarily being managed by an office administrator who states she knows and records where copies of all versions are, is the only person responsible for making changes and archives all changes that are dated for ten years. The system is viewed and there is evidence that all documents are controlled, they are reviewed every two years, or as required, and the policy on the control and management of documents is being followed.</p> <p>A comprehensive list of meetings and distribution of the minutes show that all levels and categories of staff are included in consultation about quality and risk management. The quality management team meets every two months to monitor the quality and risk plan. This is confirmed during interview with 11 staff in a variety of roles who say they are invited to participate and to become involved and that graphs and reports and meeting minutes are passed on to them and put on display in the staff room. Meeting minutes of the last three quality and risk management meetings are sighted and provide evidence that key components are being covered. These include reports on the environment, emergency management, hazards, food services, physiotherapy, restraint, equipment, health and safety, housekeeping/laundry, staff training, infection control, internal audits, corrective actions and compliments/complaints. Results of the analysis and the review of quality data from each area and for each component of quality management are presented at the following quality meeting. Quality improvements are being identified from these processes.</p> <p>Internal audits are a shared responsibility among staff and they are being undertaken according to a comprehensive schedule. Corrective actions are being implemented</p>

as required and a form for the purpose has a section for timeframes for resolution and ongoing review. An audit trends form is also in use and helps the reviewer to identify trends and prepare a report for the quality meeting. Surveys for staff and for resident are undertaken every one to two years and the results are analysed.

A risk management plan is sighted and notes that Calvary Hospital is committed to gathering, and analysing information from a variety of sources relating to business planning, environment, human resources, service and clinical management in order to decrease risks, unacceptable outcomes and minimise liability. The plan defines risk, includes how to assess the level of the risk and details the risk management process. The key components of the risk register include the identified risks, details, of it, mitigating strategies, actions taken or to be taken, level of risk, risk category, person responsible-management and staff, date logged and date updated. A risk register covers risks associated with clinical, human resource, environmental, organisational and governance aspects of the service and is updated as part of the ongoing quality management meetings.

There is a comprehensive occupational health and safety policy that covers the organisation's responsibility in ensuring, as far as practical, all employees, contractors and other groups are safe from injury and risks to health while at work. Processes include hazard identification, hazard management, accident and incident reporting, investigation and treatment, training and supervision, emergency planning and readiness, protection of employees from onsite work taken by contractors and sub-contractors, evaluation of the health and safety plan, employee consultation and participation, rehabilitation and back to work processes, and continuous quality improvement, as identified in Standard 1.1.8.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The incident and accident reporting process for staff, or serious harm to the patient/resident is included in the occupational health and safety policy. The incident and accident policy for residents is also sighted and describes the process of completion of the form for any type of incident and how it is reported through the quality management system. Incidents and accidents are recorded on an incident form and are followed up with treatment or remedial action as required. This is noted on the form and is followed up by the clinical coordinator. Examples of incident forms are sighted. All are filled in, followed up and signed off. The clinical coordinator and health and safety officer are analysing the numbers of different categories and creating graphs to illustrate the findings. Meeting minutes show that trends are being discussed at the quality meetings and follow-up preventive actions are occurring, especially at the individual level. Examples of preventive interventions sighted are: a person who was prone to falling being given a sensor mat; a 'wanderer' was transferred to a secure unit; staff education was given on ensuring residents are wearing supportive footwear when up and about; and activities were increased between 4.30 and 6.30 pm. Evaluations are being done through the ongoing analyses of trends from incident reports. Where corrective actions are implemented at the organisational level these are evaluated through the corrective action log and internal audit systems.

An open disclosure policy that is sighted states that any adverse or unplanned event is reported to the resident and/or their family as soon as practicably possible and within 24 hours of the event occurring. The incident forms indicate who has been informed and at what time. Two sets of progress notes provide additional details of follow-up with family following open disclosure.

It is evident during interview that the manager and clinical coordinator are aware of their responsibilities around reporting issues, such as major complaints, major incidents, theft and marked changes of condition, to the relevant authority.

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.

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence:
A records folder of annual practising certificates of health professionals associated with Calvary Hospital is sighted. This is divided into quarters and shows the timeframes and expiry dates with printed records or photocopies on file of practising certificates for the registered and enrolled nurses, a podiatrist, a physiotherapist, qualified nurse assistants, a dietitian, the pharmacist and for doctors. Records of individual expectations of each GP for standing orders are also in this file and are up to date.
Thirteen personnel records of staff are sighted and reviewed for evidence that recruitment and ongoing human resources processes are ensuring that staff of an acceptable calibre are being employed. Recruitment records are absent for staff who have been in the service for many years but curriculum vitae and results of referee and reference checks for the remaining employees are in place. Three monthly reviews following commencement of a role are occurring and all personnel records show

that annual performance appraisals are up to date for the remaining nine staff in the sample.

A comprehensive orientation/induction programme is in place. This includes a resource folder and a checklist that covers a series of competencies. Each is checked off when completed. The orientation programme is structured in a manner that ensures the specific needs of different roles are accommodated and the objectives of each are clearly defined. A series of questionnaires also require completion and cover the topics of fire safety, infection control, health and safety and an organisation wide one. The latter requires completion each year by all staff and covers a miscellaneous set of topics including residents' rights. Eleven caregiver staff inform during interview that they receive a good orientation that seems over the top when they first see it but find they later really appreciate how thorough the process is as it holds them in good stead.

All registered nurses complete first aid and have current updated certificates on file. Interviews with the manager and with eleven staff and the registered nurse all state that the management team is supportive of ongoing education for staff. An education facilitator oversees the training requirements of all staff at Calvary Hospital and there is evidence of ongoing progress occurring as a result of her input. She is currently progressing towards becoming an assessor for the Aged Care Education (ACE) programme. An education plan is sighted for 2012/13 - 2014 with both external and internal training opportunities listed. Despite a list of compulsory training not all items are included in this plan. Records of attendance indicate that attendance is often poor and cancellations have occurred without replacement sessions being scheduled. The education facilitator informs of people having attended training on certain topics; however these are not recorded. The overall planning, facilitation and recording of training is an area that requires improvement.

Hospital aides and caregivers are required to undertake the national certificate of the ACE training programme. Only seven have not commenced and this is reportedly due to recent employment. Twelve have completed the basic foundation skills part of the programme, five have gone on to complete the advanced level of the certificate and four have also completed the dementia module.

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: An education facilitator oversees the training requirements of all staff at Calvary Hospital. An education plan is sighted for 2012/13 - 2014 with both external and internal training opportunities listed. Despite a list of compulsory training not all items are included in this plan. Records of attendance on spreadsheets for the different categories

of staff indicate that attendance is often poor. The record of sessions provided show cancellations have occurred without replacement sessions being scheduled.

Finding:

The system in place to facilitate and record on-going training for service providers is not currently demonstrating that the identified compulsory training is being attended as required and not all training undertaken is evident in the recording system.

Corrective Action:

Service providers are to complete compulsory training as required and the recording system will reflect attendance in an accurate manner.

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

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

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

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

Attainment and Risk: FA

Evidence:

A staffing levels and skill mix policy that is sighted ensures there are adequate staffing levels and staff skill mixes in place at Calvary Hospital as it details the requirements for the rosters in both the hospital and residential wings of the facility. The policy includes the dependency and acuity levels, which are to be discussed each morning and the registered nurses, along with enrolled nurses, provide nursing care for patients who require specialist care. Eight of eight caregivers/hospital aides are confident that staffing numbers are safe, albeit they often 'get busy', and confirm staff are replaced when a person goes on annual leave or is unwell.

The manager and clinical coordinator work Monday to Friday. Three weeks of rosters for the hospital wing are sighted and show that there are ten staff working different shifts in the hospital. Two registered nurses, or a registered and an enrolled nurse are on duty every day for eight hours. The manager informs one is in charge and the other second in charge. Eight others are on duty and include a mix of enrolled nurses and hospital aides with two doing an eight hour shift, two doing a six and a half hour shift and four doing a five and a half hour shift. An enrolled nurse and a caregiver work eight hour shifts in the rest home wing with an additional caregiver working six and a quarter hours on all seven days of the week.

The afternoon shift has a total of nine staff working at different times with two of them being registered nurses, or one registered and one enrolled nurse. The latter mix is more often the case with the registered nurse doing an eight and a half hour shift. Two hospital aides or enrolled nurses do eight hour shifts, one does a six hour shift and four staff work four and a half or five and a half hour shifts. One enrolled nurse works the full shift 2.45pm – 11.15pm in the rest home, while one caregiver works 2.45pm – 7.30pm and another 4.45pm – 10pm. This roster remains the same on all seven days of the week.

Auxiliary staff of physiotherapists and activities staff may also be on site with the latter covering seven days.

Night staff work a four days on duty and a four days off duty roster of ten hour shifts. A registered nurse and a hospital aide are rostered for the hospital and a caregiver works in the rest home with access to the registered nurse if required.

The manager or the clinical coordinator is paid to be on call 24 hours a day seven days a week when both are off duty. A registered nurse will be paid to be on call if both are away or on leave.

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>Six patients' and three residents' files are reviewed. Information is entered onto an admission form in a timely manner and included as the front sheet in the integrated notes. A label is developed for all patients and fixed to each record as sighted in all pages in the files reviewed. All records are observed to be stored in the office area of both service areas. Records reviewed are legible and the name and the designation of the provider are identifiable. A signing register for allied health is maintained. Patient and resident records are not integrated into one current or archived file and this requires improvement.</p> <p>Archived files are securely stored and easily retrieved.</p>

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

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

Attainment and Risk: FA
Evidence:

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

Criterion 1.2.9.7 (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.

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: PA Low

Evidence:

Hospital and Residential: There is a ring binder file for each patient/resident that maintains current integrated notes. On discharge, notes are archived into a large brown envelope (sighted). Short term care plans are developed for issues such as skin tears, wounds and urinary tract infections; however these are not integrated into the resident or patient records, but retained in a separate folder in the office of each service.

Hospital: Multidisciplinary (MDT) meeting notes pertaining to each patient are recorded on a record sheet alongside the MDT notes of all other patients. The information is not transferred to the patient's integrated notes and is retained in the folder even following the discharge of the patient and archiving of the records.

Residential: Notes relating to each resident's activities, family support, preferences are recorded in a hardcopy record book in the diversional therapists (DT) office. When a resident is discharged there is no ability to archive these records into the resident's integrated notes.

Finding:

Hospital and Residential:

Short term care plans are developed for issues such as skin tears, wounds and urinary tract infections; however these are not integrated into the resident or patient records, but retained in a separate folder in the office of each service.

Hospital:

Multidisciplinary (MDT) meeting notes pertaining to each patient are recorded on a record sheet alongside the MDT notes of all other patients. The information is not transferred to the patient's integrated notes and is retained in the folder even following the discharge of the patient and archiving of the records.

Residential:

Notes relating to each residents activities, family support, preferences are recorded in a hardcopy record book in the diversional therapists (DT) office. When a resident is discharged there is no ability to archive these records into the resident's integrated notes.

Corrective Action:

All records pertaining to patients and residents are integrated into one current or archived file.

Timeframe (days): 180 (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

Attainment and Risk: FA
Evidence: <p>The admission package provided to all prospective patients and residents includes information and a brochure that details all requirements for both parties on admission to the facility. Admission agreements are completed for all patients/residents (six hospital and three rest home records sighted). Of those reviewed a needs assessment and service co-ordination (NASC) assessment occurs prior to all admissions to ensure the admission is appropriate.</p> <p>Patients/residents and family members interviewed confirm that the facility ensured the admission was timely and managed with dignity and respect, taking into account the family and resident's identified needs. One of one family member confirmed that the facility admitted the patient into the hospital in a timeframe suitable to the patient and family.</p> <p>There is a comprehensive assessment process on admission and on-going to ensure that all the residents' identified needs are met (documentation sighted). The admission agreement includes a statement as to when the facility requires a 'difficult resident' to leave the facility, and the clinical nurse manager (CNM) during interview confirmed this has not recently occurred, but has in the past (over two years ago).</p> <p>The relevant ARRC requirements are met</p>

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.

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

Standard 1.3.2: 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

Attainment and Risk: FA

Evidence:

The facility manager and the CNM, both interviewed, review admissions prior to acceptance to ensure the admission is appropriate. There is a documented waiting list maintained (sighted) that includes the details of the prospective resident, and communication if the management team feel that admission is not appropriate. Supporting the waiting list is admission screening processes managed by NASC. When a resident becomes unsuitable for the facility, this is then referred to NASC, however this has not occurred since the previous audit.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Six hospital patient files and three rest home residents' files are reviewed.
All files reviewed have an interRAI assessment completed prior to admission to the facility.

Care plans are developed within required timeframes based on NASC, general practitioner (GP) and detailed registered nurse (RN) and enrolled nurse (EN) assessments. The long term care plan includes identified needs/problems, goals and timeframes, and interventions in all service areas, including personal care needs, skin care, elimination, respiration, cardiovascular, communication and sensory, mobility, pain and comfort, safety, social needs, including sexuality, cultural and spiritual, nutrition, continence and behaviour needs.

A short term care plan has been developed if required for skin tears, wounds, infections, and mobility issues, as sighted in the short term care plan folder.

Discussion with the (EN) (residential) care staff and observation during the audit provide evidence that consultation with the RN relating to service provision occurs regularly. Care staff (interviewed) are observed consulting the care plan to verify the residents' care needs. Interview with one carer verifies she provides services reflective of the care plan content.

A handover from morning to afternoon shift is observed during the audit and confirms staff refer to handover notes as a reference and the content is consistent with the progress notes written for each shift (records sighted).

The facility has several GPs that visit the facility. One GP is interviewed and confirms the facility provides a high level of care and assessments and he is always notified in a timely manner of any issue. He is advised by fax or telephone of patient/residents needs prior to his weekly visit. He is very complimentary of the facility RNs and service provision.

Family members interviewed confirm that contact with them occurs regularly, either verbally on site or by phone, and is recorded in the patient/residents' progress notes or as part of the multidisciplinary team (MDT) meeting record form (records sighted).

Tracer methodology: Hospital patient

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

Tracer methodology: Residential resident

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

The relevant ARRC requirements D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e are met

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Standard 1.3.4: 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

Attainment and Risk: PA Low

Evidence:

Prior to admission the NASC agency completes an interRAI assessment to ensure that patient/resident placement is appropriate. The facility RN or EN completes appropriate patient/resident assessments (records sighted) on admission to the facility. Falls risks, pressure area risk and nutritional assessments are completed initially and at least six monthly for all patients/residents. However the information gained in the assessment tool, and in challenging behaviour forms is not always transferred to the patient's/resident's long term care plan and this requires improvement. If required, a wound assessment is completed. Goals are developed based on the nursing diagnosis and those reviewed are individualised and specific to the issue identified during the assessment process.

The facility has developed a continence assessment tool, but this has not yet been completed for all residents/patients who have continence issues and this still requires improvement.

Resident files reviewed are completed in a timely manner by the EN or RN. If an issue arises within the six month review timeframe, an appropriate assessment tool is completed prior to the development of a short term care plan. For example, two files have completed wound assessments and a short term care plan developed. At the six month review, the short term care plan is closed and the issue is transferred to the long term care plan, including the increased risk.

The ARRC requirements D16.2 are met.

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.

Attainment and Risk: PA Low

Evidence:

Hospital and Residential:

Falls risks, pressure area risk and nutritional assessments are completed initially and at least six monthly for all patients/residents. However the information gained in the assessment tool is not always transferred to the patient's/resident's long term care plan. For example one resident who now requires wheelchair for mobility, and a patient who requires assistive aids for transfers, does not have the information included on their long term care plan.

The facility has developed a continence assessment form to be completed for patients and residents who have continence issues, however in the files of those with incontinence reviewed (four hospital patients and two residential residents) a continence assessment has not been completed. The CNM is interviewed and is aware of the prior required improvement and is in the process of completing the required assessments.

There is a challenging behaviour form, however one of one resident who displays aggressive behaviour, does not have a consistent and regular behaviour assessment completed, and strategies to reduce or minimise the behaviour included on her care plan.

Finding:

Hospital and Residential:

Information gained in the initial and on-going assessment tools is not always transferred to the patients/residents long term care plan. For example one resident who now requires wheelchair for mobility, and a patient who requires assistive aids for transfers, does not have the information included on their long term care plan.

The facility has developed a continence assessment form to be completed for patients and residents who have continence issues, however in the files of those with incontinence reviewed (four hospital patients and two residential residents) a continence assessment has not been completed. The CNM is interviewed and is aware of the prior required improvement and is in the process of completing the required assessments.

There is a challenging behaviour form, however one of one resident who displays aggressive behaviour, does not have a consistent and regular behaviour assessment completed, and strategies to reduce or minimise the behaviour included on her care plan.

Corrective Action:

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.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The facility CNM, EN and RNs are interviewed. There is a comprehensive initial assessment undertaken for all patients and residents on admission to the facility, including individual assessments for pressure area risk, falls risk and nutrition (documentation sighted). On-going assessments are occurring by the EN, the RNs and allied health professionals. Patients/residents and family members interviewed verify care provision is occurring in line with the patient and residents identified needs. Care staff interviewed confirm they refer to the care plans, particularly after days off to ensure there is no change in interventions.

Assessment information gathered during the initial and on-going assessment process for mobility (physiotherapist), nutrition (dietitian) and challenging behaviours (behaviour form) is not always transferred as interventions on the resident's or patients care plans and this requires improvement.

The facility is in the process of introducing new care plans which can be electronically generated, and have the review section included. Three of three new care plans in the hospital section are reviewed. All care plans reviewed (including the three new plans) are detailed and meet requirements.

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

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

Attainment and Risk: PA Low
<p>Evidence:</p> <p>The facility CNM, EN and RN's are interviewed. There is a comprehensive initial assessment undertaken for all patients and residents on admission to the facility, including individual assessments for pressure area risk, falls risk and nutrition (documentation sighted). On-going assessments are occurring by the EN, the RN's and allied health professionals. Patients/residents and family members interviewed verify care provision is occurring in line with the patients' and residents' identified needs. Care staff interviewed refer to care plans for service interventions.</p> <p>Assessment information gathered during the initial and on-going assessment process for mobility (physiotherapist), nutrition (dietitian) and challenging behaviours (behaviour form) is not always transferred as interventions on the residents' or patients' care plans.</p> <p>In two of two resident files reviewed falls are recorded in the intervention section rather than the strategies identified during assessment process to minimise the risk of falls.</p>
<p>Finding:</p> <p>Assessment information gathered during the initial and on-going assessment process for mobility (physiotherapist), nutrition (dietitian) and challenging behaviours (behaviour form) is not always transferred as interventions on the residents' or patients' care plans.</p> <p>In two of two resident files reviewed falls are recorded in the intervention section, rather than the strategies identified during assessment process to minimise the risk of falls.</p>
<p>Corrective Action:</p> <p>Long term care plans describe the required support and interventions to achieve the identified outcomes identified during the assessment process</p>
<p>Timeframe (days): 180 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA
<p>Evidence:</p>
<p>Finding:</p>

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility's CNM or RN documents appropriate interventions on the resident's short term or long term care plan, based on prior assessments. Care plans reviewed are consistent with meeting the resident's identified needs and outcomes, are evaluated regularly and the care plan is either updated or a short term care plan is developed. Progress notes are written by care staff and those sighted confirm residents' needs are met and service delivery is provided in a timely manner. Staff are observed providing care to residents based on the care plan intervention. For example, one resident has strategies to manage her challenging behaviour, and this is observed occurring during the audit.

GP assessments sighted are detailed on the medical clinical form in the integrated patient's/resident's file and the subsequent intervention are included on the patient's/resident's short term care plan (sighted). For example, GP recommendations and interventions to treat a leg wound are included on the patient's short term care plan.

Residents and family interviewed confirm service delivery is consistent with meeting the resident's desired outcomes and they are involved in the review process, as evidenced in the family communication form and residents' MDT team meetings (records sighted).

The ARRC requirements D16.1a; D16.1b.i; D16.5a; D18.3; D18.4 are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Six hospital patients and three residents' files are reviewed. The activities person and diversional therapist (DT) are interviewed. The DT develops the activity programme each month following an activities meeting (minutes sighted).

In the residential care area the DT implements activities for residents Monday to Friday. Three activities persons provide activities for the patients in the hospital over seven days. There are two activities persons on each day. A social profile is developed on admission to the facility in all those that are reviewed. An activity plan is developed following the completion of the resident's long term care plan. Activity plans are reviewed six monthly identifying progresses and attendance at either group or individual activities. It is recommended that activity plans are more individualised to the patient/residents' preferred interests.

In both areas an activity programme includes: reminiscing, bowls, reading, quizzes, puzzles, housie, entertainers, card making, magnetic fishing game, movies, outings, sing a longs, exercises, painting, bible study, church services, rosary and mass. A pastoral carer (interviewed) assists with chapel services.

Patients/residents and family members interviewed confirm there is always something to do at Calvary Hospital.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility's CNM is interviewed along with the EN in residential and the RN in the hospital wing, regarding care plan evaluations. Nine patients'/residents' files are reviewed (six hospital and three rest home) and all are evaluated six monthly in line with required timeframes. Assessments are sometimes completed prior to the review of the care plan (refer CAR 1.3.4.2). The facility also evaluates residents' care if progress is less than expected, using the relevant assessment tools. A short term plan is then developed indicative of the resident's changed needs. Two records sighted include short term care plans reflective of their changed needs, and evaluations are included following resolution of these.

Patients/residents and family members interviewed verify they are included in care plan evaluations as part of the MDT process (records sighted) and there is evidence of this also documented in the residents' progress notes (sighted). Care staff interviewed are able to demonstrate knowledge in following short term care plans and evaluations when needs change.

The ARRC requirements D16.3c; D16.3d; D16.4a are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Standard 1.3.9: 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

Attainment and Risk: FA
Evidence: <p>Nine patients'/residents' integrated files are reviewed and the CNM, EN and RN are interviewed. Six of six files reviewed have evidence of referral to other health and disability services. For example, six patients/residents have been referred to the facility's physiotherapist. One resident referral is to a dietitian. Referrals are included in the integrated notes (sighted). The physiotherapist, podiatrist and dietitian documents recommendations in the integrated notes (records sighted for physiotherapists consultation).</p> <p>The CNM (interviewed) confirms that, if required, the facility will accompany residents on appointments if the family member is unavailable.</p> <p>Family and residents (interviewed) provide examples of input from other health and disability services, including the Invercargill Hospital outpatient services.</p> <p>The ARRC requirements D16.4c; D16.4d; D20.4 are met.</p>

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.

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

Standard 1.3.10: 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

Attainment and Risk: FA
Evidence: <p>One discharged resident's file is reviewed, and one transfer to and from hospital.. The General Manager and CNM are interviewed and verify all discharges include the involvement of the resident, family and GP and this is confirmed in documentation sighted. A discharge or transfer form is completed (sighted) and details any persons involved, any risks and measures to minimise the risk. The file reviewed is completed with evidence of family and GP involvement prior to the discharge and ensuring the resident's medications are available following discharge. One resident's transfer forms to and from hospital are sighted and complete, and the information is transferred to the resident's integrated notes on the day of transfer.</p> <p>The ARRC requirements D21 are met.</p>

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.

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>Policies and procedures for medication management reviewed detail each health professional's responsibility in relation to medicine prescribing, administration, reconciliation, dispensing, storage and disposal.</p> <p>The facility has a robotic pack medication system in place for all patients/residents requiring medication assistance. The robotic packs are reconciled into the facility by the night RN (records sighted) monthly. Discontinued medications are returned to the pharmacy at least daily if required, including controlled medications as sighted in records signed by the RN and the pharmacist.</p> <p>The resident's prescription medication record is completed electronically by the resident's GP and administered by the facility care staff. The typed record is legible and each record signed individually by the GP including when discontinued. The prescriber faxes medication prescriptions to the pharmacist, who develops the electronic record, this is then couriered to the GP for signing, and collected by the facility. The facility is commencing a trial of 'MedMAP' for medication management.</p> <p>An enrolled nurse (EN) and a carer are observed administering medications on the days of the audit. Both have medication competencies (sighted). The medication trolley holds all current medication, robotic packs and medication records and is observed to be locked and securely stored when not in use.</p> <p>Controlled drugs are reviewed and storage is in line with guidelines. There is a separate medication fridge and temperatures are recorded (observed) and within recommended guidelines.</p>

Eighteen medication files are reviewed. PRN (pro re nata) medication is recorded to a level of detail to indicate the intended use, for example for nausea, chest pain, coughing and pain.

There are no residents who self-medicate, although there are policies, procedures and resources in place should this occur.

The ARRC requirements D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d are met.

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

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

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

Criterion 1.3.12.3 (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.

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

A range of food service policies and procedures are sighted during stage one of the audit.

On admission all new residents have a personal nutritional needs profile completed. This profile covers food preferences and dislikes, any special or modified equipment, any special dietary need, food allergies or intolerances and whether or not they require assistance with feeding. A dietitian is employed to review the nutritional profile of all new hospital residents, any rest home resident for whom any special dietary need is identified and to review any significant changes in weight of a resident(s). An interview with the dietitian, who explains her role more fully, is undertaken during the audit. The dietitian formally reviews the menu every two years, however makes modifications between these timeframes if an issue arises. The menu has a four weekly cycle with winter and summer variations and the most recent review was February and March 2014. It is evident that the main meal is in the evening each day except for Wednesday and Sunday, which the dietitian advises is her recommendation as it seems to help residents to settle better at night. The dietitian's visits to Calvary Hospital may be unplanned, which enables her to see that the menu is being followed and individual needs are met. She is involved in the reviews of service delivery plans of residents who have special dietary needs as part of their care package and has ongoing email correspondence with the clinical care coordinator as required. Plates with raised sides, cutlery with built up handles, thickened fluids, soft and puree meals, fortified drinks and small and large quantities are examples of individual needs being met. Meal orders are updated daily and records of these are sighted.

Food preparation occurs in an on-site kitchen and qualified chefs lead the cooking. During interview with the kitchen supervisor explanations are provided about how staff follow the nutritional profiles provided by the registered nurses and the dietitian, how ongoing communication occurs with the dietitian and how the Hazard Analysis and Critical Control Points (HACCP) programme is maintained. The kitchen has a HACCP certificate dated March 2014 on display. Maintaining this programme ensures all food procurement, production, preparation, storage, transport, delivery and disposal follow safe guidelines and meet all legislative requirements. Records are sighted for all aspects of the programme and include temperature recordings of chilled and frozen food products on delivery, twice daily checks of fridge and freezer temperatures and twice daily recordings of hot food temperatures at two stages prior to serving. The supervisor notes all leftovers are disposed of through the insinkerator, sandwich fillings are dated and kept for 24 hours, original packaging of dry goods is kept with the container, all fridge and freezer goods are dated and kept sealed and a strict cleaning schedule is monitored and signed off by each kitchen hand. Visual observation is made for each process described by the supervisor and staff training records confirm that all cooks and kitchen hands undertake an annual refresher on food safety.

Each level of the management of residents' food and nutritional needs is dealt with in a meticulous manner with attention to detail from the assessment of individual needs through to the disposal of unused food. Three residents in the hospital wing speak favourable about all the meals and inform that options are offered 'if you don't like something'. Two residents in the rest home dining room are also positive about the meals and say there is nothing they can complain about regarding the food.

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.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>There are policies and procedures (sighted) in place for the safe management and disposal of all waste including general, documents (confidential), contaminated and clinical waste, hazards and chemical spillage. The facility has a waste officer and a maintenance officer to ensure compliance with waste standards occurs.</p> <p>General rubbish is disposed of into skips, which are managed by a contractor. The maintenance person oversees this process and informs he will contact the contractor if additional removals from those scheduled are required. All food scraps are disposed of via an insinkerator, or in the general rubbish. The sharps containers are removed and replaced by the laboratory staff who visit the facility. Infectious waste goes in yellow bags and is disposed of in the general rubbish system. The maintenance person takes some recycling items to the local refuse station.</p> <p>Personal protective equipment of plastic aprons is available and staff are observed using them. Plastic gloves are readily available throughout the building and caregiver, cleaning and kitchen staff are all observed using plastic and/or rubber gloves. Plastic goggles and face shields are accessible to staff in sluice room areas. A pandemic kit has additional supplies of protective equipment. During an interview with eleven staff, all inform they have good access to protective equipment including shoe covers and gum boots depending on personal preference.</p>

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.

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

Criterion 1.4.1.6 (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.

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

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

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

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

Attainment and Risk: FA

Evidence:

The building warrant of fitness is dated 14 May 2014 with an expiry date of 14 May 2015. A certificate of compliance for the maintenance checks of fire and emergency warming systems is also checked and is current.

A transportation of residents/patients policy as required in the contract is sighted.

During an interview with the maintenance person, he shows a comprehensive set of checklists that are categorised according to timeframes and frequencies. Items include vehicle maintenance, internal audit processes, hazard register reviews and preventive maintenance for example. Annual checks of electrical equipment are being maintained and records of these are sighted. To facilitate this process the maintenance person informs he has been trained at the required level of competency and evidence of this is sighted. The correct equipment has been purchased and he is observed undertaking this role during the audit. The maintenance person maintains equipment such as wheelchairs and walking frames, as well as any item that malfunctions. He also repairs damage to the building that sits within his level of competence. A list of preferred suppliers for trades is sighted. Staff enter any requests for repairs or maintenance into a book and there is evidence that attention is paid to these within 24 hours at the most, unless parts need to be accessed to complete a job.

A comprehensive list of specialist equipment that requires calibration, checking or monitoring in some way, such as hoists, electric beds, scales, oxygen concentrator and sphygmomanometers is also sighted. Some of the medical equipment that requires specialist checking is marginally overdue as it was last completed 14 May 2013. There is limited access in Southland to companies who will undertake this role and correspondence that relates to the efforts made to have this addressed is sighted. The auditor is provided with a confirmed date of early June from the company. There is no suggestion of any risk associated with this delay.

There is no evidence of immediate hazards in either the internal or external environments that residents and staff move around or operate within. Hand rails are in place along hallways, there are no mats or uneven surfaces and the corridors are wide. Overall the rooms are spacious and openings into rooms such as dining areas, the chapel and lounges are wide. It is noted that staff move beds and large lazy boy chairs around the hospital area of the facility with ease.

The facility sits on a number of acres and includes an open park-like environment. Immediately outside the facility and in sheltered patio areas there are plantings of flowers and shrubs. Small patio areas have level entry to and from the building and the patios are safe to mobilise around with equipment, such as walking frames and wheelchairs.

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

All buildings, plant, and equipment comply with legislation.

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

Criterion 1.4.2.4 (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.

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

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

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

Attainment and Risk: FA
Evidence:

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

Standard 1.4.3: 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

Attainment and Risk: FA
Evidence: There are adequate numbers of accessible toilets/showers/bathing facilities. There are 20 shared ensuites each with a shower, a hand basin and a toilet attached to residents' rooms in the hospital. No ensuites are attached to residents' rooms in the rest home wing. Throughout the facility there is otherwise five shower and toilet combinations, three rooms with a shower and bath, two showers and thirteen toilets for residents' use. Two rest home residents say they are happy about not having an ensuite as they never had one at home, therefore do not miss it. The maintenance person explains that hot water temperatures are checked every two months and records sighted confirm it is no more than 65 degrees Celsius in the kitchen and no more than 45 degrees in areas used by residents.

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.

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

Standard 1.4.4: 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

Attainment and Risk: FA

Evidence:

Residents' rooms are generally spacious with those in the hospital wings larger than those in the rest home. This enables the additional equipment to be moved more easily. There are three shared rooms in use in the hospital wing. A relative informs that the staff are very respectful of both the residents' needs and of relatives in the shared rooms. Two rest home residents say their room is plenty large enough despite them having brought some furniture from home. They say they can have any personal items they want and that they have lovely views from 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 manoeuvres with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There is a main lounge in the rest home area and another large lounge in the hospital wing. A separate dining room is in the hospital wing and another in the rest home. Other smaller sitting areas with pleasant views are available for people to move to as they wish. Most of the in-house activities are undertaken in the activities room that is specific for its purpose. The activities coordinator notes that there is always somewhere for people to go and that the distances encourage people to walk more.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Calvary Hospital housekeeping and laundry policies and procedures detail the requirements for the safe and hygienic maintenance of the facility and laundry. Training requirements of staff are included.

The monitoring of the effectiveness of laundry and cleaning processes primarily occurs through the internal audit system. According to the internal audit schedule, laundry

and cleaning audits are undertaken twice a year and records for the last of each of these audits are sighted with only minor issues for correction. Management of the labelling of clothes is the main concern, despite a number of processes in place to minimise this occurring. The supplier of cleaning and laundry products provides training to cleaning and laundry staff.

The laundry and cleaning information and schedules are available to all those who work in the area and these include details of safety issues around the storage of chemicals, health and safety and infection control. Laundry and cleaning product information sheets are available and are sighted.

The head of cleaning staff has been at Calvary Hospital for more than 20 years and is interviewed during the audit. She informs of how the cleaning schedule is managed and how she ensures her staff are aware of health and safety and infection control issues for example. Bulk cleaning chemicals are stored in a locked cupboard and the two cleaning trollies that have cleaning products on them are stored here when they are not in use. The cleaners accept responsibility for the trollies while working and there is a rule that they must remain within their line of sight at all times. This practise is observed during the audit.

Sheets, towels and pillow cases are laundered by a contractor who picks them up and delivers them back clean. Personal laundry is done in an on-site laundry with commercial machines. A brief interview is undertaken with the key person who accepts overall responsibility for the laundry, although two others do assist her. The laundry, where laundry chemicals are held is locked when unattended. Laundry products are automatically dispensed by the machine, rather than bulk stored.

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.

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

Criterion 1.4.6.3 (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.

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

Standard 1.4.7: 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

Attainment and Risk: FA

Evidence:

The building has fire sprinklers installed throughout, including in wardrobes in residents' rooms. Smoke detectors are in place and firefighting equipment of hoses and fire extinguishers are installed throughout. A contractor completes six monthly reviews of fire and emergency management systems in addition to monthly tests of the alarm system with records showing the last two review visits were 3 October 2013 and 27 February 2014. A fire training officer works with the fire service to ensure fire training is undertaken by all staff, rather than full evacuations, although trial evacuations to a 'safe cell' within the building may occur. The six monthly fire training, which is compulsory, was last undertaken 14 May 2014 and all registered nurses are trained as fire wardens. A fire safety questionnaire is undertaken at orientation and is distributed to staff with their pay slips on an annual basis and the records of completion are noted in a fire training register. Emergency management flip charts are visible throughout the building. These guide staff in the management of bomb or arson threats, armed confrontation, a civil defence emergency or disaster, fire, earthquake and a security alert. An approved letter of the evacuation plan from the fire service is dated September 2013.

Battery back-up is available for emergency lighting in the event of power failure. An emergency kit and an emergency medical kit, which are being checked every six months, are sighted. Sufficient food for the service to be self-sufficient is stored and there is a tank of water for emergency purposes. Diesel back up is available to heat the water for the radiators if required; there is a gas oven, a gas barbecue and a gas cooking top.

A call bell system is in place and call bells are accessible to residents throughout the building in communal lounge areas, bathrooms, dining areas and personal bedrooms. The call bells light up above the door of the room the alert is raised from, and the exact room number or bathroom is visible digitally at the ends of the different corridors. Bells are operational on the day of audit; however the screen in the nurses' station that also informs of the exact location ceased to function the weekend before the audit. The maintenance person advises that a part needs to come from elsewhere in the country before it can be repaired. Meantime all staff are informed via the communication book and aware it is not working and a notice is on the screen.

Security systems in place include the locking of doors at 8.30pm and the closing of curtains at nightfall. It is the role of an enrolled nurse in residential to check the doors are locked. Windows are on security latches and a visitor sign in and sign out book is at the front entrance. Automatic security lights are installed at the main entrances. Once a night at varying times a security company is contracted to check the grounds and some doors. The security company leaves a card under a door with the time of the visit (an example is sighted). Staff are informed they may call this company if they have lesser security concerns that do not necessarily need to be alerted to the police immediately. The security company staff will inform staff of anything untoward such as an unlocked door.

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.

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Standard 1.4.8: 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

Attainment and Risk: FA

Evidence:

The residents' rooms all have a window of reasonable proportions that is able to be opened and has security latches in situ. Communal areas are light, airy and have windows that can be opened. In the larger communal lounge and dining areas there are glass patio doors to garden areas. Fans are reportedly used in summer months when required. Two residents in the rest home wing state 'it is always warm like this in here' and that 'one thing about this place is that it is always warm'. A resident in the hospital wing states she is only cold whenever she goes outside nowadays, since she has been at Calvary Hospital.

The facility is heated via wall mounted hot water filled radiators. The hot water is heated by electricity with diesel back-up. Metal coverings protect the residents from the hot surfaces of the radiators. Five heat pumps are also installed throughout the building. The maintenance person informs he does random temperature checks around the facility, especially when he receives complaints of areas being too hot or cold. There are no records of these but one staff person independently informs that the maintenance person is always making sure it is warm enough for the residents.

Cigarette smoking is only permitted outside. Residents may go to a courtyard area and a sheltered area out the back is available for staff. There are not currently any residents who smoke at this facility.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

NZS 8134.2:2008: 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

Attainment and Risk: FA
Evidence:
<p>Policies and procedures on restraint minimisation and safe practice are in place and are sighted at audit. There is also reference to restraint minimisation in a policy and procedure on managing challenging behaviour, which was reviewed between stage one and stage two audit. It is noted that the definition of enabler, which meets expectations, is sitting under the definitions of different types of restraint. This is described as an oversight by the restraint coordinator and is remedied immediately during the audit with the document controller. The process around this is observed. An internal audit on the use of restraints and enablers was undertaken by a physiotherapist and the results are sighted.</p> <p>The type of restraints/enablers authorised for use at Calvary Hospital when required are lap belts, a fallout chair, bed rails and a table attached to a chair.</p>

The restraint approval group includes the manager, the clinical coordinator, two physiotherapists and an enrolled nurse. Minutes of the last meeting in April 2014 are sighted, as is a restraint/enabler report in the quality meeting minutes sighted. A restraint coordinator, who is the registered nurse, is interviewed and informs there are not currently any restraints in use at Calvary Hospital. This is also independently reported during an interview with eleven caregivers who are collectively able to clearly inform the difference between an enabler and a restraint. Staff training records show a recent training on this topic has been provided and there is evidence of a diagram in the staff room that clarifies the difference. The restraints register is reviewed and confirms that there has not been any restraint used since June 2013, when a fall out chair was used for one resident. A list of enablers that are currently in use is attached to the register.

The personal files of two of the people who use an enabler in the hospital and one person in the rest home are viewed and include consents for their use that are all signed by the residents themselves. Associated risks for the use of the enablers are documented and reviews are undertaken with the six monthly care plan reviews. The only enabler currently in use is bed rails, which residents are requesting to use for their own safety and/or to help pull them up.

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.

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

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

Standard 3.1: 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

Attainment and Risk: FA

Evidence:

Infection control policies and procedures are reviewed and include the role and responsibility for infection control, the link to the quality meetings and organisational management. The infection control (IC) programme is reviewed annually (sighted) with clear lines of accountability and this is approved by the board and the general manager. All requirements of the IC standard are included. The IC Co-ordinator is interviewed, and provides comprehensive records on monthly data, review and analysis of infections, statistics, and a summarised report provided for the quality meeting (meeting records sighted). There is a report provided to RN and care staff at their monthly meetings (records sighted). Care staff interviewed are able to demonstrate their knowledge on observing, reporting and documenting infections.

The facility's front entrance notice requests persons with 'flu' not to visit and hand gel is available at the front door and throughout the facility for any visitor or resident to use. If there are any internal infections, the facility has processes in place to prevent visitors and to isolate the infection. There has been no internal infections in recent years.

The ARRC requirements D5.4e are met

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Criterion 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.

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

Standard 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

Attainment and Risk: FA

Evidence:

The IC co-ordinator is an experience RN with knowledge and training in IC practice and education (records sighted). The hospital RN's and residential EN documents resident specific IC information, including treatments and conclusions on a monthly data sheet. The IC co-ordinator collects monthly reports and analyses the data into statistics and trends, and tables a summary to the quality meeting monthly (records sighted). A report is included in the agenda for monthly staff meetings (minutes sighted).

Expert advice is gained from the IC specialist and microbiologist at the Invercargill Hospital (Southern DHB) and the resident's GP as required for any resident with an infection (confirmed in GP interview).

Residents and family interviewed verify they are advised of infections and treatments. Observed throughout the facility is hand gel and soap dispensers and education on hand hygiene on walls above hand basins. The facility has an up to date outbreak kit (sighted). There have been no reported outbreaks of infections.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are documented policies and procedures sighted for the prevention and control of infections at Calvary Hospital which align with the IC Standards: 2008, and are reviewed annually. The facility's IC programme is included in the IC manual and links to the facility's practice for IC prevention and control.

Care staff and health professionals interviewed demonstrate their knowledge and responsibilities in relation to IC practice and reporting processes. The IC manual is available in the facility's nurses' station for reference for staff.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 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

Attainment and Risk: FA

Evidence:

The IC Co-ordinator is experienced in IC prevention and control, and attends an annual update day at Invercargill hospital (records sighted). Training records sighted verify that she provides relevant initial and on-going education for staff. IC education is provided initially on induction (six staff files reviewed), and then annually as part of

the internal education programme (records sighted). Induction and orientation consists of an 11 question quiz, and observation of the use of personal protective equipment (PPE) and hand hygiene (records sighted). The annual education session includes hand hygiene, PPE, influenza, coughs and colds, body fluid and blood spills, outbreak management, cleaning and disinfection, waste and laundry practices relating to IC. An IC questionnaire is completed by staff (records sighted).

Care staff interviewed confirm their participation in IC training and demonstrate IC practices (observed). A notice at the front entrance and above communal hand basins provides visual aid in the correct hand hygiene methods (sighted). One of one family member interviewed confirms that the RN has provided guidance and instruction in use of hand gel prior to assisting the patient to eat.

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.

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

Criterion 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.

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

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

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

Attainment and Risk: FA

Evidence:

A form for the purpose of collecting monthly data on all infections is kept in the residential and hospital wing office (sighted). The IC co-ordinator collects the monthly report sheets and the information is transferred to an electronic data analyses sheet (sighted), listing specific infections of urinary tract, skin and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections. Each infection is analysed for trends and patterns against the previous year's data.

Evidence in the last two quality meeting minutes and staff meeting minutes verify that IC surveillance, analyses, conclusions and specific recommendations to minimise reduction in infection have been documented and reported to the board and quality meetings.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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