# The Whalan Lodge Trust

## Current Status: 14 July 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Provisional 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

Whalan Lodge is now privately owned and operated by the Whalan Lodge Trust and is situated in Kurow, North Otago. This provisional audit was conducted to ascertain the Trust’s preparedness to operate Whalan Lodge. The Trust took over the running of Whalan Lodge from the previous owners in December 2013 and they have implemented a business plan and a quality plan. Previously the Trust owned only the land and buildings and leased the business to the previous business owners/managers.

The service provides rest home level care for up to 14 residents. The Trust has employed a manager, who has been in the role for the past six months. She is supported by the Trust, a registered nurse and care staff. Staff turnover is reported as low. The local community have been actively supporting the manager and staff of Whalan Lodge to continue to provide a residential aged care home for the elderly residents of Kurow and the surrounding areas. The quality and risk management programme is managed by the manager and registered nurse and involves the resident on admission to the service. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required around reviewing of activities care plans, aspects of medication management, safe hot water temperatures and calibration of medical equipment.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **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:** | The Whalan Lodge Trust |
| **Certificate name:** | The Whalan Lodge Trust |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Provisional Audit | | | |
| **Premises audited:** | Whalan Lodge | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 14 July 2014 | **End date:** | 15 July 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:** | 5 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 12 | **Hours off site** | 5 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 12 | Total audit hours off site | 8 | Total audit hours | 20 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 7 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 4 | Total number of staff (headcount) | 8 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 29 July 2014

## **Executive Summary of Audit**

**General Overview**

Whalan Lodge is now privately owned and operated by the Whalan Lodge Trust and is situated in Kurow, North Otago. This provisional audit was conducted to ascertain the Trust’s preparedness to operate Whalan Lodge. The Trust took over the running of Whalan Lodge from the previous owners in December 2013 and they have implemented a business plan and a quality plan. Previously the Trust owned only the land and buildings and leased the business to the previous business owners/managers. The service provides rest home level care for up to 14 residents with three permanent residents, one rest home respite resident and one carer support resident accommodated on the days of audit. The Trust has employed a manager, who has been in the role for the past six months. She is supported by the Trust, a registered nurse and care staff. Staff turnover is reported as low. The local community have been actively supporting the manager and staff of Whalan Lodge to continue to provide a residential aged care home for the elderly residents of Kurow and the surrounding areas. The quality and risk management programme is managed by the manager and registered nurse and involves the resident on admission to the service. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.  
  
This audit has identified improvements required around reviewing of activities care plans, aspects of medication management, safe hot water temperatures and calibration of medical equipment.

**Outcome 1.1: Consumer Rights**

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

**Outcome 1.2: Organisational Management**

Whalan Lodge Trust has an organisational philosophy, which includes a vision, mission statement and strategic objectives.   
The trust has owned the land and buildings for many years and leased them to the previous owners of the business. The trust took over the business in December 2013 and has employed a manager. The manager has previous involvement in Whalan Lodge and is experienced in aged care and nursing. She is supported by the trust, a registered nurse and care staff. The service is guided by a comprehensive set of policies and procedures which were implemented in July 2013 and have remained in place with the change in business ownership. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. Staffing levels are safe and appropriate.

**Outcome 1.3: Continuum of Service Delivery**

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Short term care plans are in use for short term issues. Improvements are required whereby activities care plans are reviewed six monthly. The medication management system includes policy and procedures that follows recognised standards. Staff responsible for medication administration receive training. Improvements are required whereby competency is conducted annually.

Resident medications are reviewed by the residents’ general practitioner at least three monthly. Self-medicating residents are appropriately supported to do so. A range of activities are available for residents within input from staff and volunteers. Whalan Lodge has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is planned for care staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded, the volunteer cook has completed food safety training.

**Outcome 1.4: Safe and Appropriate Environment**

Whalan Lodge has a current building certificate that expires on 8 August 2014. Maintenance is carried out. Chemicals are stored in the locked laundry and hot water temperatures are monitored and recorded. Improvements are required whereby hot water temperatures are maintained at safe levels and medical equipment is calibrated by an authorised technician. Electrical equipment is tested and tagged. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There are two lounges and a dining area, and small seating areas throughout the facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. There is a designated laundry which includes storage of cleaning and laundry chemicals. There are emergency procedures in place and the service has sufficient supplies for use in an emergency. Staff are trained in emergency management and evacuation. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

**Outcome 2: Restraint Minimisation and Safe Practice**

The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there was one resident assessed as requiring restraint and no enablers. Staff have been provided with restraint minimisation and safe practice education and have completed a restraint competency. The restraint minimisation programme is reviewed six monthly. Appropriate assessment, consent, care planning, monitoring and review of restraint is conducted.

**Outcome 3: Infection Prevention and Control**

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

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 47 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 2 | 2 | 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 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Two of three permanent residents have activities care plans which were developed in July 2013. There is no evidence that these activities care plans have been reviewed in the past 12 months. | Conduct evaluations of all care plans – long term and activities plans - six monthly or sooner if required to ensure that all plans are current. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | a) On review of the controlled drug register it is noted that six monthly stock takes have not been conducted; b) two of four medication charts reviewed did not have directions for use recorded for PRN medications. | a) Conduct six monthly stock take of all controlled drugs; b) ensure that all non-regular medications have directions for use recorded in order to guide staff in their safe use and administration | 60 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Two caregivers with medication administration responsibilities and one registered nurse do not have current medication competencies completed. | Ensure that all staff with responsibilities around medication administration and including the registered nurse, have annual competencies completed. | 60 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | a) Hot water temperatures in two bathrooms remain above 45 degrees Celsius. Advised by the manager that the hot water cylinder in this area has been adjusted to the lowest setting, however, temperatures remain above the required level. The manager has documented a corrective action to address the issue and advised that the service recognises that they will need to purchase a tempering valve on this cylinder in order to be able to regulate the temperatures more accurately; b) medical/nursing equipment including chair scales, blood pressure machine and thermometer is overdue for checking and calibration. | a) Ensure hot water temperatures in resident areas is at or below 45 degrees Celsius; b) ensure that all medical/nursing equipment is checked and calibrated by an authorised technician annually. | 90 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (two caregivers, one registered nurse and one manager) confirm their familiarity with the Code. Interviews with four residents and four relatives confirm the services being provided are in line with the Code of rights.   
Code of rights, informed consent and advocacy training is planned for July 2014.

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

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

**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 1.1.2: 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:**

The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with four residents and four relatives identify they are well-informed about the code of rights. The service provides an open-door policy for concerns or complaints.  
Resident/relative meetings (minutes sighted for June 2013)) are held infrequently due to the low number of residents. Advised by the manager and RN that residents can and do raise concerns if and when they arise. Two residents and one relative completed a recent survey (June 2014) responding to questions relating to communication, complaints, visiting hours and privacy with all of the respondents replying they are either satisfied or very satisfied.  
Advocacy pamphlets, which include contact details, are included in the information pack and are available at the entrance. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines. Two caregivers, one registered nurse and one manager were knowledgeable in regards to implementing the rights of residents and information around the Code of rights is provided to residents and families.  
D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a Code of rights pamphlet, and advocacy and Health and Disability Commissioner information.

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.   
Discussions with four residents and four relatives confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.   
D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.  
D14.4: There are clear written instructions provided to residents and family on entry regarding responsibilities of personal belongings. Personal belongings are documented and included in residents’ files.  
Church services are held monthly and Ministers of religion visit residents on a regular basis. Contact details of spiritual/religious advisors are available to staff. All four residents and four relatives confirm the service is respectful.  
D4.1a: Residents’ files include their cultural and /or spiritual values when identified by the resident and/or family.

he information pack, provided to residents and their families, includes the home's philosophy of care. Discussions with four residents confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Five care plans reviewed identify specific individual likes and dislikes. The abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training on abuse and neglect was provided in June 2014.   
Discussions with the manager and registered nurse report there have been no identified incidents of abuse or neglect.

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a cultural safety policy. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.   
There were no Maori residents living at the facility at the time of the audit. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori healthcare providers.   
D20.1: The service utilises a local Maori representative on an as-needed basis for consultation. These contacts are identified in policy.  
Interviews with two caregivers and one registered nurse confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau.   
A3.2: There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

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

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

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

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

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

**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 1.1.6: 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:**

Care planning includes consideration of spiritual, psychological and social needs. Four residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Four relatives report that they feel they are consulted and kept informed. Family involvement is encouraged.   
D3.1g: The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the registered nurse.  
D4.1c: Five of five care plans reviewed include the residents’ social, spiritual, cultural and recreational needs.

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

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

**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 1.1.7: 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:**

The staff induction programme includes a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with the manager and one recently employed caregiver. Interviews with two caregivers, one registered nurse and one manager acknowledge their understanding of professional boundaries.

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

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

**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:** FA

**Evidence:**

The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. Resident satisfaction surveys reflect high levels of satisfaction with the services that are received. The manager and registered nurse are in charge of the internal audit and in-service education programmes. There is access to computer and Internet resources. The service has instigated two monthly staff meetings and two monthly quality management meetings.   
Four residents and four relatives interviewed spoke very positively about the care and support provided. Two caregivers, one registered nurse, and the manager have a sound understanding of principles of aged care.  
A2.2: Services are provided at Whalan Lodge that adheres to the Heath & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring.  
D1.3: All approved service standards are adhered to.  
D17.7c: There are implemented competencies for caregivers and registered nurses (medication competencies require completion link #1.3.12.3). There are clear ethical and professional standards and boundaries within job descriptions.

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

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

**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 1.1.9: 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:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Whalan Lodge has policies and procedures relating to informed consent and advanced directives. A review of five files identified that five of five files included signed informed consent forms to allow for taking of photographs, collecting health information and outings as part of the admission process and agreement.  
There is a resuscitation form and process. Three permanent, one respite and one carer support resident files reviewed had completed resuscitation documentation.   
There were admission agreements sighted which were signed by the resident or nominated representative. Discussion with four family identified that the service actively involves them in decisions that affect their relatives’ lives.

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

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

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

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

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

**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 1.1.11: 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:**

An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception.  
D4.1e; The residents’ files include information on residents family/whanau and chosen social networks.  
Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.   
D4.1d; Discussions with four relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions.

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

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

**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:**

The resident information pack informs visiting can occur at any reasonable time. Interviews with four residents and four relatives confirm that visiting can occur at any time. Family and friends were seen visiting on the days of the audit. Key people involved in the resident’s life are documented in the care plans.   
D3.1.e Discussions with four residents and four relatives verify that they are supported and encouraged to remain involved in the community. Whalan Lodge support on-going access to community services (e.g. church, general practitioner visits, and family outings). There is strong community support for Whalan Lodge with volunteers attending for provision of some of the activities programme. Members of the community volunteer their time, firewood, fruit, baking, and gardening.   
D3.1h: Discussions with four families verify that they are encouraged to be involved with the service and care.

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

Consumers have access to visitors of their choice.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.   
Information on the complaint’s forms includes the contact details for the Health and Disability Advocacy Service.   
Interviews with four residents and four relatives are familiar with the complaints procedure and state any concerns or complaints are addressed.   
The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been no complaints received in 2014. Advised by the manager that should a complaint be received then a full investigation and resolution including communication with complainants will be documented for each lodged complaint. Complaints are an agenda item at the quality management meetings and staff meetings.   
D13.3h. A complaints procedure is provided to residents within the information pack at entry.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Whalan Lodge Trust has an organisational philosophy, which includes a vision, mission statement and strategic objectives. The Whalan Lodge trust have owned the land and buildings of Whalan Lodge for many years and have leased them to the previous owners of the rest home business. The trust has now taken over the business (December 2013) and they have employed a manager. The manager has previous involvement in Whalan Lodge as a manager and lease holder and is experienced in aged care and nursing. She is supported by the trust, a registered nurse and care staff. Whalan Lodge provides rest home level care for up to 14 residents with five residents accommodated on the day of audit – three permanent, one respite and one carer support. There are clearly defined and measurable goals developed for the strategic plan and quality and risk management plan. The mission statement sets out the vision and values of the service: “we believe in the right for each individual to be able to live in a warm, kind, caring and supportive environment, having their personal space and spiritual needs met with privacy, dignity and freedom of choice". The mission statement is included in the information booklet, which is given to each resident and family on admission. On interview, two trust members advised that the trust has short, medium and long term goals for Whalan Lodge – primarily to remain a viable aged care facility for the elderly residents of Kurow and surrounding areas. The trust meets monthly and the manager provides the trust with a monthly report on financials, repairs and maintenance, occupancy, staffing and quality management. Advised by the trust chairman that he visits the facility at least weekly and speaks with the manager every two to three days. Whalan Lodge is well supported by the community with volunteers providing their time and efforts to maintain the home.  
An organisational chart visually describes reporting relationships for the governance and management structure. The service has a business plan and a quality and risk management plan for 2014. The manager is an experienced registered nurse (not currently practicing) having worked in a variety of nursing roles – one of which was previously as the manager at Whalan Lodge. She works three days a week and is available after hours. The service also employs a registered nurse who works up to 20 hours per week and lives on site in attached accommodation. The registered nurse is experienced in acute care, intensive care, and primary nursing. She also works part time at the local medical centre and is PRIME trained. The manager, registered nurse and care staff have a sound understanding of aged care. The manager commenced employment in December 2013 and registered nurse commenced in January 2014.

##### **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:**

In the manager’s absence, the registered nurse is in charge. The manager is responsible for the day to day functions of the organisation, including oversight of the quality and risk management programme with support from the Trust and the registered nurse. Formal quality management meetings are held two monthly between the manager and registered nurse with discussion around occupancy, resident issues, clinical care and staffing. The manager reports to the Whalan Lodge trust once a month on a variety of issues and meets informally with the Trust chairman at least weekly.   
D19.1a; A review of the documentation, policies and procedures and from discussions with staff, identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The quality and risk management system is understood and implemented by the manager, registered nurse and staff.   
A comprehensive set of policies and procedures are in place. These policies were purchased from an external provider in July 2013 under the previous owners/management and have remained in place with the new manager and the Whalan Lodge Trust ownership of the business. The manager reports that new and/or revised policies are developed by the external provider and are available for staff to read and to sign after reading.   
The service has a business plan for 2013- 2015. The suite of policies and procedures includes a quality plan for 2014. The quality assurance and risk management plan includes 11 aims and objectives for the service including but not limited to: education and training, provision of services, resident and family communication, and provision of resident care. Progress with the quality plan is monitored through the two monthly quality management meeting and two monthly staff meetings. The quality/management meeting agenda includes (but is not limited to): occupancy, accidents/incidents, infections, complaints, clinical issues, restraint/enablers, food service, training, staff related issues, equipment and hazards (minutes sighted for 1 July 2014). The staff meeting agenda includes discussion and reporting around health and safety, restraint, laundry, meals, maintenance, infection control, audits and general business (minutes sighted for 23 June 2014). Minutes are maintained and easily available to staff. Minutes include actions to achieve compliance where relevant. Discussions with the registered nurse and two carers confirm their involvement in the quality programme. Resident/relative meetings take place as required. There is an internal audit schedule and internal audits have been completed by the manager and registered nurse since January 2014 for staff training, hand washing, weight monitoring, medications, care planning, complaints, continence, cultural safety, informed consent, privacy and safety, laundry and cleaning, environment and equipment, admissions, hygiene and grooming, infection control, wound and skin care and restraint. Risk management audits have been conducted for the kitchen and bathrooms. A resident and relative survey conducted in June 2014 (three replies) evidences that residents and relatives are over all very satisfied with the service, are complimentary of the care provided and of the food service. The service collects information on resident incidents and accidents as well as staff incidents/accidents. Corrective actions are developed following internal audits, resident/family survey and resident and staff meetings that identify opportunities for improvement and corrective actions where required. The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training plan for 2014 that is being implemented and is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are to be reviewed regularly. Documents no longer relevant to the service are removed and archived.

Falls prevention strategies include assessment of risk, safe and clutter free environment, appropriate footwear, supervision and assistance, mobility aids and as a last resort, restraint for one resident with a lap belt and bed rails which are used infrequently.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**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:**

D19.3b; There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.  
Adverse events (including but not limited to: falls, skin tears, bruising, challenging behaviours, medication errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by a registered nurse. Data is collected and collated on a monthly basis. Results are communicated to staff via handover and meetings minutes.   
Three incident forms were completed for the period January to June 2014 and were reviewed. These incidents related to two residents – one with a skin tear and one with a fall and a skin tear. Staff advised that they contact family following an incident or accident and this is evident in incident forms, family communication sheet or progress notes reviewed. Adverse events include an investigation. Follow up is conducted by the registered nurse and GP is notified if required. Either the registered nurse or manager investigates all events with further follow up by the manager if required. Short term care plans are developed for skin tears. No medication errors were reported for the time period. The adverse events form documents the follow-up actions taken. Monthly incident/accident analysis is conducted and results discussed at staff meetings. The manager maintains a running record of incidents and accidents each month on an annual summary form.  
Statutory and regulatory obligations are understood by the manager. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are eight staff employed by Whalan Lodge which includes a registered nurse, five caregivers, a new caregiver/activities person and the manager. Caregivers undertake housekeeping, laundry and kitchen duties. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for the registered nurse and general practitioner.   
Five staff files were randomly selected for review (one registered nurse and four caregivers). Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, evidence of a completed orientation programme including evidence of competency. All staff have a current first aid certificate and the registered nurse is PRIME trained. Staff undergo annual performance appraisals, evident in three of five staff files reviewed (the RN and one caregiver file reviewed commenced employment in the past six months).   
Whalan Lodge has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed caregivers are assigned to another caregiver to be their 'buddy'. New staff must demonstrate competency before working independently (evidenced in the completed orientation checklists for one new caregiver). Interviews with two caregivers confirm their orientation to the service was thorough. All five staff files reviewed reflected evidence of an orientation programme that had been completed.   
Discussion with the registered nurse and manager and review of education records confirms that a comprehensive in-service training programme is in place for 2014, which the service is in the process of implementing. The programme covers relevant aspects of care and support and meets requirements. The annual training programme exceeds eight hours annually.   
Caregivers have completed either the national certificate in care of the elderly (three caregiver files reviewed) or are to commence the course (one newly appointed caregiver). The registered nurse is in the process of becoming a certified trainer and assessor for the caregiver training programme.   
A system is in place to identify, plan, facilitate and record ongoing education for staff. Attendance records are maintained by the manager. All staff are required to attend training for fire safety and evacuation, infection control, restraint minimisation, first aid, and manual handling.

Education and training provided so far for 2014 under the new management includes (attendance in brackets): safe chemical handling (5), advanced directives (5), observations including blood sugar monitoring, blood pressure recording (4), restraint minimisation and competencies (5), infection control and standard precautions (5), fire training and evacuation drill (5), skin care and pressure area prevention (5), and abuse and neglect (5). The following education sessions are planned for remainder of 2014 and includes: code of consumer rights including informed consent and advocacy (July), food safety update (August), wound and skin tear management (September), dementia and challenging behaviours (October), restraint and challenging behaviours (November), and back care and manual handling (December). Education is provided either as face to face sessions, self-directed reading and learning or attendance at off-site sessions. The registered nurse has yet to complete interRAI training. Attendance rates are recorded and evidence good levels of attendance by staff.   
Registered nurses and caregiver competencies available include restraint, infection control, and fire questionnaire and medication administration. Medication competencies were reviewed for three caregivers but not for the remaining two caregivers and the registered nurse (link #.1.3.12.3).

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The annual leave and rostering policy includes staffing levels and skills mix. The manager works for 24 hours a week over three days and is available afterhours. The registered nurse works up to 20 hours per week either during the day, in the evenings or in the weekends. The RN also works week on week off at the local medical centre and is Primary Response in Medical Emergency (PRIME) trained. The registered nurse (RN) is available after hours to care staff and lives on site in adjacent accommodation. There is further support from another PRIME trained practice nurse in the town (who also provides RN cover when the RN is away on leave). The general practitioner, district nurses and St Johns ambulance service is available when and if required. Care staff interviewed advised that they are well supported by the manager and the registered nurse. Roster includes one caregiver on each shift. A local caterer is the volunteer cook and works Monday to Friday. Activities are provided during the day from either the caregiver or manager with support from regular volunteers, visiting entertainers and outings are provided by the manager and resident’s families.   
Staff turnover is reported by the manager as low. Staffing levels are altered according to resident numbers and acuity.  
One general practitioner was interviewed who confirms that staffing is appropriate to meet the needs of residents.  
Four residents and four relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly and endeavour to make Whalan Lodge a home.

##### **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:** FA

**Evidence:**

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

#### Standard 1.3.1: 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:**

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility as a permanent rest home resident or respite resident. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whanau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. Four family members and four residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for four of five resident files sampled (one carer support). The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission agreement.

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

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

**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 1.3.2: 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 service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whanau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.

##### **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:**

There is a policy and process that describe resident’s admission and assessment procedures. The registered nurse undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission. The long term care plan is developed within three weeks of admission. In all three permanent resident files, one respite and one carer support files sampled, the initial admission assessment and initial care plan were completed and signed off by the registered nurse. The registered nurse and manager have completed new long term care plans for the three permanent residents since January 2014 (all signed off by the registered nurse and resident and/or family member). Six monthly reviews are conducted or earlier if resident health changes are completed by the registered nurse with input from the care staff and any other relevant person. Activities assessments and care plans for the three permanent residents were developed by the previous activities coordinator, however, these have not been reviewed six monthly (link #1.3.8.2). Handover occurs at the end of each duty that maintains a continuity of service delivery. The manager and registered nurse share on-call and after hours and weekends cover.   
Medical assessments are completed within two working days of admission by the general practitioner (GP) as evidenced in the medical notes of three permanent resident files sampled. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. GP interviewed stated that the service contacted her in a timely fashion, providing her with information required to assess the residents. The service always carried out any observations and interventions she prescribed.   
There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment. The interRAI assessment tool is not yet in use. Long term care plans reviewed for three of five residents’ evidence comprehensive and resident focused goals and interventions. All five files identified integration of allied health including podiatry.   
  
Tracer Methodology:   
    *XXXXXX This information has been deleted as it is specific to the health care of a resident.*

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.3.3.3 (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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

**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 1.3.4: 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:** FA

**Evidence:**

An initial nursing assessment is completed within 24 hours of admission. The initial assessment includes: cognitive, sensory, mobility, breathing, hygiene and grooming, skin, continence, oral care, pain, safety and risk, dietary, social/values and beliefs, cultural and spiritual and sleeping. Personal needs outcomes and goals of residents are identified. There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment. Assessments are conducted in an appropriate and private manner. All four residents interviewed are satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, within progress notes, initial assessment and care plans. Four resident interviews and four family members stated they were informed and involved in the assessment process.  
The assessment tools link to the individual care plans. The care plans are individualised for each resident need such as (but not limited to): hygiene, nutrition, mobility, pain, behaviours, cultural, sleep/comfort, continence, memory loss, skin, elimination, personal cares, medical conditions such as chronic obstructive respiratory disease (COPD, and diabetes. The registered nurse also develops a daily intervention sheet which aligns with the long term care plan. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.   
The general practitioner completes a medical admission with two working days. Families and residents interviewed confirmed their involvement.

##### **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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents' files include: medical, nursing, allied health and activity notes were included in the individual file. Resident files include (but not limited to); a) admission information, b) Resuscitation status, c) daily interventions, d) care plan and short term care plan (STCP), e) monthly monitoring e.g. weights, BP, f) progress notes, g) medical profile/ medical notes, h) activity plan/progress notes, i) infection log, j) bowel chart, k) family communication, l) informed consent, m) admission agreement, n) correspondence e.g. transfer notes, NASC assessments and o) lab results.

Daily interventions includes: personal cares, mobility, behaviour, sleeping, nutrition, skin, pain, and continence.

The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. Resident comprehensive long term care plans are individually developed with the resident and family/whānau who sign to acknowledge their approval of the care plan. Four residents and four family members interviewed stated they are involved in the care planning process. Resident care plans reviewed included long term care plans and daily interventions sheets for three permanent residents and one respite resident and an initial assessment and care plan and daily interventions sheet for one resident on carer support. Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to): ): hygiene, nutrition, mobility, pain, behaviours, cultural, sleep/comfort, continence, memory loss, skin, elimination, personal cares, medical conditions such as COPD, and diabetes. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. Activities care plans are developed from the diversional therapy assessment and social profile information and signed off by the resident and/or family member.   
There is evidence that residents are seen by the GP at least three monthly and this was confirmed on GP interview.   
The GP signs that the resident is stable and for three monthly visits. Notes are well maintained.   
Short term care plans are in use for changes in health status and are recorded on a short term care plan page. Examples sighted are cares required for wounds, infections, skin tears, weight loss, and urinary frequency, sleep problems, and generally feeling unwell. Five resident files reviewed identified that family were involved.

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

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Whalan Lodge provides services for residents requiring rest home level of care. Individualised care plans are completed. The two caregivers and registered nurse interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment.   
Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment (link #1.4.2.1)   
there is currently one wound being treated and no pressure injuries. Wound assessment and management plan is completed for the wounds (pressure points on two of the resident’s toes) and there was evidence of referral to the podiatrist. Wound care education is planned for September 2014.   
Four residents and four family members interviewed confirm their current care and treatments they and their family members are receiving meet their needs.   
Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed.   
All falls are reported on the resident accident/incident form and reported to the registered nurse and manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required.   
There is one part time registered nurse employed by the service and the manager has been a registered nurse (currently does not have an annual practicing certificate). A record of all health practitioners practicing certificates is kept.   
Needs are assessed using pre admission documentation, doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals (with the exception of two permanent residents’ activities plans link #1.3.8.2). Care plans are updated to reflect intervention changes following review or change in health status. During the tour of facility it was noted that staff treated residents with respect and dignity, residents and families were able to confirm this observation.

##### **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:**

The activities coordinator role has recently been vacated and caregivers, manager and volunteers are currently providing activities for residents. Advised that a new staff member has been employed with a background in adult education, social work and psychology and will be taking over the activities coordinator position. The hours are still under negotiation, however the service stated that it would be approximately 2-4 hours per week. Activities such as walks, outings and individual time is undertaken by the care staff. There is a weekly activity planner, with activities advertised in hallway of home. Due to the size of the facility the activities programme is much individualised and features a lot of one on one activities reflecting the resident’s interest and they have choices in their level of participation. Activities include (but are not limited to): (a) outings to the local café or local places of interest, (b) exercise programmes, (c) entertainment, (d) monthly church services, (e) visits to the library, and aromatherapy activities. Residents have an initial diversional assessment and social profile completed over the first few weeks after admission obtaining a complete social history and profile of past and present interests and life events.   
A record is kept of individual resident’s activities and weekly progress notes are completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. Participation in all activities is voluntary. All residents have an interest checklist completed and activity plan documented, however, these have not been reviewed in the past 12 months as evidenced in two of three permanent resident files reviewed (link #1.3.8.2). An activities plan is in place for the respite resident. Residents interviewed confirmed that activities offered are what they would like and they love to get out and about in the community. A volunteer comes weekly to play cards with residents who wish to do so.

##### **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:** PA Low

**Evidence:**

All initial care plans were developed by a registered nurse on the day of admission and resident comprehensive long term care plans developed within three weeks of admission as evidenced in three permanent and one respite resident. Long term care plans are evaluated six monthly or if there is a change in health status. There was documented evidence that care plan evaluations were up to date in all three (of five) long term resident files sampled. A new long term care plan has been developed for all permanent residents since the change of ownership and new manager and registered nurse employed. Changes in health status trigger an update on the care plan. Care plan reviews are signed as completed by a RN. All residents have an interest checklist completed and activity plan documented, however, these have not been reviewed in the past 12 months as evidenced in two of three permanent resident files reviewed. Improvements are required in this area. GP's review residents three monthly or when requested if issues arise or health status changes. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out her instructions, giving her full confidence in the management of the residents. Short term care plans were evident for current and previous wounds, skin tears, weight loss, sleep problems, general malaise and infections. The care staff record implementation of interventions of short term care plans in the progress notes and the RN signs off the care plan when the issue has resolved.

##### **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:** PA Low

**Evidence:**

All initial care plans were developed by a registered nurse on the day of admission and resident comprehensive long term care plans developed within three weeks of admission as evidenced in three permanent and one respite resident. The resident on carer support has a care plan in place. Long term care plans are evaluated six monthly or if there is a change in health status. There was documented evidence that care plan evaluations were up to date in all three (of five) long term resident files sampled. A new long term care plan has been developed for all permanent residents since the change of ownership and new manager and registered nurse employed. Changes in health status trigger an update on the care plan. Care plan reviews are signed as completed by a RN. All residents have an interest checklist completed and activity plan documented as evidenced in one of three permanent resident file reviewed (admitted in March 2014) and for the one respite resident.

**Finding:**

Two of three permanent residents have activities care plans which were developed in July 2013. There is no evidence that these activities care plans have been reviewed in the past 12 months.

**Corrective Action:**

Conduct evaluations of all care plans – long term and activities plans - six monthly or sooner if required to ensure that all plans are current.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service facilitates access to other medical and non-medical services. The manager and registered nurse interviewed confirm that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted.   
Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider.

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records.  
Discussions with registered nurse identified that the service has access to PRIME nurse, dietitian, continence nurse, physiotherapist, podiatrist and emergency services.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care.

The service has in place policies and procedures for ensuring all medicine related recording and documentation is legible and signed and dated. The three permanent and one respite residents have individual medication charts with three monthly reviews of medication occurring by GP for three permanent residents. The resident on carer support has a list of medications taken recorded and a copy of the prescriptions is available on file. Medication charts record prescribed medications by the general practitioner, and these are kept in the medication folder. Medication instruction and administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication. Medication that is administered for PRN use has directions for use recorded in two of four medication charts reviewed. Improvements are required in this area.

The service has adequate information and supervises the self-administration of medicines. One resident on carer support self-administers his medications and these are securely stored in a locked box in the resident’s room. The resident has undergone an assessment by the general practitioner, who has deemed him competent to self-administer. Resident interviewed stated he informed the staff when he has administered his medications.

The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded. Known allergies are recorded on medication sheets as evidenced in four medication charts reviewed. There is a staff signature identification sheet in the front of the medication folder, this includes the general practitioner and PRIME nurses signatures.

There is a locked safe for controlled drugs and a controlled drug register, with one respite resident on controlled drug medication. On review of the controlled drug register it is noted that six monthly stock takes have not been conducted. Improvements are required in this area.

Whalan Lodge uses four weekly medico blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. The service has an agreement with the Twizel Pharmacy.

All staff performing medication administration receive training on medicine management policies and procedures (last conducted in May 2013). Annual competency was sighted for three caregivers but not for further two caregivers and the registered nurse. Improvement is required in this area. Two caregivers were observed safely administering medications to residents.

Medication audits have occurred in April 2014 in relation to medication trolley, cupboard and staff administration of medication.

D16.5.e.i.2; Three (of four) permanent resident medication charts reviewed identified that the GP had seen the resident three monthly and four of four medication charts were signed. All medicine charts demonstrate documentation is legible.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service has in place policies and procedures for ensuring all medicine related recording and documentation is legible and signed and dated. Whalan Lodge uses four weekly medico blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. The service has an agreement with the Twizel Pharmacy. The three permanent and one respite residents have individual medication charts with three monthly reviews of medication occurring by GP for three permanent residents. The resident on carer support has a list of medications taken recorded and a copy of the prescriptions is available on file. Medication charts record prescribed medications by the general practitioner, and these are kept in the medication folder. Medication instruction and administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication. Medication that is administered for PRN use has directions for use recorded in two of four medication charts reviewed. Advised by the RN that caregivers do not give PRN medication without first checking with her.

Controlled drugs are stored in the nurse’s station medication cupboard in a locked safe. There is a controlled drug register, with one respite resident on controlled drug medication.

**Finding:**

a) On review of the controlled drug register it is noted that six monthly stock takes have not been conducted; b) two of four medication charts reviewed did not have directions for use recorded for PRN medications.

**Corrective Action:**

a) Conduct six monthly stock take of all controlled drugs; b) ensure that all non-regular medications have directions for use recorded in order to guide staff in their safe use and administration

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Education on medication management occurred in April 2014. Advised that competencies are conducted for all care givers with medication administration responsibilities as evidenced in three caregiver’s records. The further two caregivers competencies could not be located. Competency includes insulin administration and controlled drug administration.

**Finding:**

Two caregivers with medication administration responsibilities and one registered nurse do not have current medication competencies completed.

**Corrective Action:**

Ensure that all staff with responsibilities around medication administration and including the registered nurse, have annual competencies completed.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.5 (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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Whalan Lodge has a viable kitchen and all food is cooked on site. Food safety policies include personnel, hygiene, resident access to kitchen, environment hygiene, serving, food temperatures, care of crockery and cutlery, pest control, dietary needs noted in care plan, training, and expiry dates. The four week cyclic menu has been reviewed by a registered dietitian in May 2013. The cook is a volunteer with safe food handling qualifications and has her own catering business as well. Advised by the manager that a newly employed staff member (orientating on the days of audit) has been employed to work as a weekend cook and caregiver. The cook prepares all meals and leaves instructions for the afternoon caregiver to cook or reheat the evening meal. Caregivers prepare the breakfasts for residents. Staff were able to describe the needs of a resident requiring a moist minced diet and a pureed diet. Dietary requirements and nutritional assessments are conducted and stored in the kitchen. These record the resident’s nutritional needs, special needs or preferred diets. A resident with memory loss and mild dementia was observed receiving assistance with her meals and drinks throughout the audit days. Four residents interviewed stated they enjoy the meals and are offered alternative meals if required. One resident advised that prior to admission he had a poor nutritional intake but since admission to Whalan Lodge had gained six kilograms due the quality of the meals provided.

Special equipment was available as required. This includes cups, straws, modified cutlery/crockery etc. The need for supervision, assistance or special equipment is documented in the resident care plan.

Food in the kitchen and storage areas are dated, labelled and rotated. Food in the fridges and freezers are stored correctly, dated and covered. Fridge and freezer temperatures are checked and recorded. The service provides meals on wheels to the elderly in the community. Food temperatures are recorded for meals leaving the kitchen on MOW service. Council Certificate sighted for kitchen which expires 30/6/15. There is a cleaning schedule, which is signed by the member of staff completing the tasks.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies in place in for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. The laundry and sluice room is locked when not in use. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interviews with two caregivers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in January 2014.

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

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

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

**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 1.4.2: 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:** PA Low

**Evidence:**

Whalan Lodge has a current building certificate that expires on 3 August 2014. Emergency systems are checked monthly including call bells, emergency lighting and fire alarms. Electrical testing and tagging is completed two yearly and was last conducted on 5 December 2012. Hot water temperature monitoring has been conducted and recorded over the past six months with consistently high temperatures in two bathroom areas of the facility. Improvement is required in this area. The chair scales and medical equipment have not been calibrated by a certified technician in the past two years. Improvements are required in this area. Furniture and fittings are selected with consideration to residents’ abilities and functioning. Residents and family members confirm that they are able to personalise their rooms with furnishings and possessions of their preference. There is sufficient room throughout the service for residents to mobilise safely. Floor surfaces are appropriate and equipment is obtained as identified. Corridors allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Hand rails are appropriately located in the hallways. There is a wide veranda at the front of the home with chairs for residents and family to use. It faces the sun. Some of the bedrooms have French doors that open on to the veranda. There is a sweeping lawn in the front of the facility with trees for shade. There are several outside areas where residents can sit with outside seating provided. The following equipment is available: spenco mattress, shower chairs, wheelchairs and one sling hoist.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** PA Low

**Evidence:**

Whalan Lodge has a current building warrant on fitness that expires on 3 August 2014. Emergency systems are checked monthly including call bells, emergency lighting and fire alarms. Electrical testing and tagging is completed two yearly and was last conducted on 5 December 2012. Hot water temperature monitoring has been conducted and recorded over the past six months in the kitchen, laundry and three communal bathrooms. It is noted that there has been consistently high temperatures than 45 degrees Celsius in two bathroom areas of the facility. The chair scales and medical equipment have not been calibrated by a certified technician in the past two years.

**Finding:**

a) Hot water temperatures in two bathrooms remain above 45 degrees Celsius. Advised by the manager that the hot water cylinder in this area has been adjusted to the lowest setting, however, temperatures remain above the required level. The manager has documented a corrective action to address the issue and advised that the service recognises that they will need to purchase a tempering valve on this cylinder in order to be able to regulate the temperatures more accurately; b) medical/nursing equipment including chair scales, blood pressure machine and thermometer is overdue for checking and calibration.

**Corrective Action:**

a) Ensure hot water temperatures in resident areas is at or below 45 degrees Celsius; b) ensure that all medical/nursing equipment is checked and calibrated by an authorised technician annually.

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

There are an adequate number of communal toilets and showers for the number of residents. They are conveniently located to meet the needs of the residents and are easily accessible. Communal toilets and showers are well signed and identifiable. They are lockable with locks that can be opened in case of emergency. They each have a call bell readily accessible. There is a visitor’s toilet which is clearly labelled. It is clean and well maintained with adequate hand washing facilities. Fixtures, fittings, and floor and wall surfaces appear to be made of accepted materials for this environment. Alcohol hand cleaner is available throughout the facility and at the front door for visitors.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents rooms have sufficient space to allow care to be provided and for the safe use of mobility aids. The bedroom doors are wide enough for wheel chair/walking frame access. Hallways and communal areas allow wheelchair access. Transporting residents between rooms in their bed is not necessary. Movement of residents can be made by wheelchair or ambulance stretcher if necessary.

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

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

**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 single dining room and a large lounge for residents use. Residents are able to access areas for privacy if required. A veranda runs the length of the facility, faces north and is an area where residents and family can meet for relaxation and activities. Furniture is appropriate to the setting and arranged that enables residents to mobilise. The lounge is divided in two and activities can occur in either of the lounge areas.

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##### **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:**

Whalan Lodge has policies and procedures for management of laundry and cleaning practices. The laundry is small and the caregivers are responsible for the laundry. There is a dirty/ clean flow around the laundry including and entrance and exit door. The sluice is in the laundry. There is a designated area for the secure storage of cleaning and laundry chemicals. MSDS are available for chemicals used at Whalan Lodge. Safe chemical handling training was provided in January 2014. Laundry and cleaning processes are monitored for effectiveness - laundry and cleaning audit was conducted in March 2014. Checklists for cleaning completed occurs on a daily basis.

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

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

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

**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 service has a fire and emergency procedures manual. All staff have a current first aid certificate. Whalan Lodge has a New Zealand Fire Service approved fire evacuation scheme, dated 26 August 1997. The scheme was reviewed and reapproved on 28 November 2011 following the addition of another lounge. A call bell light alerts staff to the area in which residents require assistance. The home is small and advised that most visitors are known to staff and/or management. A fire drill was last conducted in April 2014. A civil defence kit is stocked and checked six monthly. Water is stored in a large external water tank - sufficient for at least three days. Alternative heating (log fires) and cooking (gas hobs and bbq) facilities are available. Emergency lighting is installed. Advised that a generator can be hired if required. Call bell system evident and in use in the resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

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

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

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

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

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

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

**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 1.4.8: 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:**

General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Night stores are appropriately placed for warmth of the facility, heat pumps are available in lounge areas and the resident bedrooms have a heater available. The service also has three wood burners. Smoking is only permitted in designated outside areas.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Whalan Lodge has comprehensive policies and procedures on restraint minimisation and safe practice. The manager is the restraint coordinator and confirms that the service promotes a restraint-free environment.   
There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service currently has one resident assessed as requiring the use of restraint and no enablers. Restraint in use includes the use of a lap belt (commenced in March 2014) and a set of bed rails (commenced in July 2013). The care plan reviewed for the resident with restraint includes completed restraint assessment. Safety and risk assessments have been conducted and both types of restraint are used to prevent falls due to unsafe behaviours. On-going consultation with the GP and family/whanau is also identified (confirmed on interview). Falls risk assessments are completed six monthly. Policy dictates that enablers should be voluntary and the least restrictive option possible and the registered nurse, two caregivers and the manager are familiar with this. Documentation includes restraint register, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms. Restraint education last provided for staff in March 2014 with associated questionnaire and competency.

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.1: Restraint approval and processes **(**HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

Responsibilities and accountabilities for restraint are outlined in the restraint policy that includes responsibilities for key staff. The restraint co-ordinator (manager) was able to describe the role and responsibilities. Approval for each form of restraint is reviewed at a frequency as determined by organisational Restraint Minimisation policy and resident safety. One resident’s file, assessed as requiring restraint, was reviewed and evidenced consent form completed appropriately. This was confirmed on interview with the resident’s family member. Restraint discussion is conducted at staff meetings and quality management meetings. Restraint use is reviewed at resident level as part of staff meetings and at care plan reviews (or more often as needed). Last reviewed in July 2014.

##### **Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)**

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

**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 2.2.2: Assessment **(**HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

The restraint minimisation and safe practice policy outlines the service's approach to managing restraint. The policy includes the steps for assessment and use of restraint, role of the restraint coordinator, involvement of family and GP, risk assessment, the need to attempt to modify behaviour prior to the use of restraint, resident advance directives, previous tolerance of restraint application, resident medical and social history, cultural considerations, alternatives to restraint use and the goals of the restraint intervention. One resident file was reviewed - and evidenced that a documented restraint assessment, discussion and alternatives form has been completed. Family/whanau input and consent is required prior to the application of any forms of restraint at Whalan Lodge. Advised that restraint is only used as a last resort, when the resident is restless and attempts to mobilise unaided, and used infrequently as evidenced by restraint monitoring forms. Prior to use of restraint the resident is assessed and alternatives actioned.

##### **Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)**

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

**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 2.2.3: Safe Restraint Use **(**HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint policy states that the need for restraint use is monitored and reviewed as part of the six monthly care plan reviews. On review of one file, this is well documented when restraint in the form of lap belt or bed rails is used. Restraint use is documented with time frames and details of monitoring of the lap belt or bed rails in place. Monitoring occurs at 15 minute intervals when the lap belt is in use while the resident is in a wheel chair and at least two hourly when bed rails are used. Monitoring signing sheets are evident for the resident with restraint and evidence that the restraints have only been used once in July 2014 and three times in June 2014. The service reviews all restraint use as part of the individual care plan review. Restraint is only used at Whalan Lodge as a last resort after all other alternative techniques to modify behaviour or manage resident safety has been exhausted. Advised that the restraints currently in use is for safety measures to prevent falls. This is outlined as policy requirements in the restraint minimisation and safe practice policy. A restraint register is maintained with the resident’s name and restraint details included for both the lap belt and bed rails. Staff training records are maintained and individual participation in restraint training is identified. Restraint questionnaire and competencies are completed by all care staff.

##### **Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)**

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

**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 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

**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 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)**

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

**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 2.2.4: Evaluation **(**HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

The use of restraining devices is evaluated by the restraint coordinator (manager) and registered nurse as part of the care planning review process in conjunction with the resident, their family/whanau and GP. Points a) to k) above are considered as part of this review. On review of one resident file, both forms of restraint, have been reviewed three monthly as per policy. Restraint use and approval is discussed at the quality management meeting and staff meetings and is appropriate for size and complexity of the service.

##### **Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)**

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:  
(a) Future options to avoid the use of restraint;  
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;  
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);  
(d) Whether the desired outcome was achieved;  
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;  
(f) The duration of the restraint episode and whether this was for the least amount of time required;  
(g) The impact the restraint had on the consumer;  
(h) Whether appropriate advocacy/support was provided or facilitated;  
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;  
(j) Whether the service's policies and procedures were followed;  
(k) Any suggested changes or additions required to the restraint education for service providers.

**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 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

**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 2.2.5: Restraint Monitoring and Quality Review **(**HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

Whalan Lodge reviews the use of restraint as part of its internal audit processes as per the audit schedule in place (last conducted in March 2014). The results of the restraint audit are discussed at the two monthly staff meetings and two monthly quality management meeting where restraint use and approval is discussed. Any corrective actions identified are actioned through these forums.

##### **Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)**

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:  
(a) The extent of restraint use and any trends;  
(b) The organisation's progress in reducing restraint;  
(c) Adverse outcomes;  
(d) Service provider compliance with policies and procedures;  
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;  
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;  
(g) Whether changes to policy, procedures, or guidelines are required; and  
(h) Whether there are additional education or training needs or changes required to existing education.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Whalan Lodge has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by an external provider and signed off by the manager. The registered nurse is the service infection control coordinator. The management team and staff meeting incorporate the infection control committee. Discussion and reporting of infection control matters and consequent review of the programme is conducted at these meetings. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff (March 2014). Annual review of the 2013 programme was conducted in April 2014. Hand washing facilities are available for staff, residents and visitors throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised.

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

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

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

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

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

**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 3.2: 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 registered nurse is the infection control (IC) nurse. She is supported by the manager and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The registered nurse has attended infection control training. The IC nurse and staff have good external support from the local laboratory infection control team, GP and medical centre and IC nurse from Oamaru Hospital. The infection control team is representative of the facility.

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

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

**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 infection control policy and procedures appropriate to for the size and complexity of the service.  
D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by an external provider to ensure best practice information is included. The policies and procedures were provided in July 2013. Whalan Lodge’s infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; surveillance, antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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

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

**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 infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse (RN) and the manager with support from an external provider who provide the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. The IC nurse has attended infection control education in the past two years. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. No outbreaks have been reported in the past 12 months. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Education on infection control and standard precautions was provided for staff in March 2014.

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Infection surveillance is an integral part of the infection control programme and is described in Whalan Lodge’s infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the quality management meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Infection rates are low with two eye infections and one chest infection reported in the past six months.

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

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

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