

St Clair Park Residential Centre Limited

Current Status: 14 July 2014

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

General overview

St Clair Park is certified to provide residential disability services for residents with intellectual, physical, sensory and/or mental health needs and rest home level care for up to 34 residents. On the day of the audit there were 14 mental health residents, five physical disability, ten intellectual disability and four rest home residents. In addition there is one resident under a carer support contract. This makes a total of 33 residents. St Clair Park's manager and registered nurses are qualified for their roles. Staff turnover remains low. There are systems being developed to guide appropriate support for the varying needs of the residents. A quality programme is being implemented. An induction programme and in-service training programme is in place. Additional training is being implemented that will provide support staff with appropriate knowledge and skills to support the range of residents.

There are improvements required around informed consent, policy development, incident reporting, consumer and family participation, training, documentation, care planning and evaluation, activities, medication management, environment and infection control.

Audit Summary as at 14 July 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 14 July 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 14 July 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Continuum of Service Delivery as at 14 July 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 14 July 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Restraint Minimisation and Safe Practice as at 14 July 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 14 July 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.
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Audit Results as at 14 July 2014

Consumer Rights

St Clair Park is developing strengths assessments and individual resident goals to support residents. There is a cultural awareness policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are available to support individual rights and the service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is available to residents and families. A training programme is being developed and implemented that supports staff understanding of residents' rights. Individual strengths assessments and goals will identify the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. There is an improvement required around informed consent.

Organisational Management

St Clair Park is developing and implementing a quality and risk management system that supports the provision of service delivery. Key components of the quality management system link to the scheduled meetings including monthly staff meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Residents interviewed report that they are involved in choices around individual service delivery. There is no formal mechanism for consumer input into service planning, implementation, monitoring and evaluation at a management and governance level and no policy around this. Staff and residents do not receive education around maximising consumer participation in the service. There is no process or policies or procedures to ensure families are involved in the planning, implementation, monitoring and evaluation of the service at a management and governance level. Quality performance is reported to staff at monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources processes that guide recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an in-service training programme that is being enhanced to cover relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around consumer and family participation, policy development, incident reporting, training and documentation.

Continuum of Service Delivery

Residents' needs for all service levels are assessed prior to entry. There is an information pack available for residents/families/whānau at entry that has been adjusted for each service type. Assessments, care plans, goal plans (for disability residents) and reviews are completed or signed by the registered nurses. Aged care residents have InterRAI assessments completed and disability residents have strengths assessments partially completed. Care and goal plans are individualised. Short term care plans are in use for changes in health status. Care plans are reviewed six monthly or more frequently when clinically indicated. There are improvements required around GP reviews for aged care residents, strengths assessments for disability residents, care plans, wound management and evaluations.

The activities coordinator is responsible for activities and there are programmes running at the facility that are meaningful and reflect ordinary patterns of life. There are also regular group outings. Additionally there is a community links support worker who is responsible for ensuring residents are linked to community resources to meet their goals. Disability residents assist with room cleaning and personal linen changes and laundry. There is an improvement required around residents having input into household shopping and meal preparation

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner or psychiatrist three monthly or earlier if necessary. There are improvements required around medication administration.

Food is cooked off site by a contracted catering company and delivered in hot boxes before being transferred to bain maries and served. Residents discuss menus at residents meetings and are able to request menu changes. Residents' individual dietary needs are identified, documented and reviewed on a regular basis. Residents and family members interviewed were very complimentary of the food service provided and report their individual preferences are well catered. Additional snacks are available if at all times.

Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Service providers receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by staff. The service is provided over three units with joining corridors. There is a mix of service types in each unit. Staff documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is an improvement required around obtaining a building warrant of fitness and having the scales calibrated. Documented policies and procedures for the cleaning and laundry services are implemented. Staff have completed appropriate training in chemical safety. There is compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

Restraint Minimisation and Safe Practice

There is a restraint policy in place to guide staff and staff are aware of the content of the policy and have attended refresher education on de-escalation and breakaway techniques. There are no residents using enablers or restraints. All disability residents have risks and early warning signs clearly documented and risk management strategies documented.

Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size and complexity of the service. The programme has not been reviewed annually and this is a required improvement. The infection control co-ordinator (registered nurse) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are infection control policies and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

HealthCERT Service Provider Audit Report (version 6.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of a health and disability 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:	St Clair Park Residential Centre Ltd
Certificate name:	St Clair Park Residential Centre
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Certification
Premises audited:	St Clair Park, 287 Middleton Rd, Dunedin
Services audited:	Rest Home, Residential – physical, psychiatric, intellectual disability
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:	34

Audit Team

Lead Auditor	XXXXXXXX	Hours on site	15	Hours off site	8
Other Auditors	XXXXXXXXXX	Total hours on site	15	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXX			Hours	2

Sample Totals

Total audit hours on site	30	Total audit hours off site	18	Total audit hours	48
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Number of residents/patients interviewed	8	Number of staff interviewed	7	Number of managers interviewed	1
Number of residents'/patients' records reviewed	8	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	19	Total number of staff (headcount)	29	Number of relatives interviewed	3
Number of residents'/patients' records reviewed using tracer methodology	4			Number of GPs interviewed (Residential Disability providers only)	1

Declaration

I,XXXXXXXXX , 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 Thursday, 21 August 2014

Executive Summary of Audit

General Overview

St Clair Park is certified to provide residential disability services for residents with intellectual, physical, sensory and/or mental health needs and rest home level care for up to 34 residents. On the day of the audit there were 14 mental health residents, five physical disability, ten intellectual disability – one of which is funded by ACC and four rest home residents. In addition there is one resident under a carer support contract. This makes a total of 33 residents. St Clair Park's manager and registered nurses are qualified for their roles. Staff turnover remains low. There are systems being developed to guide appropriate support for the varying needs of the residents. A quality programme is being implemented. An induction programme and in-service training programme is in place. Additional training is being implemented that will provide support staff with appropriate knowledge and skills to support the range of residents. There are improvements required around informed consent, policy development, incident reporting, consumer and family participation, training, documentation, care planning and evaluation, activities, medication management, environment and infection control.

Outcome 1.1: Consumer Rights

St Clair Park is developing strengths assessments and individual resident goals to support residents. There is a cultural awareness policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are available to support individual rights and the service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is available to residents and families. A training programme is being developed and implemented that supports staff understanding of residents' rights. Individual strengths assessments and goals will identify the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. There is an improvement required around informed consent.

Outcome 1.2: Organisational Management

St Clair Park is developing and implementing a quality and risk management system that supports the provision of service delivery. Key components of the quality management system link to the scheduled meetings including monthly staff meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Residents interviewed (three mental health) report that they are involved in choices around individual service delivery. There is no formal mechanism for consumer input into service planning, implementation, monitoring and evaluation at a management and governance level and no policy around this. Staff and residents do not receive education around maximising consumer participation in the service. There is no process or policies or procedures to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level. Quality performance is reported to staff at monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources processes that guide recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an in-service training programme that is being enhanced to cover relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around consumer and family participation, policy development, incident reporting, training and documentation.

Outcome 1.3: Continuum of Service Delivery

Resident's needs for all service levels are assessed prior to entry. There is an information pack available for residents/families/whānau at entry that has been adjusted for each service type. Assessments, care plans, goal plans (for disability residents) and reviews are completed or signed by the registered nurses. Aged care residents have InterRAI assessments completed and disability residents have strengths assessments partially completed. Care and goal plans are individualised. Short term care plans are in use for changes in health status. Care plans are reviewed six monthly or more frequently when clinically indicated. These are improvements required around GP reviews for aged care residents, strengths assessments for disability residents, care plans, wound management and evaluations.

The activities coordinator is responsible for activities and there are programmes running at the facility that are meaningful and reflect ordinary patterns of life. There are also regular group outings. Additionally there is a community links support worker who is responsible for ensuring residents are linked to community resources to meet their goals. Disability residents assist with room cleaning and personal linen changes and laundry. There is an improvement required around residents having input into household shopping and meal preparation

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner or psychiatrist three monthly or earlier if necessary. There are improvements required around medication administration.

Food is cooked of site by a contracted catering company and delivered in hot boxes before being transferred to bain maries and served. Residents discuss menus at residents meetings and are able to request menu changes. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Residents and family members interviewed were very complimentary of the food service provided and report their individual preferences are well catered. Additional snacks are available if at all times.

Outcome 1.4: Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Service providers receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by staff. The service is provided over three units with joining corridors. There is a mix of service types in each unit. Staff documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is an improvement required around obtaining a building warrant of fitness and having the scales calibrated. Documented policies and procedures for the cleaning and laundry services are implemented. Staff have completed appropriate training in chemical safety. There is compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy in place to guide staff and staff are aware of the content of the policy and have attended refresher education on de-escalation and breakaway techniques. There are no residents using enablers or restraints. All disability residents have risks and early warning signs clearly documented and risk management strategies documented.

Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size and complexity of the service. The programme has not been reviewed annually and this is a required improvement. The infection control co-ordinator (registered nurse) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are infection control policies and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	32	0	11	4	0	0
Criteria	0	95	0	12	4	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	1	0	0	0	0	0	9
Criteria	0	5	0	0	0	2	0	23

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S .2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S .2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Low	(i)MH 24: Mental health residents are not routinely provided a copy of their goal plan. (ii) Informed consents are not obtained and maintained on resident files and admission agreements are not signed for one of	(i)MH 24: Ensure mental health residents are provided with a copy of their goal plans. (ii) Ensure informed consent is obtained and maintained on file and admission agreements are	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				two physical disability and one of two intellectual disability files reviewed.	signed for all residents.	
HDS(C)S .2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S .2008	Criterion 1.2.3.3	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.	PA Low	<p>The quality plan should be enhanced to include addressing Maori issues (noting there are no residents identifying as Maori at the service at the time of audit) as per contract. The suite of policies have an aged residential care focus, and were reportedly implemented when the service had an operational relationship with a local facility. The documents in place cover key aspects of service delivery such as initial assessment, incident management and challenging behaviour assessment and plans. There is a lack of procedural documents guiding development of strengths assessment and recovery goals (and/or relapse prevention planning) which are in the process of being implemented. Additionally, there is incongruence between policy and practice noted particularly in respect of incident reporting. Staff reportedly notify families of incidents based on severity, and in agreement with the family, i.e., a number of families request notification following a 'moderate' event only. There is no definition of 'moderate' in the current policy. Policy review is an objective for the current year, and at the time of audit</p>	<p>Clinical policies are to be reviewed to strengthen the accepted model of care for mental health and/or intellectual/physical disability residents. Policy and practice are to align.</p>	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				there is evidence review is commencing.		
HDS(C)S .2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate			
HDS(C)S .2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Two resident files were reviewed and in both files, a number of reported incidents did not have an associated form – one incident in file one, and 12 in file two. In file two the resident was a frequent faller, and had supporting documentation in place – including a falls log. Interview informed where a falls log and/or challenging behaviour plan is in place, an incident form is not required. This exemption is not outlined in the incident reporting policy (link 1.2.3). In both resident files, appropriate interventions are recorded in support/care plans to manage care.	Incident forms are completed as prescribed in policy.	30
HDS(C)S .2008	Standard 1.2.5: Consumer Participation	Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.	PA Low			
HDS(C)S .2008	Criterion 1.2.5.1	The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.	PA Low	There is no formal mechanism for consumer input into service planning, implementation, monitoring and evaluation at a management and governance level.	Develop a process to ensure consumer input into service planning, implementation, monitoring and evaluation at a management and governance level	180
HDS(C)S .2008	Criterion 1.2.5.2	Consumers and consumer groups involved in planning, implementation, and evaluation of services have clear	UA Low	As there is no input at this level there are no consumers or consumer groups requiring terms of reference or position	Develop terms of reference or a position description for consumers or consumer	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		terms of reference and position descriptions, and are appropriately reimbursed for expenses and/or paid for their time and expertise.		descriptions.	groups who may be involved in planning, implementation and evaluation of services.	
HDS(C)S .2008	Criterion 1.2.5.3	The service assists with training and support for consumers and service providers to maximise consumer participation in the service.	UA Low	Staff and residents do not receive education around maximising consumer participation in the service.	Ensure staff and residents receive education around maximising consumer participation in the service.	180
HDS(C)S .2008	Criterion 1.2.5.4	The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view.	PA Low	There is no policy or procedure to guide consumer input into service planning, implementation, monitoring and evaluation at a management and governance level and no policy around this.	Develop policies or procedures to guide consumer input into service planning, implementation, monitoring and evaluation at a management and governance level and no policy around this.	180
HDS(C)S .2008	Standard 1.2.6: Family/Whānau Participation	Family/Whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.	UA Low			
HDS(C)S .2008	Criterion 1.2.6.1	The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.	UA Low	There is no process to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.	Develop and implement a process to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.	180
HDS(C)S .2008	Criterion 1.2.6.2	Family/Whānau who participate in an advisory capacity have clear terms of reference.	UA Low	As there is no input at this level there are no family requiring terms of reference.	Develop terms of reference family who may be involved in an advisory capacity.	180
HDS(C)S .2008	Criterion 1.2.6.3	The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view.	UA Low	There are no policies or procedures to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.	Develop policies or procedures to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.	180
HDS(C)S	Standard	Human resource management	PA			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
.2008	1.2.7: Human Resource Management	processes are conducted in accordance with good employment practice and meet the requirements of legislation.	Moderate			
HDS(C)S .2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	There is an estimated 4-5 care/support workers (of an estimated 21) who have completed a mental health level 4 training (certificates not sighted), this does not meet requirement of MHA24 and 25. The activities coordinator does not have relevant training in respect of the resident group. The community link support worker does not have relevant training in respect of the role responsibilities she holds.	Care/support workers hold a relevant L4 qualification in mental health, the activities coordinator and community link support worker to undertake training relevant to their respective roles.	90
HDS(C)S .2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S .2008	Criterion 1.2.9.9	All records are legible and the name and designation of the service provider is identifiable.	PA Low	In eight of the eight files reviewed there are documents – eg: care/support plans and assessments – that are not dated and signed.	Date and sign all clinical records.	30
HDS(C)S .2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S .2008	Criterion 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.	PA Low	Two of two rest home resident files evidenced that three monthly medical reviews have not consistently occurred.	Ensure all rest home resident have a full medical review at least three monthly.	90
HDS(C)S .2008	Standard 1.3.4:	Consumers' needs, support requirements, and preferences are	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Assessment	gathered and recorded in a timely manner.				
HDS(C)S .2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	Six of six residential disability files (two intellectual disability, two physical disability and two mental health) do not have comprehensively completed strengths assessments.	Ensure all disability residents have a comprehensively completed strengths assessment.	90
HDS(C)S .2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S .2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	(i) One of two rest home resident files reviewed has experienced 15 falls since March (link 1.3.3) and has no interventions relating to this in the care plan. (ii) D16.3f: Two of two resident files reviewed identified that family are not involved in care plan development and this was confirmed by the one family member interviewed. (iii) One of the two mental health resident files reviewed is for a resident with a current XXXX (link 1.3.3) and there is no short term care plan around this. (iv) One physical disability resident has a history XXXX and is prescribed XXXXX but this is not addressed in the care plan.	(i) and (iii) and (iv) Ensure all identified needs are addressed in care plans. (ii) Ensure that family are included in the care planning process and that this is documented.	90
HDS(C)S .2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S .2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	When the registered nurse interviewed questioned reported there are no wounds at the facility. During a tour of the facility one resident was noted to have a dressing on his hand. The care/support worker caring for him that	Ensure all wounds are reported and assessed and a plan developed with regular dressing changes and reviews.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				duty was also not aware of the wound. When questioned the resident (who is competent) stated that he had 'lost a bit of skin' and that the registered nurse had dressed it. There is no documentation, wound assessment or plan relating to this wound.		
HDS(C)S .2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low			
HDS(C)S .2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	As all meals are prepared off site, apart from baking as an 'activity' there is no opportunity for residents to be involved in household shopping or meal preparation.	Ensure disability (particularly mental health and intellectual disability) residents are provided with opportunities to be involved in household management including household shopping and meal preparation.	180
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	The care plan evaluation is an overall comment at the end of the care plan and does not document progress toward each goal or response to interventions.	Ensure care plan evaluations document progress toward each goal or response to interventions.	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	PA Moderate	One of two residents with an XXXX has not had the XXXXX strictly adhered to on two occasions in the past seven days. One resident with a recent change in XXXX has had the	Ensure medications are documented as administered as prescribed.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		order to comply with legislation, protocols, and guidelines.		previous dose administered on one occasion in the past week. One resident with QID XXXX prescribed has not always had these administered QID.		
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	(i) There is not a current Building Warrant of Fitness with the previous one having expired in 2012. (ii) The scales have not been calibrated.	(i)Continue the process to obtain a building warrant of fitness. (ii) Ensure all medical equipment is calibrated according to manufacturer's recommendations.	90
HDS(IPC)S.2008	Standard 3.1: Infection control management	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.	PA Low			
HDS(IPC)S.2008	Criterion 3.1.3	The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.	PA Low	Infection control manual was last reviewed March 2013 and includes the programme and associated policies. The infection control programme requires annual review.	Review and evaluate the infection control programme.	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.

Attainment and Risk: FA

Evidence:

St Clair Park has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code) (link 1.2.3). Families and residents are provided with information on admission which includes the Code. Staff receive training about abuse and neglect and advocacy services that includes the Code, at orientation and as part of the in-service programme (link 1.2.7). Interview with three care/support workers (who work across service areas) demonstrate an understanding of the Code. Elder abuse training was provided November 2013 by Age Concern Otago. Residents interviewed (three mental health, two intellectual disability, one physical disability and two rest home) and relatives (two intellectual disability and one rest home) confirm staff respect privacy, and support residents in making choice where able.

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.

Attainment and Risk: FA

Evidence:

There is an admission pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Posters of the Code and advocacy information are displayed in the service. The monthly resident meetings also provide the opportunity for residents to raise issues (minutes sighted). Residents interviewed (three mental health, two intellectual disability, one physical disability and two rest home) and relatives (two intellectual disability and one rest home) inform information has been provided around the Code. The manager informs an open door policy for concerns or complaints.

D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability Commission.

D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>There are policies in place to guide practice in respect of privacy and respect (link 1.2.3). A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' and their personal privacy during the audit. Resident files are stored out of sight. Staff could describe aspects of abuse and neglect, and informed recent training on the topic (November 2013). Three relatives interviewed stated staff are respectful. A resident satisfaction survey is completed annually (March 2014). The March survey informed residents are satisfied or very satisfied with the service.</p> <p>The service involves residents in strengthens assessments and recovery goals development (care/support plans) (link 1.3.4). Resident preferences are identified during the admission and on-going goals development and review process. The service encourages residents to have choices and this includes voluntary participation in daily activities both at the facility and in community settings. The recent appointment of a Community Links Support role (March 2014) is intended to support integration into community activities (link1.2.7).</p> <p>Interview with three care/support workers describe how choice is incorporated into resident cares. Residents interviewed (three mental health, two intellectual disability, one physical disability and two rest home) and relatives (two intellectual disability and one rest home) inform staff are respectful.</p> <p>There is an abuse and neglect policy being implemented and staff attend in-service (November 2013) (link 1.2.3).</p> <p>The eight files reviewed (two from each service type) demonstrate individual values and preferences are included in the admission/assessment and goal development process (link 1.3.4).</p> <p>D4.1: Two rest home resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission and integrated with the residents' support plan. This includes cultural, religious, social and ethnic needs. Interviews with residents confirm their values and beliefs were considered. Family are encouraged to be involved.</p> <p>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</p> <p>D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>St Clair Park has a cultural responsiveness policy that includes guidelines on the provision of culturally safe services for Maori (link 1.2.3) including recognition of Māori values and beliefs. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. It has reportedly been challenging to engage family involvement. In an attempt to improve this, a letter has recently been sent to family members seeking email contact information as a means of improving family links (verified in management meeting minutes). Links are established with community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan – included in the eight files reviewed across all service areas. At the time of audit the staff report there are no residents that identify as Maori. D20.1i There are policies to guide staff in cultural safety.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

Criterion 1.1.4.7 (HDS(C)S.2008:1.1.4.7)

The service provides education and support for tangata whaiora, whānau, hupu, and iwi to promote Māori mental well-being.

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

Standard 1.1.5: Recognition Of Pacific Values And Beliefs (HDS(C)S.2008:1.1.5)

Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

Attainment and Risk: FA
Evidence: The resident and family are invited to be involved in strengths assessments, goal development and planning (also refer evidence 1.1.4). Beliefs or values are further discussed and incorporated into the support plan (link 1.3.4). Reviews are scheduled as prescribed and consider if needs are being met. Discussions with three relatives inform values and beliefs are considered. Discussion with residents (three mental health, two intellectual disability, one physical disability and two rest home) confirm that staff take into account their culture and values. There are no residents at the time of audit that identify as Pacific.

Criterion 1.1.5.1 (HDS(C)S.2008:1.1.5.1)

The service delivers and facilitates appropriate services for Pacific consumers and recognises the fundamental importance of the relationships between Pacific consumers, their families, and the community. This shall include, but is not limited to the service:

- (a) Developing effective relationships with Pacific people to support active participation across all levels;
 - (b) Where appropriate, developing services that are based on Pacific frameworks/ models of health that promotes clinical and cultural competence;
 - (c) Ensuring access to services based on Pacific people's need and planning and delivering services accordingly;
 - (d) Developing a culturally enhanced workforce that will respond effectively to the needs of Pacific consumers.
- This may include actively recruiting and employing service providers with links to Pacific people and providing suitable education/training/mentoring of service providers to respond to specific cultural requirements and preferences.

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 1.1.5.2 (HDS(C)S.2008:1.1.5.2)

The service provides education, training, and support to Pacific people or other agencies to promote the well-being of Pacific people.

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.

Attainment and Risk: FA

Evidence:

The resident and family are invited to be involved in assessment, goal development and review. Beliefs are discussed and incorporated into the support plan. Reviews are scheduled and occur to assess if needs are being met (link 1.3.8). Family are invited to attend. Discussions with three relatives inform values and beliefs are considered. Discussion with residents (three mental health, two intellectual disability, one physical disability and two rest home) confirm that staff take into account their culture and values.

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.

Attainment and Risk: FA

Evidence:

Job descriptions include responsibilities of the position and signed copies of employment documents are included in staff files reviewed. Staff meetings occur monthly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Interview with the manger informs an understanding of managing professionally inappropriate behaviour. There is evidence on staff files reviewed of manager performance management of inappropriate behaviour while on duty, and staff memos are used to clearly outline acceptable behaviour in the workplace (examples include: protected disclosure, relative contact and smoke free environment). Interviews with the registered nurse and three care/support workers confirm an understanding of professional boundaries within the context of the difference service types

being provided at St Clair.

Training was provided (by the manager) in February (2014) on mental illness: diagnosis, treatment and supporting recovery (17 attended). A community link support worker has been employed (March 2014) to support resident engagement with community activities (link 1.2.7). There is no evidence of discriminatory behaviour or exploitation during the audit.

Criterion 1.1.7.2 (HDS(C)S.2008:1.1.7.2)

Service providers should have an understanding of discrimination. Service providers shall demonstrate knowledge of the barriers to recovery posed by discrimination, which translates into provider systems that promote recovery.

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

Criterion 1.1.7.3 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.7.4 (HDS(C)S.2008:1.1.7.4)

The service does not withdraw support or deny access to treatment and support programmes when or if the consumer refuses some aspects of treatment.

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

Criterion 1.1.7.5 (HDS(C)S.2008:1.1.7.5)

The service actively works to identify and address prejudicial attitudes and discriminatory practices and behaviours within its own service and any other service it has links with.

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

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

Consumers receive services of an appropriate standard.

Attainment and Risk: FA
Evidence: St Clair Park has a suite of policies and procedures that are up to date (link 1.2.3). There is a quality improvement programme that includes monitoring against clinical

indicators including challenging behaviour (link 1.2.4). There is an on-going staff in-service programme in place and the Careerforce programme is in the process of being implemented (link 1.2.7). At the time of audit 12 care/support staff have been enrolled in the core modules of the programme. The manager reports Careerforce will be compulsory for all care/support staff and once core modules have been completed staff will have the choice of completing either mental health and/or intellectual disability modules. In addition to an annual schedule – and the Careerforce requirement - care/support staff complete a modular programme ‘care training online’. This programme includes modules linked to the HDSS – eg. aging, challenging behaviours, delirium, dementia (link 1.2.7).

It is acknowledged the service has historically delivered from an ‘aged residential care’ perspective. There is evidence of a shift towards strengthening an understanding of the specific needs of the residents with a mental health, intellectual and/or physical disability. Examples include the move to a strengths assessment and recovery (link 1.3.4) approach for care/support planning and the appointment of a full time community links support role (link 1.2.7). The in-service training schedule also shows a move to a different culture/mode of service delivery with sessions such as ‘supporting people’s goals’ (March 2014 – 14 attended), and ‘mental illness: diagnosis, treatment and supporting recovery’ (February 2014 -17 attended). A session on ‘successful teams’ was provided June (2014).

Management expectations of staff is also being documented through internal memos, and relayed to staff at meetings - with examples sighted including: dress code, smoking (staff), relative contacts, and protected disclosure.

The manager informs both registered nurses are receiving professional supervision from suitability qualified clinicians.

ARC A2.2: Services are provided at St Clair Park that adhere to the health & disability services standards.

ARC D17.7c: There are implemented competencies for care/support workers/support workers and registered nurses including but not limited to: insulin administration and medication. RNs have access to external training – one of the registered nurses (RN)’s in on the new graduate programme, completing the mental health modules.

Discussions with residents interviewed (three mental health, two intellectual disability, one physical disability and two rest home) and relatives (two intellectual disability and one rest home) were positive about the care they receive. Interview with three care/support workers (who work across both areas) inform they are well supported by the manager.

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

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.

Attainment and Risk: FA

Evidence:

There is a policy to guide staff on the process around open disclosure, and the complaints policy has recently been updated (June 2014) to include the rights as outlined in the Code. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. In addition there is a record of the family wishes in respect of notification – eg: only notify if incident is ‘moderate’ (link 1.2.4). Six of six incident forms reviewed from across the 2014 year, and an additional five from two resident files across 2014 identify family were notified according to their instruction following a resident incident. Family communication is recorded on a sheet in resident notes. Interview with three care/support workers (who work across both services) and one registered nurse report family are kept informed.

It is acknowledged previous audit activity at the service has identified instances where families report not feeling fully informed (refer previous surveillance and contract audit/s). A corrective action plan was developed following this audit feedback relating to family contact including: a staff memo outlining expectation, and notification to relatives seeking email details to improve links (link 1.2.6). Actions are reported through the management meetings (sighted). The feedback received from the three relatives interviewed informs they feel informed about health changes with their family member (link 1.2.4).

D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: one rest home relative stated that they are informed when their family members health status changes.

D11.3: The information pack is available in large print and this can be read to residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

Attainment and Risk: PA Low
Evidence: <p>Rest home: Written informed consent is gained for do not resuscitate or resuscitation orders appropriately for two of two files sampled. Two files were reviewed and found to have valid consents. It was stated by the manager and registered nurse that family involvement occurs with the consent of the resident. Other forms of written consent included consent to share information and consent for transportation. These are included in the admission agreement. A review of two files found all consents were present and signed by the resident or their EPOA. EPOA documents are kept on the resident's file. Two rest home residents interviewed confirm that they are given good information to be able to make informed choices. Three care/support workers interviewed confirm information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.</p> <p>D13.1 There were two of two rest home admission agreements sighted.</p> <p>D3.1.d Discussion with one rest home family identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Mental health: The service does not store or use body parts or substances. Residents are provided with an information pack at entry which forms part of the admission agreement and includes all consent forms they are asked to sign. One of two files reviewed include signed consents within the admission agreement. The other file was for a resident on intermittent carer support. The three mental health residents interviewed indicated they make informed choices and give consent to care provided.</p> <p>MH 24: The registered nurse interviewed confirms mental health residents are not routinely given a copy of their goal plans. This was confirmed by three of three residents interviewed and this is an area requiring improvement.</p> <p>Intellectual disability and physical disability: The informed consent forms are included as part of the admission agreement. Informed consents are obtained and maintained on resident files for one of two physical disability and one of two intellectual disability files reviewed. This is an area requiring improvement. However, resident wishes were well understood and respected as observed during the audit. Two residents with an intellectual disability and one with a physical disability interviewed stated that they are able to make their own choices</p>

and gave examples of how this occurred. Resident preferences are documented on resident files.

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: PA Low

Evidence:

Mental health: The service does not store or use body parts or substances. Residents are provided with an information pack at entry which forms part of the admission agreement and includes all consent forms they are asked to sign. One of two files reviewed include signed consents within the admission agreement. The other file was for a resident on intermittent carer support. The three mental health residents interviewed indicated they make informed choices and give consent to care provided.

Intellectual disability and physical disability:

The informed consent forms are included as part of the admission agreement. Informed consents are obtained and maintained on resident files for one of two physical disability and one of two intellectual disability files reviewed. However, resident wishes were well understood and respected as observed during the audit. Two residents with an intellectual disability and one with a physical disability interviewed stated that they are able to make their own choices and gave examples of how this occurred.

Resident preferences are documented on resident files.

Finding:

(i)MH 24: Mental health residents are not routinely provided a copy of their goal plan. (ii) Informed consents are not obtained and maintained on resident files and admission agreements are not signed for one of two physical disability and one of two intellectual disability files reviewed.

Corrective Action:

(i)MH 24: Ensure mental health residents are provided with a copy of their goal plans. (ii) Ensure informed consent is obtained and maintained on file and admission

agreements are signed for all residents.

Timeframe (days): 90 (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.

Attainment and Risk: FA

Evidence:

Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the manager, and registered nurse confirm practice. Interviews with residents (three mental health, two intellectual disability, one physical disability and two rest home) confirm that they are aware of their right to access advocacy. Interview with family members (two) of intellectually disabled residents confirm they are provided with opportunities to involved in decisions (link 1.2.6).

D4.1d; Discussions with one rest home family member confirm that the service provides opportunities for the family/EPOA to be involved in decisions
ARC D4.1e. The resident files include information on residents' family/whanau and chosen social networks.

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

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

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

Standard 1.1.12: 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.

Attainment and Risk: FA
Evidence: Residents interviewed (three mental health, two intellectual disability, one physical disability and two rest home) and relatives (two intellectual disability and one rest home) confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Maintaining links with the community is encouraged. A recent initiative has been the appointment of (March 2014) a full time community links support person (interviewed) (link 1.2.7). Although this role is still evolving, the aim is to strengthen resident involvement in community interests either 1:1 or small groups. The establishment of this role supports resident survey feedback from earlier 2014 which requested more activities. One of the registered nurses (and manager) will be supporting this role. Activities programmes include opportunities to attend events outside of the facility such as weekly resident lunches for small groups (link 1.3.7). Interviews with seven residents confirm support staff help them access the community. Discussion with three care/support workers, the activities coordinator, residents interviewed (three mental health, two intellectual disability, one physical disability and two rest home) and relatives (two intellectual disability and one rest home) confirm residents are supported and encouraged to remain involved in the community and external groups. Family involvement in service delivery and development is to be enhanced (link 1.2.6).

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a complaints policy to guide practice. The policy was reviewed June (2014) and includes the code of rights requirements (including timeframes). The manager leads the investigation and management of complaints (verbal and written). There is a complaints log/register that records activity in an ongoing fashion. Complaints are discussed at the monthly staff meeting, two weekly clinical meeting and monthly management meeting. There are no complaints recorded during 2014, and one from 2013 (23 December). The latter was reviewed and demonstrated investigation, follow up with the complainant and was closed out (29 December 2013). There are a number of compliments. Complaints that would have been reviewed as part of the October 2013 surveillance audit have not been further reviewed. Discussion with residents (three mental health, two intellectual disability, one physical disability and two rest home) and relatives (two intellectual disability and one rest home) confirm an awareness of how to make a complaint. Information about advocacy services is available.</p> <p>D13.3h. a complaints procedure is provided to residents within the information pack at entry</p>

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

Attainment and Risk: FA

Evidence:

St Clair Park provides care for up to 34 residents across multiple contract types – residential disability: physical, intellectual, mental health and aged residential care. The service is also certified for residential disability – sensory, at the time of audit the manager reports there are no residents under this service type in the facility.

On the day of the audit there were 14 mental health residents, five physical disability, ten intellectual disability – one of which is funded by ACC - and four rest home residents. This makes a total of 33 residents on the day of audit. The service is delivered across three 'units' – Ashwood, Cargill and Middleton. The units are set up to cater for different resident needs – i.e. More challenging residents in Ashwood and older/calmer residents in Cargill. The Middleton unit is smaller and low stimulus. The different resident types (eg. mental health, intellectual etal) are cared for in any of the units.

St Clair Park has a philosophy, mission and values as well as specific goals identified in the Business Plan for the 2014 year that include improving and maintaining quality documents and processes; staff education; physical environment and occupancy. Progress towards goals are minuted as discussed at the bimonthly management meetings (minutes sighted). The service is implementing initiatives in response to feedback such as the newly developed Community Support Link role (link 1.2.7). There is a quality programme being implemented that includes discussion about clinical indicators at the monthly staff meeting, the two to four weekly clinical meeting and the bimonthly management meeting.

The service is managed by an experienced registered psychiatric nurse who has been the manager (fulltime) at St Clair Park since September 2012 and holds a current practising certificate. He has approximately 40 years mental health experience in a range of settings from acute through to psychogeriatric services. Most recently he was clinical leader with SDHB and then project manager implementing strengths assessment and recovery goals within mental health services. Subsequently he took this work to the United States. The manager reports through to a director (related to the owner), who in turn reports to the owner.

The service is supported by two registered nurses who are both comprehensive trained. They work 35 hours/week each and alternate on call cover. The manager is also on call as part of the escalation process. The registered nurses are relatively junior – one is completing a new graduate programme (currently completing mental health component), and the second started just prior to the new manager. She commenced following graduation. The manager reports both registered nurses have professional supervision by appropriately skilled mental health professionals. There is a team of care/support workers, the majority have been at the service for a number of years.

There are no instances sighted where the on call arrangements have led to untimely intervention for residents.

There have been two contract audits since the last surveillance audit – DSS 12 and 19 February (2014) and Central Tas 26-28 February (2014). These audits were focused on services received by residential intellectual and physical residents and mental health residents respectively. The reports were requested (and readily provided) on day two of this certification audit.

The DSS and Tas audits resulted in a number of findings essentially identifying similar themes – i.e. service delivery being more aligned to an aged care philosophy as opposed to a normative approach. While this audit has not reviewed all findings and actions taken specifically, there is evidence that a philosophical change is in process at the service. In addition there is evidence corrective actions have been taking place following the various audits including (but not limited to): relative notification (see evidence 1.1.9, also link 1.2.6), establishment of the community support link role (link 1.2.7), complaints policy includes the code, business plan and goals reviewed, quality plan reviewed and fire extinguisher testing completed. In addition the findings from this certification audit are representative of the stage the service is at in terms of redefining service delivery and implementing a culture change – such as clinical findings around completion of the strengths assessment and recovery goal setting, and finding against training. Individual corrective actions are seen to be developed – with a number still in process – that relate to previous audit activity.

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

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

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.

Attainment and Risk: FA
Evidence: During a temporary absence, the registered nurses will cover the manager's role. The registered nurses rotate being on call with the manager available dependent on the

issue. The manager holds a current practising certificate and the registered nurse interviewed during the audit is suitably experienced in her role to manage on call requests. The second registered nurse (not on duty during the audit) reportedly contacts either the manager or RN colleague if additional advice is needed afterhours.

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.

Attainment and Risk: PA Low

Evidence:

St Clair Park is implementing a quality and risk management system. The service has a Business Plan (2014) and a reviewed Quality Plan (May 2014), the latter includes a risk management plan/policy. The business plan includes a philosophy and service risks, objectives (that are essentially mirrored across the business and quality documents), systems that will support meeting the objectives (eg. internal audit) and staff responsibilities. Resident (consumer) and family input has been identified in the business plan as an area of focus (link 1.2.5 and 1.2.6). Progress towards goals is reported through the management meeting (bimonthly). The plan is to be enhanced to include addressing Maori issues (noting there are no residents identifying as Maori at the service at the time of audit) as per contract.

While there are policies and procedures available that align to relevant standards (such as Health and Disability Services Standards) the policies have an aged residential care focus, and require modification to strengthen the accepted model of care for mental health and/or intellectual/physical disability residents. In addition review of policies should reflect current best practice. This is an area for improvement. As policies are being reviewed, previous versions are being taken from the current manuals. Policy review and update has been included as an objective in the business plan for the 2014 year with November as the target for completion of clinical policies.

The quality meetings are incorporated into the two-four weekly clinical meetings and quality matters are also included in the monthly staff meetings and the bimonthly management meetings. There is a documented expectation that staff attend a minimum of eight staff meetings per year, and six in-service sessions (sighted staff memo). The latter are generally run at the end of the staff meeting. All meeting minutes reviewed across 2014 demonstrate key components of the quality management system are discussed including (but not limited to): internal audit, infection control, incidents (and individual trends) and education. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised

are followed through and closed out, including resident meetings (monthly).

St Clair Park is implementing an internal audit programme that includes aspects of clinical care – such as file review. Issues arising from internal (and external) audits are either resolved at the time or developed into a corrective and preventative action plan. Plans reviewed are either in the process of being actioned or had been signed and closed out. Progress is reported through the management meetings, and outcomes to relevant staff meetings.

There is a health and safety and risk management programme in place. A newly appointed care/support worker is the health and safety representative for the facility who will be responsible for monitoring staff accidents and incidents. Although she has yet to attend relevant training, the manager has attended external training and provides support to the role. There is a hazard register that was last reviewed May 2014. The new representative was not available to interview.

D19.2g: Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.

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

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: PA Low
Evidence: There is reviewed Quality Plan (May 2014) in place that includes a risk management plan/policy. The quality plan includes a philosophy and service risks, objectives, systems that will support meeting the objectives (eg. internal audit) and staff responsibilities. Resident (consumer) and family input has been identified in the plan. There are policies and procedures available that align to relevant standards (such as Health and Disability Services Standards). The policies have an aged residential care focus, and require modification to strengthen alignment to the accepted model of care for mental health and/or intellectual/physical disability residents. Policies should reflect current best practice. It is noted review of the policy manuals is an objective for 2014 and at the time of audit review of documents was underway (eg. complaints refer evidence 1.1.13). Previous versions of documents are removed from manuals following update. Interview with the manager and registered nurse inform an intent to streamline the policy documents to improve 'usability'.

Finding:

The quality plan should be enhanced to include addressing Maori issues (noting there are no residents identifying as Maori at the service at the time of audit) as per contract.

The suite of policies have an aged residential care focus, and were reportedly implemented when the service had an operational relationship with a local facility. The documents in place cover key aspects of service delivery such as initial assessment, incident management and challenging behaviour assessment and plans. There is a lack of procedural documents guiding development of strengths assessment and recovery goals (and/or relapse prevention planning) which are in the process of being implemented.

Additionally, there is incongruence between policy and practice noted particularly in respect of incident reporting. Staff reportedly notify families of incidents based on severity, and in agreement with the family, i.e., a number of families request notification following a 'moderate' event only. There is no definition of 'moderate' in the current policy.

Policy review is an objective for the current year, and at the time of audit there is evidence review is commencing.

Corrective Action:

Clinical policies are to be reviewed to strengthen the accepted model of care for mental health and/or intellectual/physical disability residents.

Policy and practice are to align.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event when on site. The incident form is reviewed initially by the manager, and then forwarded to the registered nurse for final sign off. Family are notified appropriately (refer evidence 1.1.9 and 1.2.3). Two resident files were reviewed and in both files, a number of reported incidents did not have an associated form and this is an area of improvement.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.

D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the staff and tow-four weekly clinical meeting

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: PA Moderate

Evidence:

Incident forms are completed by staff following an event. The resident is reviewed by the registered nurse at the time of event if on site. The form is forwarded to the manager initially and then to the registered nurse for final sign off. Family are seen to have been appropriately notified. Interview with the registered nurse confirmed an awareness of resident incidents and resulting outcomes.

Finding:

Two resident files were reviewed and in both files, a number of reported incidents did not have an associated form – one incident in file one, and 12 in file two. In file two the resident was a frequent faller, and had supporting documentation in place – including a falls log. Interview informed where a falls log and/or challenging behaviour plan is in place, an incident form is not required. This exemption is not outlined in the incident reporting policy (link 1.2.3). In both resident files, appropriate interventions are recorded in support/care plans to manage care.

Corrective Action:

Incident forms are completed as prescribed in policy.

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

Standard 1.2.5: Consumer Participation (HDS(C)S.2008:1.2.5)

Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk: PA Low

Evidence:

The service has regular combined residents meetings and there is a policy to guide residents meetings. Residents interviewed (three mental health) report that they are involved in choices around individual service delivery. There is no formal mechanism for consumer input into service planning, implementation, monitoring and evaluation at a management and governance level and no policy around this. These are areas requiring improvement. As there is no input at this level there are no consumers or consumer groups requiring terms of reference or position descriptions. This is a further area requiring improvement. Staff and residents do not receive education around maximising consumer participation in the service. This is a further area requiring improvement.

Criterion 1.2.5.1 (HDS(C)S.2008:1.2.5.1)

The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.

Attainment and Risk: PA Low
Evidence: The service has regular combined residents meetings and there is a policy to guide residents meetings. Residents interviewed (three mental health) report that they are involved in choices around individual service delivery.
Finding: There is no formal mechanism for consumer input into service planning, implementation, monitoring and evaluation at a management and governance level.
Corrective Action: Develop a process to ensure consumer input into service planning, implementation, monitoring and evaluation at a management and governance level
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.5.2 (HDS(C)S.2008:1.2.5.2)

Consumers and consumer groups involved in planning, implementation, and evaluation of services have clear terms of reference and position descriptions, and are appropriately reimbursed for expenses and/or paid for their time and expertise.

Attainment and Risk: UA Low
Evidence: As there is no input at this level there are no consumers or consumer groups requiring terms of reference or position descriptions.
Finding: As there is no input at this level there are no consumers or consumer groups requiring terms of reference or position descriptions.
Corrective Action: Develop terms of reference or a position description for consumers or consumer groups who may be involved in planning, implementation and evaluation of services.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.5.3 (HDS(C)S.2008:1.2.5.3)

The service assists with training and support for consumers and service providers to maximise consumer participation in the service.

Attainment and Risk: UA Low
Evidence: Staff and residents do not receive education around maximising consumer participation in the service – also refer finding 1.2.7.
Finding: Staff and residents do not receive education around maximising consumer participation in the service.
Corrective Action: Ensure staff and residents receive education around maximising consumer participation in the service.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.5.4 (HDS(C)S.2008:1.2.5.4)

The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view.

Attainment and Risk: PA Low
Evidence: There is a policy around resident meetings – also refer finding 1.2.3.
Finding: There is no policy or procedure to guide consumer input into service planning, implementation, monitoring and evaluation at a management and governance level and no policy around this.
Corrective Action: Develop policies or procedures to guide consumer input into service planning, implementation, monitoring and evaluation at a management and governance level and no policy around this.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.5.5 (HDS(C)S.2008:1.2.5.5)

The service implements processes that involve consumers at all levels of 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 1.2.6: Family/Whānau Participation (HDS(C)S.2008:1.2.6)

Family/Whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk: UA Low
Evidence: There is no process or policies or procedures to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level. The standard is unmet.

Criterion 1.2.6.1 (HDS(C)S.2008:1.2.6.1)

The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.

Attainment and Risk: UA Low
Evidence: There is no process to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.
Finding: There is no process to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.
Corrective Action: Develop and implement a process to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.6.2 (HDS(C)S.2008:1.2.6.2)

Family/Whānau who participate in an advisory capacity have clear terms of reference.

Attainment and Risk: UA Low
Evidence: As there is no input at this level there are no family requiring terms of reference.
Finding: As there is no input at this level there are no family requiring terms of reference.
Corrective Action: Develop terms of reference family who may be involved in an advisory capacity.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.6.3 (HDS(C)S.2008:1.2.6.3)

The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view.

Attainment and Risk: UA Low
Evidence: There are no policies or procedures to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.
Finding: There are no policies or procedures to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.
Corrective Action: Develop policies or procedures to ensure families in the planning, implementation, monitoring and evaluation of the service at a management and governance level.
Timeframe (days): 180 (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.

Attainment and Risk: PA Moderate

Evidence:

There are human resources policies to support recruitment practices (link 1.2.3). Copies of practising certificates is maintained. Six staff files were reviewed (one registered nurse who is the infection control coordinator, three care/support workers, activities coordinator, community link support worker) and all had documentation relating to employment. Interview with the manager informed staff are now under a collective employment agreement due for renegotiation June 2014 (service and food workers). Performance appraisals are current in all files reviewed.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes competencies and induction checklists (sighted in files of newly appointed staff). There is a 'buddying' process in place for new staff (interview registered nurse and three care/support workers). The manager (and care/support staff) inform recruitment for casual staff is in process - there were no reported instances where unexpected absence was unable to be covered. Staff interviewed (three care/support staff and one registered nurse) were able to describe the orientation process and believed new staff were adequately orientated to the service.

There is an education plan that is being implemented. In addition care/support staff are required to complete Care Training Online – a modular programme that covers core training requirements in accordance with HDSS. Careerforce training is also due to be implemented with a focus on core competencies followed by the ID and mental health modules. There are approximately 12 staff enrolled at the time of audit. At the time of audit there are reportedly 4-5 care/support workers who have completed a mental health level 4 training (certificates not sighted) and this is an area of improvement. In addition the activities coordinator and community links support worker require training in respect of their roles.

The manager informs the registered nurses both have professional supervision by an appropriately qualified RN. Interview with three care/support workers confirm participation in the Care Training Online programme and an understanding of the Careerforce programme. A competency programme is in place for medication and insulin. Staff interviewed are aware of the requirement to complete competency training.

There is a staff member with a current first aid certificate on every shift.

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: PA Moderate
Evidence: There is an education plan that is being implemented. In addition care/support staff are required to complete Care Training Online – a modular programme that covers core training requirements. Careerforce training is also due to be implemented with a focus on core competencies followed by the ID and mental health modules.

Finding:

There is an estimated 4-5 care/support workers (of an estimated 21) who have completed a mental health level 4 training (certificates not sighted), this does not meet requirement of MHA24 and 25.
The activities coordinator does not have relevant training in respect of the resident group.
The community link support worker does not have relevant training in respect of the role responsibilities she holds.

Corrective Action:

Care/support workers hold a relevant L4 qualification in mental health, the activities coordinator and community link support worker to undertake training relevant to their respective roles.

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

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

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

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows: each RN works 35 hours/week and alternates on call. The manager is also on call.
Three care/support workers 0700-1530 – one based in each unit. There are two 0700-1300 and one 0800-1300.
Three care/support workers 1500-2300 – one based in each unit. There is one 1700-2300 and one 1700-1930.
There are two care/support workers overnight (2300-0700)
The short shifts are used to support additional funded hours for one resident.
There is at least one first aid qualified person on each shift. The nurse manager and clinical coordinator alternate on-call. The care/support workers, residents and relatives interviewed inform there are sufficient staff on duty at all times.
The staffing levels and on call arrangements meet the requirements of MHA24.

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

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.

Attainment and Risk: PA Low
Evidence: <p>The resident files are appropriate to the service type. Residents entering the service have relevant initial information recorded within required timeframes into the resident's individual record. An initial care/support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care/support plans and notes are legible, however in the files reviewed there are documents that are not dated and signed. This is an area of improvement. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.</p>

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (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: PA Low
Evidence: Relevant information is recorded within required timeframes into the resident's individual record. An initial care/support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care/support plans and notes are legible.
Finding: In eight of the eight files reviewed there are documents – eg: care/support plans and assessments – that are not dated and signed.
Corrective Action: Date and sign all clinical records.
Timeframe (days): 30 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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.

Attainment and Risk: FA
Evidence: Rest home: The service has an information pack that is included in the admission agreement and given to all inquiring residents or their families. Entry criteria and access process are defined in policy and the resident information pack. Interview with two rest home residents and one rest home family member indicate that entry criteria and access processes were made clear to them. Two of two rest home resident files sampled have a current needs assessment indicating they have been assessed for rest home level care. D13.3 The admission agreement has been recently updated and the new agreement reviewed aligns with a) -k) of the ARC contract. D14.1 Exclusions from the service are included in the admission agreement. D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement. Mental health: Access processes and entry criteria are outlined in policy. All referrals are made by the mental health service and discussed on an individual basis with the manager to ascertain suitability. The mental health residents the service caters to are often those whose needs are unable to be met in other services. Residents come for an initial visit where possible, usually with family and the case manager. They are invited to come to tea or for a meal to get to know other residents. All potential residents have a needs assessment completed by the service coordination service prior to referral.

Each new or prospective resident is given an information pack that is part of the admission agreement. The resident information includes information around the code of rights, health and disability advocates, information on how to make a complaint, consent forms etc. Residents interviewed were familiar with the information and had received it.

Intellectual and physical disability: The service has a policy which describes entry processes. Relevant paperwork is signed (link 1.1.10) and this was visible in one of two physical and one of two intellectual disability resident files reviewed. Information gathered at admission is retained in resident's records.

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

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

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

Criterion 1.3.1.5 (HDS(C)S.2008:1.3.1.5)

To facilitate appropriate and timely entry to the service, a system is implemented to prioritise referrals and identify potential risks for each consumer, including considering previous risk management plans.

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

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

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

Attainment and Risk: FA

Evidence:

Rest home and intellectual and physical disability: The service has policies around declining entry and processes to be followed when an entry is declined including communicating with the referrer and the potential resident and/or their family. The service has not declined entry to any potential consumer as reported by the manager.

Mental health: Residents have not been declined unless there is a lack of suitable placements, although residents after the initial tour may decide not to come to the service and they are referred back to the needs assessment service. All declined entries are discussed with referrers.

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.

Attainment and Risk: PA Low

Evidence:

Rest home:

Admission procedures are carried out by the registered nurses. Assessments and care plans are developed by the registered nurses. Cares and support are primarily provided by care/support workers under the supervision of the registered nurses (current practicing certificates sighted). There is a registered nurse on duty or on call at all times. There is an in-service programme for all staff.

D16.2, 3, 4: In two of two rest home resident files reviewed, an assessment was completed within 24 hours and in both files reviewed the long term care plan was completed within three weeks. Two of two rest home care plans evidenced documented evaluations completed six monthly (link 1.3.8.2).

D16.5e: Two of two rest home resident files reviewed identified that the general practitioner had seen the resident within two working days of admission. Both files evidenced that three monthly medical reviews have not consistently occurred. This is an area requiring improvement. It is noted that as needed issue specific GP consultations have occurred regularly. The GP interviewed confirms that he visits weekly but does not often complete routine reviews. He reports that the service provides a good service to complex and challenging clients.

Three monthly medication reviews by a general practitioner are documented on medication charts reviewed.

A range of assessment tools were completed in rest home resident files on admission and completed at least six monthly including (but not limited to); falls and pressure area risk for two of two rest home resident files sampled. Weights are monitored at least three monthly and are stable in both rest home files reviewed.

There is evidence in two of two rest home resident files of continuity of service delivery including progress notes written at least daily. GP's and other health professionals including the podiatrist and the mental health service for older people document notes in the resident file. Three care/support workers and the registered nurse interviewed report a thorough handover and use of the communication book to ensure service delivery continuity.

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

Mental health:

Assessment is completed prior to entry and then annually by the service coordinators and support planning is developed in partnership with the resident as appropriate.

There is input from the GP during the admission process if required. The clinical team provide assessment information including a risk assessment and plan.

Initial assessments are completed when a person enters the service although each comes with a NASC assessment as sighted in each of two mental health files sampled. The care plan is developed during the first two weeks following admission.

MH 24: Each person using the services is encouraged to take a lead role in the preparation, implementation and evaluation of their individually planned support services.

Three of three mental health residents interviewed report having had input into the goal planning process.

Strengths assessments are partially completed (link 1.3.4.2) and are used as a baseline for further support.

Two of two mental health goal plans sampled had been evaluated with progress documented in the past six months (link 1.3.8.2 around care plans). Staff are rostered to work in each unit and this ensures and maintains continuity of care. There is a staff handover at the beginning and end of each shift, which involves all care/support workers. Residents (three mental health) stated that staff were supportive and worked well together with a team approach.

The service employs a community link support worker and who links with the service into relevant MH community activities.

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

Intellectual and physical disability:

Goal plans are developed with input from residents and staff as stated by residents interviewed (two intellectual disability and one physical disability). Personal background information is documented in the partially completed strengths assessments (link 1.3.4.2) and this information is used to make goal plans relevant and appropriate to meet the needs of the residents. Residents have a key worker who, along with the registered nurses, is responsible for ensuring that plans are documented and reviewed. There are goals documented in all files reviewed (four files reviewed – two intellectual disability and one physical disability). Timeframes for review of personal plans are documented in the policy i.e. six monthly. Four files reviewed (two intellectual disability and two physical disability) have goal plans reviewed. Care plans have been reviewed six monthly (link 1.3.8.1). There is a handover at the beginning of every shift as confirmed by three care/support workers interviewed. The GP reports he visits the service weekly and sees any residents who require review. He states the services caters well to residents with complex needs.

Tracer physical disability: XXXXXX This information has been deleted as it is specific to the health care of a resident.

Tracer intellectual disability: 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: PA Low

Evidence:

D16.2, 3, 4: In two of two rest home resident files reviewed, an assessment was completed within 24 hours and in both files reviewed the long term care plan was completed within three weeks. Two of two rest home care plans evidenced documented evaluations completed six monthly (see 1.3.8.2).
D16.5e: Two of two rest home resident files reviewed identified that the general practitioner had seen the resident within two working days of admission. It is noted that as needed issue specific GP consultations have occurred regularly. The GP interviewed confirms that he visits weekly but does not often complete routine reviews. He reports that the service provides a good service to complex and challenging clients.
Three monthly medication reviews by a general practitioner are documented on medication charts reviewed.

Finding:

Two of two rest home resident files evidenced that three monthly medical reviews have not consistently occurred.

Corrective Action:

Ensure all rest home resident have a full medical review at least three monthly.

Timeframe (days): 90 (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.)

Criterion 1.3.3.5 (HDS(C)S.2008:1.3.3.5)

The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

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 1.3.3.6 (HDS(C)S.2008:1.3.3.6)

The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.

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

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.

Attainment and Risk: PA Low
Evidence: <p>Rest home: Two of two rest home residents files sampled have evidence of an initial assessment that includes activity level, orientation, sleep patterns, mobility, nutrition, elimination, perception, mental ability, behaviour, depression, pain, social history, independence, skin integrity, sexuality, privacy and values and beliefs. Both files sampled also have a falls assessment and a pressure risk assessment that have been reviewed six monthly and a dietary profile completed at admission. Both also have a current InterRAI assessment and one of the two registered nurses has completed InterRAI training. Information gained from these assessments is used to inform the initial and long term care plans. Issues identified in assessments are being transferred to the long term care plan (link 1.3.5.2).</p> <p>Mental health: Resident files include an assessment completed by the needs assessment service. The needs assessment team reassesses each person annually as sighted in the two mental health files reviewed. However a strengths assessment has been started but not comprehensively completed and this is an area requiring improvement.</p> <p>Information is captured via the strengths assessment process and used as the basis to plan care.</p> <p>MH 24 and 25: A holistic assessment is intended to be completed for all residents including using domains of physical, mental wellbeing including early warning signs and risks, communication, social, employment, ethnicity/cultural, spiritual, sexuality, planning for greater independence (discharge). These will be captured in the strengths assessment when this is fully completed.</p> <p>Intellectual disability and physical disability: Needs are assessed in the initial assessment by the needs assessors and the information gathered at assessment is used to set plans and goals for residents. Any individualised equipment required is assessed on admission. However for four of four files sampled (two intellectual disability and two physical disability) do not have comprehensive strengths assessment on which to base care plans and goals. This is an area requiring improvement.</p>

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

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

Attainment and Risk: PA Low
Evidence: The two rest home files each have an up to date InterRAI assessment completed. Six of six residential disability files (two intellectual disability, two physical disability and two mental health) have a strength assessment that has been begun but not completed.
Finding: Six of six residential disability files (two intellectual disability, two physical disability and two mental health) do not have comprehensively completed strengths assessments.
Corrective Action: Ensure all disability residents have a comprehensively completed strengths assessment.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.4.5 (HDS(C)S.2008:1.3.4.5)

Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.

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.

Attainment and Risk: PA Moderate

Evidence:

Rest home: Two resident files were reviewed: One for a resident who has been referred for reassessment for hospital level care and one for a resident with XXXX. Assessments completed on admission are comprehensive. Care plans are a template document that includes support needs, problem/goal, interventions and evaluation. In one of two residents files sampled all identified areas of need are well completed and individualised and reflect needs identified in the assessments. The other resident has experienced 15 falls since March (link 1.3.3) and has no interventions relating to this in the care plan. This is an area requiring improvement. Three care/support workers and one registered nurse) interviewed report care plans are easy to follow. Newer care plans are linked to the InterRAI assessment tool. Both residents files sampled include input from GP's podiatrists, physiotherapists, mental health services and all staff from the facility.

D16.3k: Short term care plans are in use for changes in health status.

D16.3f: Two of two resident files reviewed identified that family are not involved in care plan development and this was confirmed by the one family member interviewed. This is an area requiring improvement.

Mental health: Two resident files were reviewed and files include goal plans, progress notes and goal reviews. Goals are written in residents words. Medical health notes and clinical notes are included along with any correspondence, property list and entry/exit documentation. Progress notes are documented at the end of each shift. Individual plans reviewed are individualised and up to date. However one of the two resident files reviewed is for a resident with a current fractured xxxxxxx (link 1.3.3) and there is no short term care plan around this. This is an area requiring improvement.

Wellness recovery action management plans (WRAMP) identify goals and plans under the domains of the whare tapa wha model. Each file has a mental health crisis plan that includes early warning signs and relapse prevention strategies.

Intellectual and physical disability:

Goal plans describe goals and interests for the individual resident in four files sampled (two physical disability and two intellectual disability). Each resident also has a care plan that outlines their care needs. However one physical disability resident has a history of XXXXX and is prescribed XXXX but this is not addressed in the care plan. This is an area requiring improvement. Behavioural management strategies are well documented and there is good input from the behavioural support specialist.

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

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

Attainment and Risk: PA Moderate

Evidence:

Rest home: Two resident files were reviewed: One for a resident who has been referred for reassessment for hospital level care and one for a resident with depression and anxiety.

Assessments completed on admission are comprehensive. Care plans are a template document that includes support needs, problem/goal, interventions and evaluation. In one of two residents files sampled all identified areas of need are well completed and individualised and reflect needs identified in the assessments. Three care/support workers and one registered nurse) interviewed report care plans are easy to follow. Newer care plans are linked to the InterRAI assessment tool. Both residents files sampled include input from GP's podiatrists, physiotherapists, mental health services and all staff from the facility.

D16.3k: Short term care plans are in use for changes in health status.

Mental health: Two resident files were reviewed and files include goal plans, progress notes and goal reviews. Goals are written in residents words. Medical health notes and clinical notes are included along with any correspondence, property list and entry/exit documentation. Progress notes are documented at the end of each shift. Individual plans reviewed are individualised and up to date.

Wellness recovery action management plans (WRAMP) identify goals and plans under the domains of the whare tapa wha model. Each file has a mental health crisis plan that includes early warning signs and relapse prevention strategies.

Intellectual and physical disability:

Goal plans describe goals and interests for the individual resident in four files sampled (two physical disability and two intellectual disability). Each resident also has a care plan that outlines their care needs. Behavioural management strategies are well documented and there is good input from the behavioural support specialist.

Finding:

(i) One of two rest home resident files reviewed has experienced 15 falls since March (link 1.3.3) and has no interventions relating to this in the care plan. (ii) D16.3f: Two of two resident files reviewed identified that family are not involved in care plan development and this was confirmed by the one family member interviewed. (iii) One of the two mental health resident files reviewed is for a resident with a current fractured collar bone (link 1.3.3) and there is no short term care plan around this. (iv) One physical disability resident has a history of epilepsy and is prescribed anticonvulsants but this is not addressed in the care plan.

Corrective Action:

(i) and (iii) and (iv) Ensure all identified needs are addressed in care plans. (ii) Ensure that family are included in the care planning process and that this is documented.

Timeframe (days): 90 (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.)

Criterion 1.3.5.4 (HDS(C)S.2008:1.3.5.4)

The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/whānau if appropriate.

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

Standard 1.3.6: 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.

Attainment and Risk: PA Low
Evidence: <p>Rest home: Two of two rest home residents interviewed and one rest home family member interviewed reported that they were warmly welcomed to the service, shown around and introduced to staff and residents.</p> <p>Residents care plans are completed by the registered nurses. Care delivery is recorded and evaluated by care/support workers at least daily (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. GP documentation is kept in the resident's file. Interviews with three care/support workers and one registered nurse indicate that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Sighted on the day of the audit were thermometers, a sphygmomanometer, a stethoscope, scales and blood glucose testing equipment. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Two of two rest home residents interviewed and one rest home family member interviewed were complimentary of care received at the facility.</p> <p>The care witnessed to be provided appears to meet the needs of consumers and at all times was seen to be respectful.</p> <p>D18.3 and 4 Dressing supplies are available.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p> <p>Specialist continence advice is available as needed and this could be described.</p> <p>Continence management in-services and wound management in-service have been provided.</p> <p>When the registered nurse interviewed questioned reported there are no wounds at the facility. During a tour of the facility one resident was noted to have a dressing on his hand. The care/support worker caring for him that duty was also not aware of the wound. When questioned the resident (who is competent) stated that he had 'lost a bit of skin' and that the registered nurse had dressed it. There is no documentation, wound assessment or plan relating to this wound. This is an area requiring</p>

improvement.

The manager interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

Mental health: Each resident has a goal plan which is based on a strengths assessment of the resident's needs, taking into account each resident's individual preferences (link 1.3.4.2). Residents at St Clair Park under a mental health contract are often those whose needs are unable to be met at other services. Most have long term needs.

MH 24: Mental health services are loosely planned based upon regular support needs assessment that informs a goal plan that is designed to meet a person's individual needs, reduces their need to utilise more intensive mental health services, is inclusive of the person's cultural needs and contributes to meaningful, positive change in that person's life.

One of the registered nurses oversees the individual plans. Three of three mental health residents interviewed report that staff are respectful and supportive and staff were sighted to treat residents with dignity and respect throughout the audit.

MH 24: Care plans identify the relative roles of the support staff and visiting DHB community mental health team's clinical staff, including matters (but not limited to) relating to personal, clinical, cultural, spiritual and social domains.

There are brochures and pamphlets about a variety of mental health issues and recognising and preventing these issues in the foyer. Residents are supported to access a range of support services in the community that help build their resources to limit the onset of mental ill health.

Intellectual and physical disability:

The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. In managing the referral process the service provides relevant information and where necessary follow-up occurs. Examples of services accessed include dental services and speech language therapist. Residents spoken to where happy with the support provided to them.

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: PA Low

Evidence:

Two of two rest home residents interviewed and one rest home family member interviewed reported that they were warmly welcomed to the service, shown around and introduced to staff and residents.

Residents care plans are completed by the registered nurses. Care delivery is recorded and evaluated by care/support workers at least daily (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. GP documentation is kept in the resident's file. Interviews with three care/support workers and one registered nurse indicate that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Sighted on the day of the audit were thermometers, a sphygmomanometer, a stethoscope, scales and blood glucose testing equipment. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Two of two rest home residents interviewed and one rest home family member interviewed were complimentary of care received at the facility.

The care witnessed to be provided appears to meet the needs of consumers and at all times was seen to be respectful.

D18.3 and 4 Dressing supplies are available.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

Finding:

When the registered nurse interviewed questioned reported there are no wounds at the facility. During a tour of the facility one resident was noted to have a dressing on his hand. The care/support worker caring for him that duty was also not aware of the wound. When questioned the resident (who is competent) stated that he had 'lost a bit of skin' and that the registered nurse had dressed it. There is no documentation, wound assessment or plan relating to this wound.

Corrective Action:

Ensure all wounds are reported and assessed and a plan developed with regular dressing changes and reviews.

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

Criterion 1.3.6.3 (HDS(C)S.2008:1.3.6.3)

The consumer receives the least restrictive and intrusive treatment and/or support possible.

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 1.3.6.5 (HDS(C)S.2008:1.3.6.5)

The consumer receives services which:

- (a) Promote mental health and well-being;
- (b) Limit as far as possible the onset of mental illness or mental health issues;
- (c) Provide information about mental illness and mental health issues, including prevention of these;
- (d) Promote acceptance and inclusion;
- (e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

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

Standard 1.3.7: 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.

Attainment and Risk: PA Low
Evidence: Rest home: In each of the two rest home files reviewed an activities assessment has been completed soon after admission and an activities plan developed that has been regularly reviewed. An activities coordinator works 40 hours per week. All activities provided are mixed across the service types and the two rest home residents interviewed report being appreciative of this. One to one activities are available where required, particularly in Middleton unit where residents require a lower stimulus environment and activities are generally provided on a one to one basis by the community link support worker or the care/support workers. The activities programme provided includes a range of appropriate activities including (but not limited to): newspaper reading, walking groups, board games, scrapbooking, arts and crafts, movies and visiting entertainers. There are also regular outings including a twice weekly lunch outing (for different genders each time) to a local café or restaurant. Disability (mental health, physical and intellectual disability): Three of three residents described activities residents are involved in. All residents are able to join in the programme described above. Additionally the service has employed a community link support worker who works full time and has been in the role for three months. Her role is to support mental health and intellectual and physical disability residents to access community resources to meet their individual goals. When interviewed she was able to describe a number of initiatives to liaise with the community and support residents. Neither the activities coordinator nor the community link support worker have undertaken training relating to working with people with disabilities (link 1.2.7.5).

MH 24: Mental health and disability residents are encouraged to take responsibility for aspects of household management and activities depending on resident's level of ability for example cleaning their room, changing sheets and personal laundry. However as all meals are prepared off site, apart from baking as an 'activity' there is no opportunity for residents to be involved in household shopping or meal preparation. This is an area requiring improvement. Residents confirm staff assist with support to access community resources.

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

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

Attainment and Risk: PA Low

Evidence:

Disability (mental health, physical and intellectual disability): Three of three residents described activities residents are involved in. All residents are able to join in the programme described above. Additionally the service has employed a community link support worker who works full time and has been in the role for three months. Her role is to support mental health and intellectual and physical disability residents to access community resources to meet their individual goals. When interviewed she was able to describe a number of initiatives to liaise with the community and support residents. Neither the activities coordinator nor the community link support worker have undertaken training relating to working with people with disabilities (link 1.2.7.5).

MH 24: Mental health and disability residents are encouraged to take responsibility for aspects of household management and activities depending on resident's level of ability for example cleaning their room, changing sheets and personal laundry.

Finding:

As all meals are prepared off site, apart from baking as an 'activity' there is no opportunity for residents to be involved in household shopping or meal preparation.

Corrective Action:

Ensure disability (particularly mental health and intellectual disability) residents are provided with opportunities to be involved in household management including household shopping and meal preparation.

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

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

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

Attainment and Risk: PA Low

Evidence:

Rest home: Evaluations are documented for the two of two rest home resident care plans sampled. However the evaluation is an overall comment at the end of the care plan and does not document progress toward each goal or response to interventions. This is an area requiring improvement. . All care plans are updated and reviewed six monthly (although progress is not documented). Both resident's files sampled show care plans are updated as changes occur in the resident's condition. D16.3k: Short term care plans are in use for changes in health status. Residents' files evidenced a short term care plan in use for pain and decreased mobility.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.
ARC: D16.3c: All initial care plans were evaluated by the managers (registered nurses) within three weeks of admission.

Mental health:

MH 24: The goal plan sets out specific plans and goals that are reviewed in an informal manner monthly and formally at least six monthly in both mental health plans sampled with a formal reviewing at least six monthly in the one plan sampled at Nile.

MH 24: When plans are reviewed the review includes the resident, the registered nurse and the key worker.

Daily progress notes support identifying significant changes with the resident and subsequent review of the individual plan. There was evidence in files reviewed that changes were initiated in response to needs of the individual.

Intellectual and physical disability: Goal plans and care plans are documented for all residents files sampled (two physical disability and two intellectual disability) and in two of the files (one physical and one intellectual disability), indicate that achievement and process has been reached. Care plans and lifestyle plans reviewed had been reviewed on a six monthly basis. However for care plans the evaluation is an overall comment at the end of the care plan and does not document progress toward each goal or response to interventions. This is an area requiring improvement.

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:

Rest home: Evaluations are documented for the two of two rest home resident care plans sampled. . All care plans are updated and reviewed six monthly (although progress is not documented).

D16.3k: Short term care plans are in use for changes in health status. Residents' files evidenced a short term care plan in use for pain and decreased mobility.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

ARC: D16.3c: All initial care plans were evaluated by the registered nurses within three weeks of admission.

Mental health:

MH 24: The goal plan sets out specific plans and goals that are reviewed in an informal manner monthly and formally at least six monthly in both mental health plans sampled with a formal reviewing at least six monthly in the one plan sampled at Nile.

MH 24: When plans are reviewed the review includes the resident, the registered nurse and the key worker.

Daily progress notes support identifying significant changes with the resident and subsequent review of the individual plan. There was evidence in files reviewed that changes were initiated in response to needs of the individual.

Intellectual and physical disability: Goal plans and care plans are documented for all residents files sampled (two physical disability and two intellectual disability) and in two of the files (one physical and one intellectual disability), indicate that achievement and process has been reached. Care plans and lifestyle plans reviewed had been reviewed on a six monthly basis.

Finding:

The care plan evaluation is an overall comment at the end of the care plan and does not document progress toward each goal or response to interventions.

Corrective Action:

Ensure care plan evaluations document progress toward each goal or response to interventions.

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.)

Criterion 1.3.8.4 (HDS(C)S.2008:1.3.8.4)

Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if 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 1.3.9: 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.

Attainment and Risk: FA

Evidence:

All service levels: Where referral to other health providers occurs, the service provides appropriate transfer of relevant information and follow up occurs as required. The service provides residents and their family/whanau with information on the services that can be accessed by residents. This includes dietitian, medical practitioner, optician and specialist consultation as required.

Residents and their families/whanau are involved when referral to other services occurs. In managing the referral process the service ensures appropriate transfer of relevant information. This may include medication chart, copy of doctor's notes and medical history. Correspondence and referral notes are kept in resident files.

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.

Attainment and Risk: FA

Evidence:

Rest home: The service has policies for transfer or exit of the service which describes guidelines for death, discharge, transfer, documentation and follow up. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities with a transfer letter from the facility photocopied with accompanying relevant documentation including medication charts (ARC D 21.1). When a resident wishes to leave the facility the NASC service is notified as reported by the manager (ARCD21.3). All relevant information is documented and communicated to the receiving health provider or service, notes

are photocopied. A referral form and any other relevant documentation accompany residents to receiving facilities. These were evident in two of two rest home resident files. Two of two rest home residents interviewed were satisfied that they were kept well informed in regard to referrals and/or transfer to hospital where this had occurred. Staff could describe the referral and or transfer processes and demonstrated an understanding of resident's right to be informed.

Mental health: The service does not have a policy includes guidelines for discharge and transfer (link 1.2.3). When a resident is discharged or transfers from the service there is a completed documentation in the resident record. There have been no discharges for mental health residents in the time the current manager or registered nurse have been at St Clair Park. This is due to the enduring nature of the conditions of the mental health residents. Therefore no discharged resident's files could be sampled.

Intellectual disability:

The service does not have a policy and supporting procedures (form) to facilitate discharge and access to others services (link 1.2.3). Residents and or their family/whānau are involved as appropriate when referral to another service occurs.

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: A consistent medication system is used in all three units for residents of all service types. Nineteen medication charts were sampled and all medication was looked at in the locked cupboards, the medication fridge and the three trolleys. The facility uses the medication management system of blister packs that are delivered in a four week supply. Medication is checked on delivery and stored safely and all medication charts are legible and reviewed three monthly. Controlled drugs are kept in the Cargill office and weekly stocktakes have occurred. There are appropriate medication policies and procedures including around residents who self-administer medicines. There

are currently no residents who self-administer medications. The registered nurses and care/support workers administer medicines. There has been training around medication administration and all staff who administer medicines have current competency assessments. Nineteen of 19 medication charts sampled have photo identification and 19 of 19 medication charts document allergies. Medication charts are signed by the prescribing GP or psychiatrist. Sixteen of 19 medication administration signing sheets have been accurately completed. One of two residents with an XXXX has not had the XXXX strictly adhered to on two occasions in the past seven days. One resident with a recent change in insulin dose has had the previous dose administered on one occasion in the past week. One resident with QID polytears prescribed has not always had these documented as administered QID. These are areas requiring improvement.
 Rest home: D16.5.e.i.2; medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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:

A consistent medication system is used in all three units for residents of all service types. Nineteen medication charts were sampled and all medication was looked at in the locked cupboards, the medication fridge and the three trolleys. The facility uses the medication management system of blister packs that are delivered in a four week supply. Medication is checked on delivery and stored safely and all medication charts are legible and reviewed three monthly. Controlled drugs are kept in the Cargill office and weekly stocktakes have occurred.

Finding:

One of two residents with an insulin sliding scale has not had the sliding scale strictly adhered to on two occasions in the past seven days. One resident with a recent change in insulin dose has had the previous dose administered on one occasion in the past week. One resident with QID polytears prescribed has not always had these administered QID.

Corrective Action:

Ensure medications are documented as administered as prescribed.

Timeframe (days): 30 (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: FA

Evidence:

Finding:

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

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

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

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

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

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

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

Criterion 1.3.12.7 (HDS(C)S.2008:1.3.12.7)

Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

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

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

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

Attainment and Risk: FA
Evidence: <p>All food is prepared and cooked off site by an external contractor and delivered in hot boxes at meal times. It is then transferred into Bain Maries and temperature checked before being served by care/support workers. A dietitian reviews all menus and this last occurred in May 2013. Staff have completed food safety training as sighted in training records. Special diets and likes and dislikes are catered to as reported by staff and residents interviewed. When there is a change to the menu (at least ever season) the menu is provided one to two months prior to the change and discussed in the residents meeting. Changes suggested/requested by residents are faxed to the kitchen and the menu altered accordingly as reported by the activities coordinator and residents interviewed. The meals observed (lunch on two different days and one evening meal) where appropriate to the client group with individual meals supplied that cater to likes and dislikes. There are no specific special diets being catered to at this time as the menu is suitable for diabetics. Breakfast is kept in each pantry and served as residents are ready for it. There is a wide variety of bread and spreads, cheese, eggs and cakes/biscuits available in the pantry in each unit for residents to have snacks if they choose. Morning and afternoon tea are delivered with the main meals. Fridge, freezer and hot water temperatures are monitored in all units with records sighted and temperatures noted to be within safe ranges. Notices are visible on safe food handling and hygiene requirements, i.e. hand washing. A meal satisfaction survey in February 2013 indicates satisfaction with meals.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

Attainment and Risk: FA

Evidence:

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facilities and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by service providers when required. The facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.

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

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

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

Attainment and Risk: PA Low
Evidence:
<p>St Clair Park is divided into three units. All units cater to residents from all contract types (physical disability, intellectual disability, rest home and mental health. Cargill has 15 rooms, Ashwood has 12 rooms and Middleton has seven rooms. Middleton caters to residents with higher needs. There is evidence that there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Planned and reactive maintenance systems are in place and were reviewed. Medical equipment was calibrated in September 2013 except the scales. This is an area requiring improvement. The hoist was purchased second hand from an approved equipment provider within the past year. Hot water temperatures are checked monthly and records show that they are maintained in a safe range. There is not a current Building Warrant of Fitness with the previous one having expired in 2012. This is also an area requiring improvement. The manager reports that regular monthly required building checks had not been completed monthly until mid-2013 so the BWOFF could not be issued until a full years monthly checks had been completed. These have now been completed and the service is awaiting a new BWOFF. The manager reports that he has checked that the building remains insured despite not having a BWOFF.</p> <p>There is evidence of: safe storage of medical equipment. Corridors are wide enough in all areas to allow residents to pass each other safely; safety rails are secure and appropriately located; minimal changes in floor surface and levels occur; equipment does not clutter passageways etc.; transitions between surfaces or coverings are without abrupt change in level or gradient; and floor surface changes are identifiable by the consumer. The external areas are safely maintained and are appropriate to the resident group and setting and include seating and shade.</p> <p>Three care/support workers, the registered nurse and the manager interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.</p> <p>Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.</p>

Rest home: ARC D15.3: The following equipment is available: shower chairs, wheelchairs, a hoist and lifting aids.

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:

St Clair Park is divided into three units. All units cater to residents from all contract types (physical disability, intellectual disability, rest home and mental health. Cargill has 15 rooms, Ashwood has 12 rooms and Middleton has seven rooms. Middleton caters to residents with higher needs. There is evidence that there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Planned and reactive maintenance systems are in place and were reviewed. Medical equipment was calibrated in September 2013 except the scales. Hot water temperatures are checked monthly and records show that they are maintained in a safe range. There is not a current Building Warrant of Fitness with the previous one having expired in 2012. The manager reports that regular monthly required building checks had not been completed monthly until mid-2013 so the BWOFF could not be issued until a full years monthly checks had been completed. These have now been completed and the service is awaiting a new BWOFF. The manager reports that he has checked that the building remains insured despite not having a BWOFF.

Finding:

(i) There is not a current Building Warrant of Fitness with the previous one having expired in 2012. (ii) The scales have not been calibrated.

Corrective Action:

(i)Continue the process to obtain a building warrant of fitness. (ii) Ensure all medical equipment is calibrated according to manufacturer's recommendations.

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

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

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

Attainment and Risk: FA
Evidence: <p>Toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents in each area. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.</p> <p>The requirements of the New Zealand Building Code are met. There is adequate number of toilets and showers to cater to all residents. The toilets have appropriate access for residents based on their needs and abilities and facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet facilities have a system that indicates if it is engaged or vacant. There is also a safe locking system that provides for privacy but allows service providers access in the case of emergency. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p>

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

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

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

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

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

Attainment and Risk: FA
Evidence: Adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. Eight of eight residents (three mental health, two intellectual disability, one physical disability and two rest home) report satisfaction with their bedrooms.

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.

Attainment and Risk: FA

Evidence:
There is adequate access is provided to lounge, dining and other communal areas and that residents are able to move freely within these areas. There is a lounge and dining area in each unit. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

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.

Attainment and Risk: FA

Evidence:
Cleaning policy and procedures, and laundry policy and procedures are available. Product user charts, chemical safety data sheets for all chemicals used in the facilities,

and cleaning & laundry task sheets reviewed. There are policies and procedures for the safe storage and use of chemicals / poisons.

There is a cleaner employed and residents who are able are expected to assist with cleaning/changing linen etc. in their personal areas. Residents who are able are also expected to complete their personal laundry. There is a small but adequate laundry. The effectiveness of the cleaning and laundry services has been audited via the internal audit programme in 2014. There are: safe and secure storage areas are available and service providers have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste - i.e. Convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Staff files reviewed indicate attendance at chemical safety education, last in May 2013 (verified during staff interviews).

Residents and family interviewed state their satisfaction with the cleaning and laundry services.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan (letter dated 24 November 2004) and fire evacuations are held six monthly (last drill was completed 9 July 2014). There is staff across 24/7 with a current first aid certificate. There is a civil defence/emergency plan and pandemic plan in place (as per MH24). The civil defence kit is readily accessible. The facility is prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept primarily in the Middleton kitchen. At least three days stock of other products such as personal protective equipment (PPE) are kept. There is a store cupboard of supplies necessary to manage a pandemic.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: All resident rooms and communal areas have external windows and adequate natural light. The service is heated with electric heating throughout and residents report the facility is maintained at a comfortable temperature. There are designated outdoor smoking areas. The staff offer quit smoking advice and one registered nurse is trained to prescribe nicotine replacement therapy and provide quit smoking advice.

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

Attainment and Risk: FA
Evidence: No residents require restraint (confirmed in discussions with the manager, a registered nurse and three care/support workers). Policies record that the resident will voluntarily agree to the use of an enabler to promote their independence and safety, if enablers are required. There are also no enablers in use. Staff are aware of the enabler and restraint policy (confirmed in discussions with three of three care/support workers). There have been no reported episodes of restraint under this management team. Policies and procedures are in place if restraint was ever required. Residents have strategies to manage behaviours outlined in care plans and risk management plans. Staff have received training in de-escalation and breakaway techniques in January 2013.

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The infection control programme and its content and detail, is appropriate for the size and complexity of the service. The scope of the infection control programme and associated policies are available (link 1.2.3). There is a job description for the infection control coordinator. There is an implemented infection control programme that is linked into the quality management system. The infection control coordinator is responsible for leading the development of the infection control programme and its review. The programme has not been reviewed annually and this is an area of improvement. The facility has access to GPs, local Laboratory, the infection control and public health departments at the local DHB for advice. Infection control matters are reported through the monthly meetings and two-four weekly clinical meetings.

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: PA Low

Evidence:

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme and associated policies are available. Infections are reported and aggregated monthly. There is a year-by-year comparison that shows the service is tracking lower than the previous two years. There have been no reported outbreaks.

Finding:
Infection control manual was last reviewed March 2013 and includes the programme and associated policies. The infection control programme requires annual review.
Corrective Action:
Review and evaluate the infection control programme.
Timeframe (days): 90 (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.

Attainment and Risk: FA
Evidence:
The infection control coordinator reports infection control matters through the clinical and staff meetings. The facility also has access to an infection control nurse specialist, public health and GP's. There are adequate resources to implement the infection control programme for the size and complexity of the organisation.

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

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.

Attainment and Risk: FA
Evidence: D 19.2a: The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures (link 1.2.3).

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.

Attainment and Risk: FA

Evidence:

The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has completed appropriate IC training including attendance at an outbreak coordination in October 2013. The orientation package includes hand washing. The IC coordinator provides training both at orientation and on-going. Training on infection control is included in as part of the training schedule and is part of the Care Training Online programme (refer evidence 1.2.7). Infection control/hand washing was last provided as an in-service in January (2014) and 12 attended. Resident education occurs as part of providing daily cares, including hand washing and 1:1 education if there are particular issues (link 1.2.5).

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection report forms are completed for infections. Infections are included on a monthly register and reported to staff and clinical meetings. Definitions of infections are in place appropriate to the complexity of service provided. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. Hand hygiene audits are included in the audit schedule (last completed January 2014). There is liaison with the GP that advises and provides feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.</p>

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

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

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

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

Criterion 3.6.4 (HDS(IPC)S.2008:3.6.4)

Regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policies shall be a component of the facility's infection control programme.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

