Karaka Court Limited - Woodlands of Feilding

Current Status: 8 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

Karaka Court Limited operates two facilities in the Manawatu area. Woodlands of Fielding is certified to provide hospital and rest home level care for up to 39 residents. On the day of the audit there were 10 hospital residents and 17 rest home residents. All beds at the facility are approved as dual-purpose. Woodlands of Fielding's manager and clinical nurse leader are well qualified for their roles. Staff turnover remains low. There are developed and implemented systems and policies to guide appropriate quality care for residents. A quality programme is being implemented. An induction programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

There are improvements required around consent, policy implementation and document control, data collection, training, assessments, environment and restraint documentation.

Audit Summary as at 8 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
	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 8 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.

Organisational Management as at 8 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 low risk.

Continuum of Service Delivery as at 8 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.

Safe and Appropriate Environment as at 8 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.

Restraint Minimisation and Safe Practice as at 8 July 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.

Infection Prevention and Control as at 8 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.		Standards applicable to this service fully attained.

Audit Results as at 8 July 2014

Consumer Rights

Woodlands of Fielding provides care in a way that focuses on the individual resident. There is a Maori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies in place to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. 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 readily available to residents and families. Policies are in place to support residents' rights. A staff training programme supports staff understanding of residents' rights. Care plans accommodate 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 a required improvement relating to consent.

Organisational Management

Woodlands of Fielding is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly staff meeting and registered nurse meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including 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 covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around policy implementation and document control, data collection and training.

Continuum of Service Delivery

There are processes in place to ensure the assessed needs and outcomes/goals are documented and monitored in an ongoing manner. Care plans are developed in consultation with residents and family. Plans are maintained by registered nurses. Evaluations are conducted six monthly or as required. Residents are reviewed three monthly or earlier if their health status changes by their general practitioner. The home employs one qualified diversional therapist providing activities 35 hours a week. The activities programme is well established and enjoyed by residents. Residents also have the use of an onsite recreation centre that is attended by people who live in the attached retirement village.

The service has in place policies and procedures to guide staff at each stage of medicines management. All staff administering medication are assessed for competency. Food is prepared onsite in a spacious kitchen. Kitchen staff have completed food handling certificates. Residents with special dietary needs have their needs reviewed six monthly as part of the care planning process. Special equipment is available. The kitchen is viewed as essential in providing a homelike environment. The main meal of the day is served in the evening at the request of the residents. Their preferences are monitored at the resident meetings. Improvements are required related to admission documentation, and assessment.

Safe and Appropriate Environment

The building is a spacious converted old homestead where additional bedrooms have been added to accommodate the current number of residents. There are a mix of rest home and hospital level rooms spread across two stories and there is a mezzanine area, which has two bedrooms. There is a central lift and stairs. There is sufficient room throughout the building, including bedrooms, for residents to mobilise safely and to find a quite area. There are adequate numbers of toilets and showers with access to a hand basin and paper towels. Fixtures, fittings and floor and wall surfaces are appropriate and the facility has a current building warrant of fitness. Furniture is appropriate to the setting and arranged to allow residents to mobilise safely. Personal furniture is accommodated where space allows. Hot water temperatures are monitored monthly and maintained at 45 degrees. General laundry is outsourced and personal laundry is done on site. Cleaning is done on site by dedicated staff. The service has policies and procedures for civil defence and other emergencies. There is an improvement required around the maintenance of one upstairs toilet area.

Restraint Minimisation and Safe Practice

The service has a restraint minimisation programme in place. There are currently six residents using restraints for their personal safety. The restraints are bed gates at night and seat belts during the day. No residents are using voluntary enablers. There is a designated restraint coordinator and there is daily restraint monitoring and six monthly reviews. On-going training occurs. An improvement is required to the restraint documentation.

Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (clinical nurse leader) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are a suite of infection control policies, standards 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. Staff receive on-going training in infection control.

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Karaka Court Limited
Certificate name:	Karaka Court Limited - Woodlands of Feilding

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Certification Audit
Premises audited:	Woodlands Of Feilding
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 8 July 2014 **End date:** 9 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:	27

Audit Team

Lead Auditor	XXXXX	**Hours on site**	15	**Hours off site**	8

Other Auditors	XXXXX	**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	XXXXX			**Hours**	2

Sample Totals

Total audit hours on site	30	Total audit hours off site	18	Total audit hours	48

Number of residents interviewed	6	Number of staff interviewed	7	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	9	Total number of managers (headcount)	3
Number of medication records reviewed	12	Total number of staff (headcount)	30	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Tuesday, 19 August 2014

Executive Summary of Audit

General Overview

Karaka Court Limited operates two facilities in the Manawatu area. Woodlands of Fielding is certified to provide hospital and rest home level care for up to 39 residents. On the day of the audit there were 10 hospital residents and 17 rest home residents. All beds at the facility are approved as dual-purpose. Woodlands of Fielding's manager and clinical nurse leader are well qualified for their roles. Staff turnover remains low. There are developed and implemented systems and policies to guide appropriate quality care for residents. A quality programme is being implemented. An induction programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. There are improvements required around consent, policy implementation and document control, data collection, training, assessments, environment and restraint documentation.

Outcome 1.1: Consumer Rights

Woodlands of Fielding provides care in a way that focuses on the individual resident. There is a Maori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies in place to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. 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 readily available to residents and families. Policies are in place to support residents' rights. A staff training programme supports staff understanding of residents' rights. Care plans accommodate 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 a required improvement relating to consent.

Outcome 1.2: Organisational Management

Woodlands of Fielding is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly staff meeting and registered nurse meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including 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 covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around policy implementation and document control, data collection and training.

Outcome 1.3: Continuum of Service Delivery

There are processes in place to ensure the assessed needs and outcomes/goals are documented and monitored in an ongoing manner. Care plans are developed in consultation with residents and family. Plans are maintained by registered nurses. Evaluations are conducted six

monthly or as required. Residents are reviewed three monthly or earlier if their health status changes by their general practitioner. The home employs one qualified diversional therapist providing activities 35 hours a week. The activities programme is well established and enjoyed by residents. Residents also have the use of an onsite recreation centre that is attended by people who live in the attached retirement village.

The service has in place policies and procedures to guide staff at each stage of medicines management. All staff administering medication are assessed for competency. Food is prepared onsite in a spacious kitchen. Kitchen staff have completed food handling certificates. Residents with special dietary needs have their needs reviewed six monthly as part of the care planning process. Special equipment is available. The kitchen is viewed as essential in providing a homelike environment. The main meal of the day is served in the evening at the request of the residents. Their preferences are monitored at the resident meetings. Improvements are required related to admission documentation, and assessment.

Outcome 1.4: Safe and Appropriate Environment

The building is a spacious converted old homestead where additional bedrooms have been added to accommodate the current number of residents. There are a mix of rest home and hospital level rooms spread across two stories and there is a mezzanine area, which has two bedrooms. There is a central lift and stairs. There is sufficient room throughout the building, including bedrooms, for residents to mobilise safely and to find a quite area. There are adequate numbers of toilets and showers with access to a hand basin and paper towels. Fixtures, fittings and floor and wall surfaces are appropriate and the facility has a current building warrant of fitness. Furniture is appropriate to the setting and arranged to allow residents to mobilise safely. Personal furniture is accommodated where space allows. Hot water temperatures are monitored monthly and maintained at 45 degrees. General laundry is outsourced and personal laundry is done on site. Cleaning is done on site by dedicated staff. The service has policies and procedures for civil defence and other emergencies. There is an improvement required around the maintenance of one upstairs toilet area.

Outcome 2: Restraint Minimisation and Safe Practice

The service has a restraint minimisation programme in place. There are currently six residents using restraints for their personal safety. The restraints are bed gates at night and seat belts during the day. No residents are using voluntary enablers. There is a designated restraint coordinator and there is daily restraint monitoring and six monthly reviews. On-going training occurs. An improvement is required to the restraint documentation.

Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (clinical nurse leader) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are a suite of infection control policies, standards 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. Staff receive on-going training in infection control.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	43	0	6	1	0	0
Criteria	0	92	0	8	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	0
Criteria	0	0	0	0	0	0	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: 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	One of six residents sampled did not have a current admission agreement on file.	Ensure all residents sign an admission agreement on the day they receive services and ensure a copy is available on record (D13.1).	30
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	PA Low	The content of policy and procedures are sufficiently detailed to allow effective implementation by staff, however	Align policy to practice.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.		there are instances where the documented policies do not align to current practice. Examples include: a) policy – Staff and Senior Quality Management Meeting references a Quality Council meeting three monthly, however there are no meeting minutes, c) policy – Falls: Management of, references a Falls Minimisation checklist, which could not be located and reportedly is not used. There is no evidence resident outcomes have been compromised and the risk is therefore considered low.		
HDS(C)S.2008	Criterion 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.	PA Low	The following are examples where the development of new documents/forms has not been effectively managed through the document control process: a) the complaints process has recently been updated and the copy in the operating manuals differ from that in the resident agreement, b) the frequent faller form is sitting at the front of the manual as opposed to the aligning with the policy, c) the infection control policy/programme includes short term care plans for head injury and falls (as well as STCP for infections).	Remove documents/forms that are no longer in use. Align forms to policies to ensure the most up to date versions are currently in use.	90
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Incidents and infections are collated monthly and reported at staff meetings. There are anomalies noted between the two pieces of information for example: a) incidents January summary reports four falls no injury, while meeting minutes record four falls	Incident and infection data is accurately recorded and meeting minutes record outcomes of issues raised.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				with injury, b) incidents February summary reports four falls with injury and two skin tears/bruising, while meeting minutes report five falls no injury and five skin tears/bruising, c) incidents June summary reports two falls no injury, two skin tears/bruising, one 'other', while meeting minutes report one fall no injury, one fall injury, one skin tear, one pressure area. The infection data for March shows: a) the infection stats sheet shows three Skin and Soft Tissue infection (SST) and four UTI, the resident infection assessment sheet reports four SST and four UTI and meeting minutes record four UTI and five SST. Meeting minutes do not consistently record follow-up of issues, examples include: a) June (6th) resident meeting minutes record satisfaction with two cleaners, the cleaners meeting (17th) does not record resident satisfaction, b) April resident meeting records issue with cold gravy, this is seen in cooks meeting minutes, however there is no feedback to residents in May meeting re outcome, c) January (7th) resident meeting records issues with food (eg. cut stem out of silverbeet, meat cut too thick) to be reported to cooks meeting (16th), not evident in minutes.		
HDS(C)S.2008	Standard 1.2.7: Human Resource	Human resource management processes are conducted in	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	accordance with good employment practice and meet the requirements of legislation.				
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Infection control training scheduled June 2013 has not been delivered – verified training records and interview with staff. Training was again scheduled June 2014, and at the time of audit had yet to be delivered. Records confirm staff surveillance is completed monthly that includes observation of hand washing and environmental inspection. Lifting training is scheduled annually – March – three staff attended last year. There was a recent incident where two staff members lifted a resident from the floor (hoists are available at the facility).	Deliver training according to the schedule.	60
HDS(C)S.2008	Standard 1.3.1: Entry To Services	Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	The admission agreement in use did not fully align with section D13.3 ARC Agreement.	Revise the format of the admission agreement to include D13.3 ARC Agreement (note action was completed during audit)	7
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Two residents were not weighed on admission (refer evidence 1.3.3) and one of those two residents had XXXX which was not recorded on assessment refer evidence 1.3.3)	Ensure all residents are comprehensively assessed on admission.	30
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 1.4.2.4	The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	One toilet area upstairs has wheelchair damaged wallboard and a broken window catch that needs maintenance.	Fix the broken window catch and the damaged wall board in the upstairs toilet area.	60
HDS(RMSP)S.2008	Standard 2.2.2: Assessment	Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.2.1	In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved	PA Low	The assessment form does not include documentation on the assessment of restraint form which includes consideration of (c) existing advance directives the consumer may have made; (d) whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) any history of trauma or abuse, which may have involved the consumer being held against their will; (g) the desired outcome and criteria for ending the restraint); or (h) possible alternative intervention/strategies	Ensure all assessment information is documented on the restraint assessment form.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.				

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Woodlands of Fielding has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). 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. Interview with three caregivers (who work across rest home and hospital) demonstrate an understanding of the Code. Code of rights training was provided June 2014 (nine attended). Residents interviewed (three rest home and three hospital) and relatives (two rest home and two hospital) 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.

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

Attainment and Risk: FA

Evidence:

There is a welcome 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. Large print posters of the Code and advocacy information are displayed through the facility. The monthly resident meetings also provide the opportunity for residents to raise issues (minutes sighted). Residents interviewed (three rest home and three hospital) and relatives (two rest home and two hospital) inform information has been provided around the Code. The manager and clinical nurse leader inform 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, CoR pamphlet, advocacy and Health & Disability Commission. The manager, clinical nurse leader and registered nurses describe discussing the information pack with residents/relatives on admission.
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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA

Evidence:

There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Resident files are stored out of sight. Staff could describe aspects of abuse and neglect, and informed recent training on the code of rights (June 2014). Relatives interviewed stated that the care provided is very good and staff are respectful. A resident satisfaction survey is completed annually (August 2013). The 2013 survey informed all respondents are either satisfied or very satisfied with the service.
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. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with three caregivers describe how choice is incorporated into resident cares. Interview with residents (three rest home and three hospital) and relatives (two rest home and two hospital) inform staff are respectful. There is an abuse and neglect policy being implemented. Interviews with residents and family members were extremely positive about the care provided.
D4.1a: Six resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with residents confirm their values and beliefs were considered.
D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.
D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)
Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)
Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

Attainment and Risk: FA

Evidence:

A3.2: Woodlands of Fielding has a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups as requested by the resident/family. Cultural needs are addressed in the care plans. Review of files confirms consideration of cultural preferences.
D20.1i: There are policies being implemented that guide staff in cultural safety. Special events and occasions are celebrated and this could be described by staff.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)
Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with four relatives inform values and beliefs are considered. Discussion with residents (three rest home and three hospital) confirm that staff take into account their culture and values.
D3.1g: The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau.
D4.1c: Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Staff meetings occur monthly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with

the clinical nurse leader and one registered nurse confirm an awareness of professional boundaries. Interview with three caregivers (who work across both rest home and hospital) could discuss professional boundaries in respect of gifts.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

Woodland of Fielding has a suite of appropriate policies and procedures that are updated as necessary. They use the Registered Nurse Guides as a base to develop policies and procedures to maintain 'best practice'. There is a quality improvement programme that includes performance monitoring against clinical indicators (link 1.2.3). There is an on-going staff development with regular in-service and evidence of attendance at external training such as attendance at a respiratory in-service and wound update via the PHO.
ARC A2.2 Services are provided at Woodlands of Fielding that adhere to the health & disability services standards.
ARC D1.3 all approved service standards are adhered to.
ARC D17.7c There are implemented competencies for caregivers and registered nurses including: insulin administration and medication. RNs have access to external training.

Discussions with residents (three rest home and three hospital) and relatives (two rest home and two hospital) were positive about the care they receive. Interview with three caregivers (who work across both areas) inform they are well supported by the RN's and management team.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Ten incident forms reviewed between February and July (2014) and in all instances family had been notified following a resident incident. Interview with three caregivers (who work across both services) and one registered nurse (RN) inform family are kept informed.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b Relatives (two rest home and two hospital) interviewed 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: PA Low

Evidence:

There are policies/procedures for choices and informed consent (link 1.2.3). There are written consents in resident files (confirmed in review of sample of six of six clinical records (i.e.: three rest home and three hospital).

However one of the six residents in the sample does not have a consent signed for her current admission. The consent on her record relates to a previous admission. The same resident does not have a current admission agreement on record. The other five residents had current admission agreements that contain consents. These admission agreements were signed on or before the day of their admission unless admitted directly from hospital (refer 1.3.3). Informed consent processes are discussed and implemented with residents and family or representatives .Residents are informed about their choice to make an advanced directive and there was evidence of advanced directives on resident's records. Staff are aware of advance directives where these are in place.

D3.1d; Residents are involved in the consent process where they can make an informed choice.

D11.3; The consent form is easy to read and understand.

D12.2 & D 13.1; Residents sign their admission agreement or if not able, the Agreement is signed by their representative. The agreement is based on the Aged Care Association's agreement template and contains consents.

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:

One resident who was admitted following a previous admissions does not have a consent signed for the current admission in 2014. The consent on file was recorded on a previous admission.

Finding:

One of six residents sampled did not have a current admission agreement on file.

Corrective Action:

Ensure all residents sign an admission agreement on the day they receive services and ensure a copy is available on record (D13.1).

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

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)
Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)
Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

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

Attainment and Risk: FA

Evidence:

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 clinical nurse leader confirm practice. Interviews with residents (three rest home and three hospital) confirm that they are aware of their right to access advocacy.
D4.1d; Discussions with four family members 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA

Evidence:

D3.1h: Interview with six residents and four relatives confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Interviews with six residents confirm the activity staff help them access the community such as going shopping, going on site seeing tours, and going to church.
D3.1.e: Discussion with three caregivers, the diversional therapist, four relatives and six residents confirm residents are supported and encouraged to remain involved in the community and external groups.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The complaints policy to guide practice. The manager (and director/owner if necessary) leads the investigation and management of complaints (verbal and written). There is a complaints register that records activity in an on-going fashion. Complaints are discussed at the monthly staff meeting. Complaints forms are visible around the facility. There are no complaints during 2014 and two recorded during 2013. The 2013 complaints were reviewed and had been investigated and a close out letter to the complainant. Discussion with six residents and four relatives confirm they are aware of how to make a complaint. There have been a number of compliments that have been received across the 2014 period.
D13.3h: a complaints procedure is provided to residents within the information pack at entry.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)
An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)
The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

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

Attainment and Risk: FA

Evidence:

Woodlands of Fielding provides care for up to 39 residents across two service levels (rest home and hospital). On the day of audit there were 17 rest home residents and 10 hospital residents. All rooms have previously been assessed as suitable as dual purpose. The facility provides care on two levels, with the ground floor having the more frail residents. There is a sizeable (internal) lift and during the audit residents were observed easily moving between the two floors.

The manager reports to the director/owner who lives locally and has a regular presence at the facility. Karaka Court Limited has a 2014-2014 Business Plan that includes goals and objectives for both the Fielding and Palmerston North facilities. Goals include to provide top quality care, proactive medical and health care.

There is a quality programme being implemented that includes monthly discussion about clinical indicators (eg. incident trends, infection rates), at the monthly staff meeting (link 1.2.3).

The service is managed by a non-clinical manager who has been in post since 2001 (and was previously a caregiver). The manager is supported by a full time clinical nurse leader (RN) and has been in post since 2009. There is a team of registered nurses who have experience within the aged residential care environment.

ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

During a temporary absence, the clinical nurse leader will cover the manager's role (and vice versa). Both the manager and clinical nurse leader are on-call afterhours dependant on the issue (i.e. clinical vs non clinical). The director/owner is also available afterhours.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Woodlands of Fielding is implementing a quality and risk management system. There are policies and procedures to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff, however there are instances where the documented policies so not align to practice. In addition there are instances where document control processes have not been effectively implemented. These are areas of improvement.

Quality matters are taken to the monthly staff meetings and also discussed at monthly registered nurse meetings. There are monthly resident meetings. Staff meeting minutes demonstrate key components of the quality management system are discussed including infections and incidents. The monthly incident and infection figures reported in meeting minutes do not always align with the monthly collation sheets and this is an area of improvement. In addition review of all meeting minutes show that issues raised are not consistently reported back at subsequent meetings and this is an area of improvement.

Woodlands of Fielding is implementing an internal audit programme that includes aspects of clinical care – such as file review. Issues arising from internal audits are seen to be resolved at the time. Internal audits are completed and results fed back to staff and registered nurse meetings. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff.

D19.3: There is a H&S and risk management programme in place including policies to guide practice. A caregiver is the health and safety coordinator for the facility who monitors staff accidents and incidents.
D19.2g: Falls prevention strategies are in place that includes 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: PA Low

Evidence:

There are policies and procedures that have been developed to meet relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a three yearly basis – of more frequently if necessary.

Finding:

The content of policy and procedures are sufficiently detailed to allow effective implementation by staff, however there are instances where the documented policies do not align to current practice. Examples include: a) policy – Staff and Senior Quality Management Meeting references a Quality Council meeting three monthly, however there are no meeting minutes, c) policy – Falls: Management of, references a Falls Minimisation checklist, which could not be located and reportedly is not used. There is no evidence resident outcomes have been compromised and the risk is therefore considered low.

Corrective Action:

Align policy to practice.

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

Criterion 1.2.3.4 (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: PA Low

Evidence:

Policies are reviewed on a three yearly basis, or more frequently if required. The management team are responsible for ensuring effective document control practices when there have been changes to documents and/or policies.

Finding:

The following are examples where the development of new documents/forms has not been effectively managed through the document control process: a) the complaints process has recently been updated and the copy in the operating manuals differ from that in the resident agreement, b) the frequent faller form is sitting at the front of the manual as opposed to the aligning with the policy, c) the infection control policy/programme includes short term care plans for head injury and falls (as well as STCP for infections).

Corrective Action:

Remove documents/forms that are no longer in use. Align forms to policies to ensure the most up to date versions are currently in use.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Quality matters are taken to the monthly staff meetings and also discussed at monthly registered nurse meetings. There are monthly resident meetings. Staff meeting minutes demonstrate key components of the quality management system are discussed including infections and incidents. The monthly incident and infection figures reported in meeting minutes do not always align with the monthly collation sheets. In addition review of all meeting minutes show that issues raised are not consistently reported back at subsequent meetings and this is an area of improvement.

Finding:

Incidents and infections are collated monthly and reported at staff meetings. There are anomalies noted between the two pieces of information for example: a) incidents January summary reports four falls no injury, while meeting minutes record four falls with injury, b) incidents February summary reports four falls with injury and two skin tears/bruising, while meeting minutes report five falls no injury and five skin tears/bruising, c) incidents June summary reports two falls no injury, two skin tears/bruising, one 'other', while meeting minutes report one fall no injury, one fall injury, one skin tear, one pressure area. The infection data for March shows: a) the infection stats sheet shows three Skin and Soft Tissue infection (SST) and four urinary tract infections (UTI), the resident infection assessment sheet reports four SST and four UTI and meeting minutes record four UTI and five SST.

Meeting minutes do not consistently record follow-up of issues, examples include: a) June (6th) resident meeting minutes record satisfaction with two cleaners, the cleaners meeting (17th) does not record resident satisfaction, b) April resident meeting records issue with cold gravy, this is seen in cooks meeting minutes, however there is no feedback to residents in May meeting re outcome, c) January (7th) resident meeting records issues with food (eg. cut stem out of silverbeet, meat cut too thick) to be reported to cooks meeting (16th), not evident in minutes.

Corrective Action:

Incident and infection data is accurately recorded and meeting minutes record outcomes of issues raised.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the integrated meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event and the form is forwarded to the clinical nurse manager for final sign off. Family are notified. The ten incident forms reviewed had all been completed as prescribed and closed out.

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 (link 1.2.3).

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Nine staff files were reviewed (clinical nurse leader – who is the restraint and infection control coordinator, one cook, one kitchen hand, diversional therapist, one registered nurse and four caregivers) and all had relevant documentation relating to employment. 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 documented competencies and induction checklists (sighted in files reviewed). Staff interviewed (three caregivers, 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 includes all required education as part of these standards. There are instances where training scheduled on plan has yet to be implemented and this is an area of improvement. There is evidence that additional training opportunities are offered to staff such as wound care and a respiratory session. Interview with three care givers confirm training is provided. A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse, and kitchen). Core competencies are completed and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. 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 Low

Evidence:

There is an education plan that includes all required education as part of these standards. There is evidence that additional training opportunities are offered to staff such as wound care and a respiratory session. Interview with three care givers confirm training is provided. A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse, and kitchen). Core competencies are completed and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed are aware of the requirement to complete competency training

Finding:

Infection control training scheduled June 2013 has not been delivered – verified training records and interview with staff. Training was again scheduled June 2014, and at the time of audit had yet to be delivered. Records confirm staff surveillance is completed monthly that includes observation of hand washing and environmental inspection. Lifting training is scheduled annually – March – three staff attended last year. There was a recent incident where two staff members lifted a resident from the floor (hoists are available at the facility).

Corrective Action:

Deliver training according to the schedule.

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

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

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

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

Attainment and Risk: FA

Evidence:

The 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: four caregivers in the morning (for varying times), three during the afternoon (varying times and duties) and one on night shift (2300-0730). There is at least one registered nurse and one first aid qualified person on each shift. The manager and clinical nurse leader are both on-call. The diversional therapist works a total of 35 hours per week. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. An initial care 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 plans and notes are legible. 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. Policies contain service name.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)
All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)
Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

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

Attainment and Risk: PA Low

Evidence:

There is an entry criteria policy which clearly describes entry criteria to the service. Staff complete pre- entry forms. The building is open during normal operation hours. Doors are secured during hours of darkness. Staff, residents and families interviewed stated there is no restriction of visiting times (confirmed in discussion with the clinical nurse leader, six residents (three rest home and three hospital) and four relatives (two rest home and two hospital). The service has an information pack available for residents/families/whanau at entry. The information pack includes all relevant aspects of the service and residents and or family/whanau are provided with associated information.

The criteria for entry is documented in the service policy which clearly describes entry criteria for the hospital and rest home level residents. Prospective residents/ families complete pre entry forms at the time of the interview. Residents are assessed prior to entry to the service by the NASC agency. The clinical nurse leader or registered nurses (RNs) complete the entry requirements and liaise with assessment services and service coordinators as required.

A13.2d; Information to residents is contained in the Admission Agreement, which is based on the Aged Care Association's template

D11.1; D11.2: An entry pack of information is given to prospective residents and their families.

D13.3; D13.4; The admission agreement reviewed aligns with a) -k of the ARC Agreement except it omitted to include D13.3d. This omission was rectified on the day of audit and the intention is to use the new form for all newly admitted residents.

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.

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: PA Low

Evidence:

The facility has recently changed its admission agreement and the form in use on the day of audit was based on the content of the Aged Care Association's template. However the form omitted to include the statement, as specified in ARC D13.3d. The agreement form was revised during the audit and now includes the statement. The new version of the agreement now aligns with a) -k of the ARC Agreement.

Finding:

The admission agreement in use did not fully align with section D13.3 ARC Agreement.

Corrective Action:

Revise the format of the admission agreement to include D13.3 ARC Agreement (note action was completed during audit)

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

Declining entry to the service is included in the entry criteria policy. The process includes informing the referrer and the family/advocate/whànau of the reason for the decision to decline. When a prospective resident is declined access to the service they are informed of alternative services available to them. Prospective residents would be referred back to the original referrer for other options that may assist them to meet their needs and the process is documented. The clinical nurse leader reports that they have not declined anyone who has been referred as usually discussions occur with the NASC prior to any referral being made.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The registered nurses are responsible for undertaking the assessments on admission and activity assessments and individual activities care plans have been completed by the qualified diversional therapist.

D16.2, 3, 4; Six residents files were reviewed (three hospital and three rest home).

D16.5e; Medical assessments were documented in all six files within 48 hours of admission where the person had not been admitted directly from hospital.

One to three monthly medical reviews were documented in by the GPs in the residents' files.

More frequent medical assessment/ review is occurring in residents with higher needs. Initial data gathering and assessments include but are not limited to; past medical history, current condition, observations, allergies, use of aids or equipment, known infections, wounds, hygiene, nutrition, dressing, mobilisation, continence, sensory, communication, skin care, pain, sleep, sexuality, spiritual and cultural care, social, other needs and behaviours including cognitive abilities. Nursing assessment tools that are completed on entry to the service include; incontinence assessments, coombe assessment tools for falls, Braden Scale for pressure sores, pain assessments and assessments of any challenging behaviour.

The six files reviewed (three hospital and three rest home) have assessments in place and are reviewed when the plan of care is developed.

Caregivers interviewed (three who work across both rest home and hospital and all shifts) could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Progress notes were written each shift or more frequently as required. One of the several GPs who attend residents at the facility was interviewed by telephone. He stated that he is very happy with the care provided and has confidence in the clinical nurse leader and registered nurses. He feels confident that staff keep him informed of any changes residents are experiencing. One hearing field officer (employed under a separate contract with the DHB) was visiting residents on the day of audit. She reported that she believes residents are happy with the services provided.

Six residents (three hospital and three rest home) stated that overall the care was good and the staff were very caring and respectful. Four relatives (two rest home and two hospital) reported that the care is very good.

Tracer Methodology: Rest Home resident:

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

Tracer Methodology: Hospital resident

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

An initial assessment is completed on entry followed by the development of the residents care plan (confirmed in discussion with the clinical nurse leader).

Two residents who were admitted recently in 2014 had not been weighed as part of admission to record baseline information (refer 1.3.3). One of those residents was admitted with a XXXXXXX and this was not noted on her assessment information and these are areas of improvement.

Initial data gathering and assessments are completed within 24 hours of admission (confirmed in discussions with three of three caregivers). The assessment includes but is not limited to; past medical history, current condition, observations allergies, known infections, wounds, hygiene, nutrition, dressing, mobilisation, continence, sensory, communication, skin care, pain, sleep, sexuality, spiritual and cultural care, social, other needs and behaviour (confirmed in review of six clinical records - three hospital and three rest home).

Nursing assessment tools are completed on entry to the service and include incontinence assessments, Coombe falls risk assessments, Braden Scaled assessments for pressure sores, pain assessments and challenging behaviour assessments. Assessments and interventions are shared with the residents and families. Following the assessment process a long term care plan is developed, which includes goals, intervention and evaluation. This plan is developed within three weeks of admission.

All six resident files (three rest home and three hospital) sighted, provided evidence of completed assessments and care plans.

Residents and families report that individual needs and preferences are discussed (confirmed in discussion with six of six residents - three rest home and three hospital) and four of four relatives (two rest home and two hospital).

D 16.2: Each resident is assessed on admission.

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 Moderate

Evidence:

The practice is to weigh people on admission as part of recording baseline information so that future health changes can be analysed and so that the GP can prescribe the correct dosages of medicines where weight must be considered. Each resident has a comprehensive assessment within 24 hours of admission to guide their care.

Finding:

Two residents were not weighed on admission (refer evidence 1.3.3) and one of those two residents had XXXXXX which was not recorded on assessment refer evidence 1.3.3)

Corrective Action:

Ensure all residents are comprehensively assessed on admission.

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents have their medical status reviewed at least three monthly, or in conjunction with any medical reassessment that takes place. All six files reviewed (three rest home and three hospital) revealed that residents are examined on admission by a GP within two working days if they have not been admitted from hospital. All residents are able to choose their own GP. There is documented evidence in the medical notes /medication charts that GPs review medications three monthly (confirmed in review of twelve medicine charts (six rest home and six hospital).

D16.3b: An initial care plan is commenced on admission and a long term plan is developed within three weeks of admission (confirmed in review of six of six resident's records (three rest home and three hospital). Caregivers' report that the plans are easy to understand (confirmed in discussions with three of three caregivers who work across all shifts and areas).

D16.3f: Residents and family have an opportunity to contribute to the plans of care (confirmed in discussions with four of four relatives (two rest home and two hospital).

D16.3g, h,l,j,: the Plan addresses the resident's current abilities.

D16.3k: Short term plans are used when relevant. Short term care plans are well utilised in the rest home and hospital. Short term care plans were sighted for general health issues, falls, suspected head injuries, wounds, as well as urinary tract infections. There is a separate wound book with wound management records that link to the short or long term care plans.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)
Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)
Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)
Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

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

Attainment and Risk: FA

Evidence:

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes (confirmed in discussions with six of six residents (three rest home and three hospital) and four of four families (two rest home and two hospital).

Care plans are completed by registered nurses (confirmed in discussion with the clinical nurse leader and a registered nurse). Care delivery is recorded and evaluated by caregivers on each shift (evidenced in the progress notes of six of six residents (three rest home and three hospital). When a resident's condition alters, the registered nurse initiates a review and if required, a GP or specialist consultation.

Staff have access to sufficient equipment to provide the care specified in care plans (confirmed in discussions with one RN, and three of three caregivers (who work in all areas). Equipment necessary to provide care, includes hoists, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. There are adequate continence and dressing supplies available (confirmed by observation and in discussions with the clinical nurse leader, the RN and three of three caregivers).

Six residents (three rest home and three hospital), and four family members (two rest home and two hospital), interviewed were very complimentary of care received at the facility.

D18.3 and 4 Dressing supplies are available and a treatment room is well stocked for use. Wound assessment and wound management plans are in place for four residents. Wounds include one resident with a hospital acquired pressure area who was in hospital on the days of audit, one chronic leg ulcer (refer 1.3.3) and two skin tears.

These are recorded are in the wound register, with on-going assessment and monitoring using documentation that has been designed to be consistent with documentation used by the DHB Tissue Viability Service . The clinical nurse leader described the referral process for accessing specialist nursing advice and says she has good access and feels well supported by the DHB specialist nursing teams. 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

Continence management in-services was last provided August 2013) and wound management in-service was last provided October 2013.

The facility has registered nurse cover 24 hours a day, seven days a week.

During the tour of facility it was noted that all staff treated residents with respect and dignity.

D16.1a &.1b.i: Residents are orientated to the facility on entry.

D16.5a; Routines in the facility reflect community norms

D18.3: Dressing supplies are provided.

D18.4: Continence supplies are provided.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service employs one qualified diversional therapist who works 35 hours a week. A profile sheet is completed for residents on admission. The service records interests, family, values/beliefs, likes/dislikes, personality, culture and spirituality and other information.

A range of activities are provided, which includes activities such as, a) housie, b) bowls, c) cooking, d) newspaper reading, e) outings (has van which can seat residents and a driver), f) entertainment, g) exercises, h) quizzes, I) flower arranging, j) crafts, k) reminiscing, and l) library. Activities involves family and the wider community. Residents go on outings in the van to shopping, beaches, schools, farms, concerts and to the art centre. Outside entertainers visit to provide musical entertainment.

Spiritual needs are addressed by on onsite communion monthly which is interdenominational. A Catholic communion is held weekly. The Salvation Army visit.

Residents can enjoy going to an onsite recreation centre to watch movies, attend fashion parades and socialise. The facility has one van, which is not hoist capable. The hoist mobility van owned by the Fielding community is booked if needed.

Residents (and their relatives) were observed enjoying 'happy hour' prior to lunch and this was appreciated. Residents have monthly residents meetings held in the dining room. Staff report residents contribute well to the meetings.

Residents and relatives are very happy with the activities programmes on offer (confirmed in discussions with six of six residents (three rest home and three hospital) and in discussions with four families (two rest home and two hospital).

D16.5c.iii; Each resident has a written individual activities plan which is evaluated and reviewed each time the care plan is reviewed.

D16.5d The programme includes group and individual activities.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur (sighted in six of six care plans sampled (three rest home and three hospital) and confirmed in discussions with the clinical nurse leader and the RN). Changes to the long term lifestyle care plan are made as required and at the six monthly review if required. There is at least a three monthly review by the resident's GP. There are short term care plans to focus on acute and short-term issues.

D16.3c, All initial care plans were evaluated by the RN within three weeks of admission.

D16.3d: Care plans are reviewed by an RN where necessary.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated and residents and relatives are involved (confirmed in discussions with six of six residents (three hospital and three rest home) and four relatives (two rest home and two hospital).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service facilitates access to other services. Referral documentation is retained in resident files. A discharge record is reviewed. The clinical leader liaises with the residents' GP and the family members before the arrangements to transfer a resident is made. This is documented in the progress notes.

D16.4c; the service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care

D 16.4d: Residents are reassessed by the NASC as needed. There are no residents waiting for reassessment currently.

D 20.1 Discussions with the clinical nurse leader confirmed the service has access to GP services, physiotherapy, wound care and other specialist nursing advice.

D 20.4: Staff accompany residents to appointments as appropriate if no family are available.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

The service has policies around transfer and discharge to facilitate safe transfer to another service. Policies are implemented. There is a system in place for when residents are required to be transferred to hospital, which includes communication with all parties involved.

D21: There are appropriate discharge and transfer systems in place.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are policies and procedures for the medicines management system to guide staff. Prescribing is managed by the resident's GP. Residents have their own GPs. There are several GPs who attend residents at the facility. Dispensing is managed by one pharmacy (pharmacy licence sighted and a copy of the signed agreement dated 1 March 2012 was sighted).

Administration of medicines is managed by RN's and caregivers. The clinical nurse leader has been assessed as competent and she has assessed the RNs as competent to administer medicines. The clinical nurse leader assesses the caregivers for competency. Medicine administration education was last provided in February 2014. The facility uses the Douglas blister pack system for packaging of tablets and other medicines have pharmacy generated labelling on the dispensed packages or bottles. Medication administration was observed at one medication round and the process was correct. Medications and associated documentation are kept on the medication trolley, in locked a treatment room, which is located on the ground floor.

Controlled drugs are stored in a fixed locked metal container inside a locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register

The pharmacist checks controlled drugs 6 monthly and records the stock count in green (last checked 3 July 2014). There is a drug refrigerator in the medicines room which is monitored weekly by the clinical nurse leader. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies are on all the drug charts. Disposal is managed by quarantining medicines that need to be returned to the pharmacy. There is a pharmacy return system in place. The pharmacy visits the facility each week night at around 5 pm to drop off and pick up medicines.

There is one resident self-administering her medicines. A self-medication assessment had occurred for the one resident who self-administers her medicines. She has a locked safe in her room and keeps the key on her person (sighted).

Standing orders are in place for all GPs providing services at the facility.

Medication charts sighted (six rest home and six hospital) were reviewed by the GP at least three monthly.

There is an internal audit programme in place that includes audit of medicines management (last audit conducted May 2014).

D1.1g; The system has been designed to comply with the Medicines Act (with the exception of policy identified above)

D15.3c; Medicines are stored safely

D16.5e.i.2; The GP reviews each residents medicines three monthly and notes and signs the medication chart.

D19.2d: Medicines are managed and administered safely.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)
The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)
Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility has a large kitchen that supplies all food for the rest home and hospital residents. There are three cooks and two kitchen assistants. Breakfast is prepared by a kitchen assistant and the cooks prepare lunch and tea. Supper is done by the tea kitchen assistant. The main meal of the day is served in the evening as this is the preference of the residents. Staff check meal preference times at each residents meetings and report that residents are clear on their preferences. Staff have completed food safety certificates. Food is ordered by the cooks against the menu which has been approved by a dietitian. Most food is produced on site. Food is stored either in a dry store, chiller, refrigerators or a freezer. Food is stored off the floor and is dated. There is a stock list to guide purchasing. An external person comes in daily to pick up food waste. Residents' likes and dislikes are known and documented and on display on a white board to guide staff when serving. Residents needing special equipment, or supervision at meal times is documented in the kitchen. Special equipment or preparation of food requirements are accommodated. One resident is fed by a PEG tube and her feeding regime is documented by the dietitian. Another resident has a swallowing problem and has a special diet as they can only swallow through a straw. Hats are worn in the kitchen. The kitchen has a gas hob, gas oven and electric microwave. A slow cooker is used for the porridge, which is turned on by the night staff. Refrigerator, freezer and food serving temperatures are checked daily and results recorded. The kitchen stores at least a week's supply of food and there is more food stored elsewhere on the site.

Six residents interviewed (three hospital and three rest home) and four relatives (two rest home and two hospital) stated that overall the food was very good. The lunch time meal was observed. All residents had place names on the table (and staff say these are really loved by residents). Staff were observed acting as waiters while serving the lunch meal to residents. This was very well done. Residents commented that they felt like they were living in a hotel.

A food satisfaction survey was completed in January 2014 which was satisfactory.

A kitchen internal audit was conducted in March 2014 which was fully compliant.

Staff received in-service education in January 2014.

D1.1a; Food hygiene regulations are respected.

D15.2b; The food service reflects the needs of the residents. The food service is perceived as a very important aspect of resident enjoyment.

D19.2c; Staff have attended safe food handling course.

D19.2 staff have been trained in safe food handling

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Waste management and chemical safety is included in the orientation programme for all new staff, and in the annual staff education plan. Ecolab provides training (the last training was provided in February 2014). The service has access to Material Safety Data sheets. Chemicals are labelled and stored appropriately. Protective eye wear, gloves and aprons are available for staff use.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Maintenance is performed by external contractors. Maintenance is logged in a book for management to action. Reactive and preventative maintenance occurs and is overseen by the owner. The building holds a current warrant of fitness which expires 1 September 2014. The warrant includes the internal passenger lift. The medical equipment is calibrated (which includes the sphygmomanometers, sitting scales, hoists, hydraulic beds) and is due May 2015. There are three hoists in use. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet except for one which has vinyl (i.e., Room 11). The facility is fully equipped with electric beds in some rooms. It has 'low-low' hospital beds and ordinary hospital beds which are used to match residents' requirements. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens are attractive. There is garden furniture and shaded areas to sit. There is flat access to all areas. There is an internal audit programme in place that includes audit of building maintenance (last audit conducted April 2014). One toilet area upstairs was observed to have a wheelchair damaged wallboard and a broken window catch that needs maintenance.

D4.1b; The premises are homelike.

D15.1; The premises are designed to meet the needs of the elderly.

D15.2a; D15.2e; D15.3; All furniture, fixtures and fittings are provided. Residents can bring their own furniture.

D20.2; D20.3; D20.4 Transport is provided. The facility has one van which is not hoist capable. The hoist mobility van owned by the Fielding community is booked if necessary.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)
All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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: PA Low

Evidence:

There is a toilet upstairs that has a broken window catch and wheelchair damaged wallboard.

Finding:

One toilet area upstairs has wheelchair damaged wallboard and a broken window catch that needs maintenance.

Corrective Action:

Fix the broken window catch and the damaged wall board in the upstairs toilet area.

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)
Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

The service has sufficient toilet and showering facilities to meet the need of the residents. Some rooms upstairs have ensuites. All rooms have a hand basin. The service carries out regular hot water temperature checks. The temperature is monitored weekly using different rooms and the temperature fluctuates between 42-43°C. The service has adequate hand washing facilities. Toilet and showers are identifiable and have appropriate signage when it is in use. Showers have privacy curtains.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Resident rooms are sufficiently large to allow for care to be provided and for the safe manoeuvring of mobility aids. Resident transfer between rooms is not required in a bed. An ambulance stretcher could manoeuvre within the rooms if required and could be used in the lift.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

The service has a number of lounges and a large dining room area. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged in a way that enables residents to mobilise. Residents have access to a recreational centre which is located on the grounds and some residents utilise and enjoy using this communal area that is also used by residents who live in the large retirement village located on site.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)
Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)
Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

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

Attainment and Risk: FA

Evidence:

There are written policies and procedures for effective management of laundry and cleaning practices. Ecolab provides monitoring and training of their supplied chemicals in both the laundry and cleaning services. Chemical safety information data sheets are available for staff to access. There is an internal audit programme in place that includes audit of the cleaning and laundry (last audit conducted March 2014). Cleaning is performed every day. Cleaners are employed Monday to Sunday, mornings only and they work in the kitchen in the afternoon. Ecolab supplies the chemicals. The cleaners have specialist trollies to assist them when cleaning. Laundry of personal clothing is done onsite and general Laundry is outsourced to a commercial operator. All laundry is done by caregivers. There are two washing machines and two driers and an outside clothesline. Staff can soak heavily soiled clothing. Effectiveness is monitored by visual examination, internal audit and feedback from residents and relatives. There is a designated area for the storage of chemicals, which is locked. This laundry is well laid out and there is a sluice room next door to the laundry.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)
The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan (letter dated 04/09/1998). Fire evacuations are held six monthly and the last drill was completed 18 March 2014. There is staff across 24/7 with a current first aid certificate. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well 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 in the kitchen. Hoists have battery backup. Oxygen cylinders are available. At least three days stock of other products such as incontinence products and personal protective equipment (PPE) are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas. During the tour of the facility residents were observed to have easy access to the call bells and residents interviewed stated their bells were overall answered in a timely manner.
D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

General living areas and resident rooms are appropriately heated and ventilated. Heating is a mix of gas heating, electricity and heat pumps. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated area, which is outside the dining room on the veranda. There is one resident who smokes and he periodically uses an electric cigarette.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The service endeavours to minimise restraint usage. The use of enablers is voluntary and the least restrictive option to meet the needs of the consumer. No residents were using enablers on the day of audit. Six residents were using restraints, which included bed gates (all six) and three of the six were also restrained by seat belts to stop them falling out of their wheelchairs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

The responsibility for restraint process and approval is defined in policy. Responsibility is delegated to the restraint coordinator who is the clinical nurse leader. She reports to the facility manager. The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. There is an approval process in place which is outlined in the policy and procedures. There is an assessment process in place which is as follows: the RN (usually the clinical nurse leader/restraint coordinator) commences the assessment and completes a restraint assessment form. The RN will consult with the NOK/Family and discuss the use of restraint and the consent process. The Consent for Restraint form is completed and signed by the resident's doctor, the resident or their family and a registered nurse. The consent form includes the duration of the restraint. Ongoing education on restraint occurs (last provided May 2014). There is an internal audit programme in place that includes audit of restraint management (last audit was conducted in April 2014).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There is an assessment process in place. Assessment documentation aligns to the standard. Assessment is documented on the restraint assessment form, which includes the factors are taken into consideration by the RN in proposing the restraint. This information includes but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; and (f) maintaining culturally safe practice;

The form does not include consideration of (c) existing advance directives the consumer may have made; (d) whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); or (h) Possible alternative intervention/strategies. Staff are in the process of reviewing all of the restraint policies and associated procedures and forms to ensure they match the current standards.

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

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

Attainment and Risk: PA Low

Evidence:

Assessment of restraint occurs and is documented on the assessment of restraint form. The form does not include consideration of (c) existing advance directives the consumer may have made; (d) whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) any history of trauma or abuse, which may have involved the consumer being held against their will; (g) desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); or (h) possible alternative intervention/strategies.

Finding:

The assessment form does not include documentation on the assessment of restraint form which includes consideration of (c) existing advance directives the consumer may have made; (d) whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) any history of trauma or abuse, which may have involved the consumer being held against their will; (g) the desired outcome and criteria for ending the restraint); or (h) possible alternative intervention/strategies

Corrective Action:

Ensure all assessment information is documented on the restraint assessment form.

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

Approved restraint is only applied as a last resort, with the least amount of force. Alternative interventions are considered prior to implementing restraints, although not recorded in assessment form (link 2.2.2.1). The decision to approve restraint only occurs after an assessment process that involves the RNs and the resident's GP. There is consideration of the environment prior to implementation and consideration of the resident's safety. Each episode of restraint is documented on a monitoring form. The form includes a link to the care plan which identifies the indication for use. The monitoring form lists the restraint intervention (i.e., method), the duration (i.e., time on and time off), its outcome, observations/, comments which on restraint and staff signatures. A restraint register is maintained which records who has an approved restraint or enabler in place.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

Restraints in use in the facility are ongoing. Restraints are being formally reviewed every six months. The evaluation form is in the process of review.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The Restraint Coordinator conducts a quality review of restraint use six monthly. The review includes the extent of restraint use and any trends; the organisation's progress in reducing restraint, service provider compliance with policies and procedures; if individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation and whether changes to policy, procedures, or guidelines are required. The quality review form is in the process of being reviewed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

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 policy and infection control programme description are available. 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 committee is responsible for the development of the infection control

programme and its review. The programme is reviewed annually. 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 taken to the monthly staff and registered nurse 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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control team is essentially the staff with the clinical nurse leader taking the lead. The facility also has access to an infection control nurse specialist, public health and GP's.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D 19.2a: The infection control manual outlines a comprehensive 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. Policy development involves the infection control coordinator and the management team.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control (IC) coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has completed appropriate IC training including attendance at a one day New Zealand Nurses Organisation (NZNO) infection control study day in May 2014. The orientation package includes specific training around hand washing. The IC coordinator provides training both at orientation and ongoing. Training on infection control is included in as part of the training schedule (link 1.2.7). Monthly surveillance audits also include opportunistic education with staff. Resident education is expected to occur as part of providing daily cares.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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 all infections. Infections are included on a monthly summary sheet completed by the infection control coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at both the registered nurse and staff meetings (link 1.2.3). The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. Infection control surveillance of staff is included in the audit schedule (completed monthly). There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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