# Admatha Dementia Care Limited

## Current Status: 13 August 2014

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

Admatha Dementia Care provides psychogeriatric and dementia level care for up to 57 residents. There are two distinct homes; a secure psychogeriatric home of 25 beds that is divided into two smaller homes. Also a secure dementia unit of 32 beds, divided into two smaller homes. Occupancy at the audit was 24 residents in the psychogeriatric unit and 30 residents across the dementia homes.

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings.

The service is managed by an experienced operations manager who has been in this position for four and half years. She has a background in home care management and is supported by the clinical nurse manager and the management team at Dementia Care NZ. The service has addressed a previous audit finding in regards to signing for medications. There were no findings at this audit.

## Audit Summary as at 13 August 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 13 August 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. |  | Standards applicable to this service fully attained. |

### Organisational Management as at 13 August 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 13 August 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 13 August 2014

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

### Restraint Minimisation and Safe Practice as at 13 August 2014

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

### Infection Prevention and Control as at 13 August 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. |

# 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:** | Admatha Dementia Care Limited |
| **Certificate name:** | Admatha Dementia Care Limited |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Admatha Dementia Care; Admatha Lodge | | | |
| **Services audited:** | Hospital services - psychogeriatric; dementia level care | | | |
| **Dates of audit:** | **Start date:** | 13 August 2014 | **End date:** | 14 August 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:** | 54 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 12 | Total audit hours off site | 10 | Total audit hours | 22 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed |  | Number of staff interviewed | 9 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 45 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## Declaration

I, XXXXXX, 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 | Yes |
| 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 Wednesday, 17 September 2014

## Executive Summary of Audit

**General Overview**

Admatha Dementia Care provides psychogeriatric and dementia level care for up to 57 residents. There are two distinct homes; a secure psychogeriatric home of 25 beds, divided into two smaller homes. Also a secure dementia unit of 32 beds, divided into two smaller homes. Occupancy at the audit was 24 residents in the psychogeriatric unit and 30 residents across the dementia homes.

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings.

The service is managed by an experienced operations manager who has been in this position for four and half years. She has a background in home care management and is supported by the clinical nurse manager and the management team at Dementia Care NZ. The service has addressed a previous audit finding in regards to signing for medications.

**Outcome 1.1: Consumer Rights**

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. Education on informed consent has been provided. The complaints process and forms for completion are available in the reception area. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

**Outcome 1.2: Organisational Management**

Dementia Care NZ Ltd is the proprietors/directors of Admatha Dementia Care. The operations manager of Admatha reports to the general manager on a monthly basis against the quality and risk management plan. The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings. The service is active in analysing data. Corrective actions are identified and implemented and include follow up and review. Friends and family satisfaction surveys are completed and regular resident/relative meetings are held. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

**Outcome 1.3: Continuum of Service Delivery**

Care plans are developed by the services registered nurses and are reviewed six monthly in the dementia home, three monthly in the psychogeriatric home and monthly for any resident with restraint. Families are involved in the development and review of the care plan. A multi-disciplinary meeting occurs six monthly. The service has strong vision that is reflected in a team approach with a comprehensive mentoring programme that assists with support and values.

All staff are highly qualified in their roles and complete on-going training around the specific needs of people with dementia. All assessments linked into the comprehensive care plan.

Care plans are individually developed, holistic and meets resident’s needs and include diagnosis/needs, aim and action. Other specific needs of residents such as medical conditions are also included. There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes. The service has a physiotherapist that visits weekly.

There are comprehensive policies/procedures to provide psychogeriatric level care and dementia specific care. There is a planned seven days activities programme that is developed by the two trainee diversional therapy staff members and two trained diversional therapists. They are supported by an organisational Diversional Therapist that supports the team.

The medication management system includes medication policy and procedures and there is on-going education and training of staff in relation to medicine management. The service has addressed a previous audit medication finding in regards to signing for medications

The main kitchen provides food to all the kitchenettes in each unit. The service also has a monthly visit from a dietician for review of resident nutritional status and needs and notes are included in resident files.

**Outcome 1.4: Safe and Appropriate Environment**

There is a current building warrant of fitness displayed in the foyer of both buildings.

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

There is a Restraint Minimisation and Safe Practice Policy and Procedure applicable to the type and size of the service and includes definitions of restraint and enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint training is provided at orientation and is scheduled as part of the services annual training schedule. This includes restraint a self-directed learning and competency for restraint minimisation. Individual restraint interventions are evaluated monthly and documented in the care plan and on the restraint register. There are 10 residents assessed as requiring restraints and no residents using enablers.

**Outcome 3: Infection Prevention and Control**

The infection control management systems are well documented and implemented to minimize the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality and risk management plan. The infection control nurse completes a monthly infection summary. Infection control education is provided and records maintained.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

## 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 1.1.9: 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:**

Six family (two from the dementia home and four from the psychogeriatric home) stated they and the resident were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur monthly in the dementia unit and the psychogeriatric unit. In each of the four areas, residents are encouraged to attend and to comment on the questions asked. Meeting minutes reviewed for July 2014 evidence that staff have recorded all residents present and any response they may have made to questions around activities, meals and arrivals and departures.

A family support group meeting is held monthly which is facilitated by an independent facilitator. Reports from this meeting are available for the operations manager. A family focus meeting (gathering) is held annually (3 March 2014) and is chaired by the directors. Advised by the operations manager that staff do not attend this meeting as it provides opportunities for residents/families to talk openly and freely about what works best and what improvements could be made to the service. Outcomes of this meeting are fed back the operations manager and any issues that arise are dealt with through the quality improvement activities programme. At the last meeting a new big TV screen was requested and with more activity entertainment. These measures have been implemented. The service runs a family orientation course twice a year. At these course representatives from age concern, needs assessment and coordination for elderly care and family support are present. The course explains the information in a residents file to the family members participating.

The clinical nurse manager and the operations manager have an open-door policy and both have regular contact with residents and families. The service has policies and procedures available for access to interpreter services. There is an open disclosure policy, a complaints policy and an incident/accident reporting policy.

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 Residents/family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.

D16.4b Six family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.

##### 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 1.1.13: 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 service has a complaints policy in place that complies with Right 10 of the Code and family are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the both homes. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family. There is a complaints register in place. There have been written and verbal complaints. A complaints folder is maintained with all documentation. These demonstrate that complaints are actively managed.

Six families (two from the dementia home and four from the psychogeriatric home) confirm they are aware of the complaints process and they would make a complaint to the clinical nurse manager or operations manager if necessary.

D13.3h. Information about the complaints procedure is provided to residents in the information pack provided prior to entry to the service. This is discussed with the family on admission. Six families (two from the dementia unit and four from the psychogeriatric unit) confirm that they understand the complaints process and that they are able to access advocacy services. Discussions with the regional manager, operations manager, clinical nurse manager, two registered nurses, four caregivers and a review of documentation identifies that the service is responsive to the values, culture and beliefs of consumers and documentation reflects that they respond appropriately when concerns are raised. There has been three complaints (written) for 2014 and six complaints for 2013. All complaints have been resolved. There are no current complaints.

ARHSS D13.3g: The complaints procedure is provided to relatives on admission. It is included in the admission agreement.

##### 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:**

Dementia Care NZ Ltd is the parent company of Admatha Dementia Care. Admatha Dementia Care provides care for up to 32 dedicated dementia rest home level residents in the home and 25 psychogeriatric level residents in the Lodge. On the day of the audit, there were 30 residents in the Home and 24 in the Lodge. Admatha is arranged into two residential facilities (the Home and the Lodge). Within each of these facilities there are two 'small home' homes - Tai and Awa in the Home and Amour and Mon-Ami in the Lodge. Each 'home' has no more than 16 resident’s rooms with a main lounge and dining area, kitchenette and nursing/staff office. The intention is to provide a home-like atmosphere for residents.

Dementia Care NZ Ltd has well established business, strategic, quality and risk organisational plans being implemented for Admatha Dementia Care. The service is managed by an operations manager who is supported by a team of experienced staff -, clinical nurse manager, registered nurses, care givers and the management team of Dementia Care NZ. The operations manager is supported by a clinical manager and is responsible to the General Manager and reports on a monthly basis on a variety of issues relating to the strategic and quality plan. Dementia Care NZ Ltd is the parent company and operates Admatha Dementia Care in Richmond, Christchurch. The operations manager has been in the position for four and a half years. The organisation has recently employed a new general manager and introduced two new organisational positions, a new clinical nurse advisor and an extra regional manager. Each facility has also implemented a staff member to review falls prevention.

The proprietors have vision and values, an organisational structure, and business plan as well as a current quality and risk organisational plan for 2014. The quality programme is managed by the operations manager and a quality and systems manager for the organisation. There are objectives for the current financial year including (but not limited to): vision and values, quality plan, health and safety, infection control, resident occupancy, benchmarking, medication management, complaints process, human resources, restraint minimisation, continuous quality improvement, communication, education and training for staff including orientation and competencies, food safety, fire and evacuation and code of residents rights.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. Admatha Dementia Care is governed by directors/proprietors who provide specialist dementia care services to residents in facilities around New Zealand. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. The vision for the organisation is: 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'. The service aims to achieve the vision by promoting the uniqueness of each person, acknowledging the immense value of each person and by promoting openness, honesty and integrity. Philosophy of care incorporates: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and involved in their loved one’s care. They are encouraged to share their knowledge of their loved one to build trust and to promote honesty and openness; c) small homely homes provides residents with a stable and familiar environment; d) staff are acknowledged as people with skills and abilities who have the potential to be a positive impact on residents, families and their work teams; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. The philosophy of care is to promote participation in life activities, promote physical and emotional wellness. This is well demonstrated at Admatha. The service has a robust quality and risk management systems implemented at Admatha Dementia Care. Service appropriate management systems, policies, procedures, guidelines, codes of practice, competency assessments, orientation programmes and annual education programmes are implemented. The operations manager has maintained at least eight hours annually of professional development activities related to managing the facility including attending two days training for leadership (August 2013) , completing the online dementia course, mentoring with the general manager and attended an organisational managers day (August 2014).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The quality and risk management system is understood and implemented by the operations manager and staff at the service and supported by an organisational team.

A comprehensive set of policies and procedures are in place. The operations manager reports that new and/or revised policies are developed by the organisational team and with input from staff. The operations manager signs off on all new policies. They are available for staff to read and to sign after reading.

Policies and procedures are stored in hard copy at the facility. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed two yearly unless changes occur more frequently. There is an amendments sheet in each manual, and lists of policies and procedures that have been either recently developed or revised are documented.

Admatha has a strategic business plan and a quality and risk management plan that are implemented and managed at service level by a quality services manager. There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through monthly quality meetings, monthly internal management meetings, monthly registered nurse meetings, monthly home managers’ meetings, monthly health and safety meetings, monthly infection control meetings, monthly reports to the General Manager and six monthly organisational meetings for health and safety, infection control and education. The quality committee meeting includes (but is not limited to): infection control, accidents/incidents, restraint, quality goals, quality activities, policies and procedures, health and safety, staff, family issues, complaints, marketing, education and clinical issues. Minutes are maintained and easily available to staff in a folder. Minutes include actions to achieve compliance where relevant. Benchmarking is used as a means of identifying trends and potential risks or for advanced planning. This, together with comprehensive staff training, demonstrates Admatha's commitment to on-going quality improvement. Discussions with the, operations manager, clinical nurse manager, registered nurses (two) and four care givers (who work across the service) confirm their involvement in the quality programme. The service has local goals/initiatives including but not limited to: reviewing the data/trends from each month, reducing urinary tract infections, reducing falls, managing behaviour issues (BPSD), raising awareness of “magic moments” of residents with families and promoting “busy hands”.

Resident meetings take place in the dementia unit and psychogeriatric unit monthly (July 2014), family gathering meeting annually (2014) and relative support meetings twice monthly. The service holds a resident meeting monthly in the dementia and the psychogeriatric unit and all responses are recorded. Items discussed include meals and activities. Six family members interviewed (two dementia unit and four psychogeriatric) stated they have the opportunity to talk to management or staff and are able to request changes if needed. Families also stated that they are contacted if there are changes in a resident's health status. Annual friends and family satisfaction surveys are conducted. In the survey completed in January 2014, respondents were very satisfied with the care being provided (47 surveys were posted out with 29 responses). A family newsletter is compiled three monthly. Newsletter for March 2014 includes feedback from family surveys. Information includes visiting, free online course on dementia, hip protector benefits, six week post admission surveys, friends and family survey ‘orientation for families’ and 'sharing the journey.

The quality system and internal audit programme is designed to monitor contractual and standards compliance and the quality of service delivery. The monthly, quarterly and annual reviews of this programme reflect the service’s on-going progress around quality improvement.

The service has an internal audit schedule that is implemented. Internal audits are completed and actions identified if compliance percentage score is below 95%. Internal audits completed include (but are not limited to): restraint –January 2014, medication management –January 2014 and May 2014, safe and appropriate environment –February 2014, cleaning (household, kitchen) – March 2014, infection control -March 2014, residents files- March 2014, resident falls -March 2014, community resource information -April 2014, resident admission procedure –April 2014 and resident care –May 2014. A process is implemented to measure achievement against goals in the strategic business plan and quality and risk management plan. Formal review takes place six monthly.

Internal audits are completed and include the identification of any issues and corrective actions where required. Corrective actions are discussed at the monthly quality meetings and monthly staff meetings and the service ensures that all corrective actions are followed through and signed off. Incidents, accidents, hazards, complaints, infections, education, activities, marketing, quality systems and restraint are monitored through the monthly quality meetings.

Monthly internal benchmarking and quarterly New Zealand standards benchmarking of the service in areas (but not limited to) resident accidents and infections are used to measure the effectiveness of the objectives of the quality and risk management plan.

Six week post admission surveys provides early feedback to the service friends and family satisfaction surveys are conducted annually.

There is a hazard register that is reviewed annually. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate.

The monthly health and safety meetings identify actual and potential risks and corrective actions are initiated. Monthly incident/accident data is collated and actual and potential risks are identified.

D10.1: Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner.

D19.3: there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.

D19.2g Falls prevention strategies are in place that include: assessment of risk, medication review, bone health introducing vitamin D, vision and hearing assessments, mobility assessments with physiotherapy input, exercises/physical activities, training for staff on detection of falls risk, and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. The physiotherapist conducts education sessions for activities staff on how to run the exercise group.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an incident/accident policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents in monthly quality, health and safety and staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and family members interviewed stated they are informed of changes in health status and incidents/accidents.

D19.3b There is an incident and accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, investigation, and documentation. Incidents, accidents and near misses are investigated. Corrective actions are identified and these are followed through to ensure implementation. Incidents are analysed on a monthly basis and discussed at the quality meetings, health and safety, registered nurse, and home managers’ meetings and reported to the General Manager and to the directors by the operations manager on a monthly basis.

D19.3d the service is aware that they will inform the DHB of any serious accidents or incidents

Discussions with the operations manager and clinical nurse manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required. Minutes of the monthly quality and health and safety meetings, and monthly staff meetings (registered nurse and home managers) and the monthly staff bulletin reflect a discussion of incidents/accidents and actions taken. Six of six family members (two dementia and four psychogeriatric) interviewed stated that they are kept fully informed. Incident forms have a section to indicate if family have been informed (or not) of an incident/accident. Eight incident/accident forms were reviewed for August 2014. All demonstrated that there was clinical follow up by the registered nurse and/or clinical manager. The clinical manager confirmed that neurological observations are completed for residents with head injuries. The registered nurses (two) and clinical nurse manager advised that they contact family following any incident - either face to face or via a phone call. Following an incident/accident, assessments are reviewed, and care plans are updated. In all eight forms reviewed, contact with families after an incident/accident is documented in the progress notes.

Statutory and regulatory obligations are understood by the operations manager and clinical manager. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are job descriptions available for all positions and staff have employment contracts. A record of practising certificates is maintained. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Discussion with staff and management confirm that there is a comprehensive in-service training programme in place covering relevant aspects of care and support and the requirements

Admatha Dementia Care employs a total of 45 permanent and casual staff. Human resource manual policies and procedures include - training and supervision, staff training, ACE programme, maintaining training records, performance management and appraisals policy and procedures. Staff orientation policy and procedures includes training and support packages for operations manager, clinical manager registered nurses, caregivers, activities team and cook and kitchen staff. There are job descriptions available for all positions and staff have employment contracts.

Six staff files were reviewed (operations manager, one registered nurse/infection control nurse, one caregiver, one caregiver/safe handling officer/health and safety rep, one cook, and one diversional therapy leader/weekend manager). Reference checks are completed before employment is offered and are evident in the six staff files reviewed. All files showed evidence of orientation to roles with competency packages completed. Job descriptions were evident in all files reviewed. The operations manager conducts annual performance appraisals. These were completed for five of six staff whose files were reviewed (one staff member has recently been employed and therefore appraisal is not yet due). The new staff member has completed a comprehensive orientation programme. Competency packages for registered nurses include restraint minimisation and safe practice, first aid, ACE dementia series, medication, neurological conditions and leadership. Caregivers competency package, restraint minimisation and safe practice, first aid, safe medication administration, ACE programme and leadership. Staff also complete safe food handling, chemical safety, safe manual handling (hoist use), bi-cultural awareness and infection control.

ARHSS D17.7 The diversional therapist working in the special care home has completed ACE dementia modules. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity.

A copy of practising certificates sighted for all registered nurses (RN), dietician, physiotherapist , Occupational Therapist, podiatrist, and GP is kept.

E4.5d the orientation programme is relevant to the dementia home and includes a session on how to implement activities and therapies.

ARHSS D17.1 and E4.5f : There are 32 caregivers who work across the dementia home and psychogeriatric home. Twenty nine caregivers have completed the required dementia standards and three are in the process of completing (have been at the service less than one year).

Discussion with the Admatha operations manager, clinical nurse manager, registered nurses (two) and four caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar completed for 2014 which is currently being implemented. The annual training programme well exceeds eight hours annually. Additionally, all caregivers are encouraged to complete the aged care education certificate core and dementia standards (25 caregivers have completed ACE core). Four caregivers interviewed advised that they have all completed the ACE training. The registered nurses attend external training including conferences, seminars and sessions provided by the local DHB. The operations manager has completed the ACE training standards and the core competencies for care giving staff. The operations manager attends training provided by the organisation in leadership and management, and attends organisational wide managers’ meetings as well as professional supervision. The operations manager and weekend manager attended an organisational conference on the day of the audit. An education coordinator is employed to oversee the organisation's education programme for all homes and is available to facilitate sessions. The education coordinator develops the annual education plan in conjunction with the operations manager. There are essential/compulsory attendance sessions. Other topics are added to the plan as required following feedback from audits, complaints, incidents/accidents, infection, health and safety issues and quality improvement initiatives.

Education completed so far for 2014 includes, intercultural awareness-January, best friends sessions-January, hoist training- March, fire drill –March, restraint minimisation –March, Infection control and waste management –April, communication skills – April, pain management –May, chemical safety-May, medication administration –May, come in to my world –July, wound care –July, health and safety.

Other initiatives are programmes called ‘orientation for families’ and 'sharing the journey' which are designed for dementia residents’ families to assist them to understand and cope with dementia progression, behaviours, and respond to behaviours. Six family members interviewed (two dementia and four psychogeriatric) confirmed that they felt well supported and appreciated the service's provision of education for them around understanding dementia. Families also have information on how to access the online dementia course.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mix for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is a policy and procedure in place for human resource management including set up and management of the roster, staffing levels, on call, responsibilities of senior person on duty, and staff replacement. The policies are sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. Staffing and skill mix is reviewed by the operations manager and quality committee monthly or more frequently if required. Interviews with four caregivers (who work across the service) and six family members (two dementia, four psychogeriatric) identify that staffing is adequate to meet the needs of residents and that they are well supported by the operations manager and clinical manager and registered nurses. Roster includes five caregivers on the morning shift and afternoon shift and one registered nurse in both the dementia home and the psychogeriatric home. On the night shift there is one caregiver and one registered nurse in the psychogeriatric home and two caregivers in the dementia home. There is also a floating caregiver who works predominantly in the psychogeriatric home. There are two activity staff during the day in each home.

Operations Manager and clinical manager - Monday to Friday 35 hours per week and on call at any time.

Staff turnover is reported by the owner/ manager/owner as low. Staffing levels are altered according to resident numbers and acuity.

One general practitioner was interviewed who confirms that staffing is appropriate to meet the needs of residents.

Six family (two dementia and four psychogeriatric) confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.

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

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

**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 1.3.3: 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 complete the initial assessment on admission. The initial support plan and 24 hour care plan is completed within 24 hrs. of admission with an in-depth progress notes entry. Within three weeks the long term care plan is completed. Evaluations and reviews are completed by the registered nurses. In all files reviewed (three from the psychogeriatric unit, and three from dementia), the initial admission assessment and long term care plan were completed by a registered nurse. The resident's choice of general practitioner completes a physical assessment within 48 hours of admission with on-going one to three monthly reviews (and as needed).

There is a staff handover at the beginning and end of each shift, which involves RNs/EN and carers. There is a Handover Policy. The care plan is integrated to include a multi- disciplinary focus and DT input balances the clinical and ADL with spiritual, social, sexual and cultural needs. Resident files and multidisciplinary meetings evidence an integrated team approach. Input from allied health such as physiotherapist and dietician is evident in care planning. All staff are highly qualified in their roles and have completed on-going training around the specific needs of people with dementia. All staff are required to undertake training around 'Best Friends approach to Dementia Care'. A wound care folder is available. Wound care assessments/management plans and on-going review is completed by the registered nurses. Activity assessments and activities care plans were completed by the activity co-ordinator in all files reviewed. Nursing assessment and care plan is developed with the family and residents. All six files reviewed (three from the psychogeriatric unit, and three from dementia) all evidenced family input/ communication with family signatures evidenced on care plans and MDT meeting forms. Two registered nurses and one clinical manager interviewed stated that family are, where appropriate, involved from time of admission and continue to be involved when there is a review of the care plan.

Families interviewed (four from the psychogeriatric unit and two from dementia), confirmed their involvement on a regular basis and appreciated the close contact they have with staff. Resident files from the dementia home and psychogeriatric home were noted to contain in-depth notes regarding family meetings and family discussion. Initial assessment and the ADL care plan completed on resident admission with the 24 hour MDT care plan completed within three weeks. Care planning policy states that full care plan is to be completed within three weeks of admission. Diversional therapy care plan is documented.

Each resident has a 24 hour multi-disciplinary team (MDT) care plan. These care plans include a) visual signs of wellness, b) interventions/ de-escalations, c) signs of stress, d) morning habits, e) afternoon habits and f) night sleep pattern. The 24 hour MDT plans include input from RN, activities and allied health (such as Occupational Therapist, physiotherapist)

Care plan evaluations/ reviews of care are every six months for dementia and three months for psychogeriatric or earlier as needed. Residents with restraint have the entire long term care plan reviewed monthly (and this was evidenced in six restraint care plan reviewed- one dementia and five psychogeriatric). Meeting specific timeframes (as per contractual requirements) and resident specific needs are monitored and reviewed as being met and included in care planning through the annual resident admission audits, and twice yearly resident care audits.

Carer’s complete progress notes each shift as well as a care checklist.

D16.2, 3, 4; An assessment and initial care plan is completed within three weeks. The care plan is reviewed by the RN at least six monthly and amended when current health changes.

D16.5e; Resident files reviewed identified that the GP had seen the resident within two working days. The service has strong vision that is reflected in a team approach with a comprehensive mentoring programme that assists with support and values. There is a staff handover at the beginning and end of each shift, which involves RNs/EN and carers.’ handover policy'. The handovers are documented in the 'hand over log' and a daily report is provided to the facility manager.

D17.1 (b) Copies of registered nurses, GPs and other allied health providers practising certificates are copied and kept on file by the management team

Tracer Methodology Dementia:

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

Tracer Methodology Psychogeriatric:

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 1.3.6: 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:**

Admatha Dementia Care provides services for residents requiring dementia care and psychogeriatric care. The care plans are individualized, well written, in-depth and reflect the service philosophy of care and support. The four caregivers and two registered nurses interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment The service facilitates access to other services, medical and non-medical ,and where access occurs referral documentation is maintained. The staff and facilities are appropriate for providing these services and are meeting the needs of residents. Needs are assessed using pre admission documentation, doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at three monthly intervals for psychogeriatric residents and six monthly for dementia residents. Care plans are updated to reflect intervention changes following review or change in health status. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation. The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussion with caregivers, registered nurses, activity/Diversional Therapist staff and management. The passion of staff towards their value statement 'promoting the uniqueness of each person' is reflected in the holistic plan of care and interventions documented, training of staff around the special needs of residents with dementia.

All falls are reported on the resident accident/incident form and reported to the registered nurse and manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required.

A physiotherapist visits weekly and the GP visits twice a week. The GP commented that the care is very good and the nursing staff well informed.

Families interviewed (four from the psychogeriatric unit, and two from dementia) were supportive of the care provided and the needs of their family member being met. Families noted that staff would act on any request and made huge efforts to ensure that residents are well cared for, supported and happy.

Allied health input includes dietitian input, Physiotherapist and Mental Health Services Older People (MHSOP). The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained.

The service actively links with community groups such as Alzheimer’s. There is a Maintaining Links with Community policy. A community resource information audit is completed. The service has also had input from wound specialist, speech and language specialist and a gerontology nurse.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management in-service (July 2013 wound management in-service (July 2014), pressure area in-service (October 2013), training on mattresses available to maintain integrity of pressure areas (Sept 2013) have been provided.

Wound assessment and wound management plans are in place for six residents (one dementia and five psychogeriatric) with wounds. Wound care plans are well documented and include an assessment, evaluations and are managed within the documented time frame.

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

##### 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:**

Activities staff are supported by a trained diversional therapist and an organisational diversional therapy coordinator who provides over-sight and leadership to the recreation teams. The diversional therapist leader has been at the service for three and a half years. She also acts as the weekend manager. There are five activity staff (two diversional therapists, two trainee diversional therapists and one staff member who has just been employed and is completing ACE). The activity staff meet monthly to plan the activity calendar (minutes for July sighted). Diversional therapy staff are supported by monthly teleconferences with other diversional therapy staff. The programme reflects resident’s interest in the environment as appropriate to dementia care and they have choice in their level of participation. The activity staff complete individual assessments on resident admission, this is documented on the activities profile sheet, which is then used to develop the 24 hour activities care plan. This plan is reviewed regularly and attendance records are maintained. The diversional therapy plan is a key part of the overall long term care plan and the service is pro-active in providing a meaningful programme. The diversional therapy plan is reviewed three monthly for psychogeriatric residents and six monthly for dementia residents along with the long term care plan. Activity review is discussed at the six monthly multi-disciplinary meeting. The programme is regularly reviewed with family and is extensive across the day as observed on the day of the audit. Interview with three activities staff from both homes noted that they are committed to working with residents and families to provide 'magic moments'- a moment of engagement, for residents and all described how they had developed good connections with residents and got to know them.

Everyday life activities are included in the programme, such as baking, arts and crafts, reminiscence and folding laundry, exercises as well as expressive programmes such as sing-a-longs and entertainers. The programme currently includes focus on “busy hands” with displayed photos of what residents hands are busy with. The programme also has “theme” activities as suggested form the organisational team. The design of the homes ensures that a homely, family environment is in place to assist with normalising the service and provide activities in a calm environment. There are community visits such as shopping trips, walks in the park and van trips. Family are encouraged to join in the activities programme. Resident preferences, including spiritual and cultural preferences and capabilities are considered in the delivery of the service activities programme. Daily attendance records are kept and activity staff document in the residents progress notes at least weekly. Resident feedback is obtained through resident surveys, resident/family meetings, multi-disciplinary reviews and 1:1 sessions with the residents. Activity staff facilitate the residents meetings. All activity staff are trained in first aid.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review. A range of activities are available for residents to choose from, with staff spending a large proportion of their time with 1 on 1 interaction with the residents. Families report that they are involved and can join in activities. The monthly activities plan is posted throughout each home and in resident bedrooms. There is also a special celebrations calendar for 2014.

ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered, is included in the long term care plan. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least three monthly.

ARHSS 16.5g.iv: Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.

##### 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:**

Nursing care plans are reviewed regularly and care plans are evaluated three monthly in the psychogeriatric unit, six monthly in the dementia unit and monthly for any resident with restraint and more frequently when clinically indicated. Two dementia (one resident has been at the service less than six months) and three psychogeriatric files reviewed had care plan reviews completed. A multidisciplinary six monthly review is also completed. Short-term care plans are reviewed as required. There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes.

Care plans are evaluated three monthly in the psychogeriatric unit, six monthly in the dementia unit and monthly for any resident with restraint and more frequently when clinically indicated.

The Nursing Care Plans policy identifies that evaluations are the responsibility of the RN. Written evaluations have been completed as per care plan.

There is at least a three monthly review by the medical practitioner of the resident and their medications.

On-going nursing evaluations occur daily/as indicated and are included within the progress notes Residents' care plans sighted were well documented and individualised. The files demonstrate evaluation of changes in behaviours or health status with subsequent interventions documented. Care plans are evaluated. The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussions with staff, family and management. Short-term care needs are documented using short-term care plans and changes to the long-term care plan are completed. Short term care plans in use included infections (cellulitis, conjunctivitis, oral thrush, chest infections and urinary tract infections).

Short-term care plans are reviewed as required. There is a system in place to ensure staff and family are made aware of when each resident’s three/six monthly review is due.

##### 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 1.3.12: 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:**

The medication management system includes Medication Policy and Procedures that follows recognised standards and guidelines for safe medicine management practice.

The service uses a two weekly robotic system, these are checked on arrival from the pharmacy by two registered nurses.

Medication reconciliation is implemented via the 'Medication Management on Admission and Transfer policy'. The service maintains a medication information folder with information on common medications for staff.

Resident medications are reviewed 3 monthly by the resident’s general practitioner and this was sighted on six of six psychogeriatric medication charts and six of six dementia medication charts.

Controlled drugs are stored in a locked safe in a locked cupboard in the medication room in each home (the dementia home had one resident on controlled drugs on the day of audit). A Controlled Drug register is maintained and checked weekly in each unit.

Psychogeriatric home; six medication charts reviewed and the medication room.

The medication room has a fridge which has daily temperature recorded. There are weekly checks of the oxygen cylinder and medications are checked monthly.

There is one medication trolley and a medication storage area. Both are well kept with no issues noted. Medication chart and prescription charts are easy to read and correctly documented.

Dementia home six medication charts reviewed and the medication room.

The medication room has a fridge which has daily temperature recorded. There are weekly checks of the oxygen cylinder and medications are checked monthly.

There is one medication trolley and a medication storage area. Both are well kept with no issues noted. Medication chart and prescription charts are easy to read.

All PRNs have a documented reason for use by the general practitioner

There is evidence of on-going education and training of staff in relation to medicine management (26 & 27 May 2014). RNs are responsible administering medication in the psychogeriatric home and enrolled nurses or senior caregivers in the dementia home. Annual competencies are in place for both RNs, enrolled nurses (EN)s and caregivers who administer medications. The service has a system in place to ensure, residents’ medicine allergies/sensitivities are known and recorded. All signing charts have been appropriately completed. The previous audit identified signing gaps on the medication charts. This finding has now been addressed.

There is an area on front of resident files that documents sensitivities and allergies also on each medication chart. There is an area on each medication chart for special instructions, as well as a significant events form in each resident file. Medication errors are treated as an incident and captured as part of the incident management system. There are no residents within the service that self-medicate.

Two registered nurses were observed safely administrating medications in both homes. Six eye drops in use in the dementia unit and eight eye drops in use in the psychogeriatric unit all were dated on opening.

Twelve of 12 medication charts reviewed identified that the GP had seen and reviewed the resident 1-3 monthly and the medication chart was signed.

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

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

**Attainment and Risk:** 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 service has a central kitchen in the psychogeriatric home that serves directly to the dining room. Food is also provided to the Admatha Home (dementia unit) via hot box trolleys. There are two cooks and three kitchen hands/care staff that regularly work in the kitchen. All have completed food safety certificates.

Temperature checks are undertaken on food prior to serving, and for the main chiller and freezers. Daily dishwasher temperature are also taken and recorded.

There is a Kitchen Service Manual located in the kitchen which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures.

A dietitian the food services management consultant who reviews and advises on menus 12 monthly and more often if necessary. The menu was last reviewed 2013. The service also has access to a dietitian monthly for review of resident needs. A nutrition and dietetic assessment is undertaken on each resident on admission, a copy provided to the cook and updated as required by the RN’s.

Special diets are catered for example gluten free for two residents. The cook described fortifying meals with cream and yoghurt for those residents with weight loss. Ice cream is readily available and residents were observed having ice-cream at the movie afternoon. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed 3 - 6 monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the Kitchen. A Dietitian is consulted for the provision of special diets where required. A nutrition and dietetic record is maintained for residents. Monthly weights are completed and where there is an issue this is addressed through the care planning process. Care plans include clear instructions for nutrition needs across the 24 hours. A nutrition and dietetic assessment is undertaken on admission with input from a dietician that includes a nutrition care and treatment plan. A copy provided to the cook and updated as required by the RN’s and dietitian. Nutrition and hydration is identified as a component of the care plan and these were noted in three dementia and three psychogeriatric resident files. Admission food and nutrition information form is provided to the kitchen also. Likes and dislikes are documented.

Meals viewed in both homes noted that staff made efforts to provide meals that resident would eat.

E3.3f, there is evidence that there is additional nutritious snacks available over 24 hours. Special equipment is available as required such as lipped plates. Instructions are included in care plans. There is a food service manual that is kept in the kitchen. The main kitchen provides food to all the kitchenettes in each unit. Food is transported by hot box trolleys. Temperature checks are undertaken for the fridges and freezers. Food in the pantry is stored off the floor and food is covered and dated in the fridge. The cooks have undertaken food safety training. Kitchen service audits are undertaken regularly.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service displays a current building warrant of fitness for both buildings which expire on 1 June 2015 for the dementia home and 1 April 2015 for the psychogeriatric home.

##### 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.)*

# 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:**

There is a Restraint Minimisation and Safe Practice Policy and Procedure applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The Restraint Minimisation and Safe Practice Policy includes (but is not limited to) the following: a] definition and type of restraints, b) risk and education, c) approval group, d) consumer support and communication, e) dignity and privacy, f) cultural recognition, g) assessment, h) informed consent, i) monitoring, j) restraint assessment and approval, k) evaluation and review and, l) discontinuation of restraint. There are also policies for enablers, safe and appropriate use of restraint, and emergency restraint. There is one dementia resident with a thigh belt restraint. There are 10 psychogeriatric residents with 15 restraints (five residents have two restraints). Restraints used included nine thigh belts, one bedrail and five hand holding. There are no enablers in use. Restraint training is provided at orientation and is scheduled as part of the services annual training schedule. The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention and it reviews past assistance / interventions. The service reviews the entire care plan monthly if a resident has restraint and this was documented well in six (one dementia and five psychogeriatric) restraint files reviewed. These are undertaken by suitably qualified and skilled staff in partnership with the family. The restraint coordinator (clinical manager) is involved in the assessment process along with the family and GP. Care plans include a full description of the approved restraint intervention and monthly evaluation.

The care plans reviewed focused on promotion of quality of life. Enabler policy/procedure is established to guide staff in their use. There are no residents with enablers at present.

There is a managing disturbed behaviour policy. Restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence such as a lap belt in a wheelchair. There is also a policy for Enablers. The Restraint Minimisation and Safe Practice Policy and Procedure sets out the staff education requirements and these include (but are not limited to): a) restraint policies/practices, b) code of rights and advocacy services c) managing challenging behaviour, d) informed consent, and e) cultural safety.

Restraint training is provided at orientation and is scheduled as part of the services annual training schedule.

Restraint minimisation and safe practice training (March 2014). Non-violent crisis intervention training (de- escalation) 15,16 & 17 April 2014.

##### 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.)*

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

#### 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:**

The Surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. It includes risk factors and needs of the consumers and service providers. The Infection Control (IC) nurse (registered nurse) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. Systems in place are appropriate to the size and complexity of the facility. GPs are notified if there is any resistance to antimicrobial agents. The service benchmarks surveillance results with other organisation owned facilities and with New Zealand standards benchmarking. Effective monitoring is the responsibility of the infection control nurse. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. There is an IC register in which all infections are documented monthly. A monthly IC report is completed. Infection control data is collated monthly and reported to the infection control committee. The results are subsequently included in the operations manager’s report on quality indicators.

Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infection control programme describes the responsibilities and duties of the IC nurse in relation to routine monthly infection surveillance and reporting. Surveillance is described in full in the programme, responsibilities and assignments are described and documented including monitoring of infections, recording trends of infections, and monthly surveillance. There have been no outbreaks since December 2012 (norovirus outbreak). The IC nurse attends monthly infection control education at Christchurch Hospital. The registered nurses have attended a study day on infection control in 2013. Infection control competencies for staff are completed annually. Infection control and waste management in-service held April 2014.

##### 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.)*