# The Napier District Masonic Trust - Elmwood House and Hospital

## Current Status: 22 September 2014

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

## General overview

Elmwood House and Hospital provides residential care for up to 39 residents and occupancy on the first day of the audit was 37. The service provider is certified to provide rest home dementia level care and hospital level care. The facility is currently operated by Elmwood House Partnership.

This provisional audit was undertaken to establish the extent to which the existing provider conforms to the requirements of the Health and Disability Services Standards and the District Health Board (DHB) funding contract prior to a change in ownership. This audit also established how well prepared the prospective provider is to provide a health and disability service. A representative for the prospective provider, Napier District Masonic Trust, was interviewed prior to this audit. Residents and family members interviewed provided positive feedback on the care provided.

There were four areas identified during this audit that require improvement relating to the development and review of corrective action plans to address shortfalls identified in meeting minutes, the management of complaints, the management of medicines, and the currency of medication competency assessments.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | The Napier District Masonic Trust |
| **Certificate name:** | The Napier District Masonic Trust - Elmwood House and Hospital |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Provisional Audit | | | |
| **Premises audited:** | Elmwood House and Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 22 September 2014 | **End date:** | 23 September 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:** | 37 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 15 | Total audit hours | 39 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 2 | Number of staff interviewed | 10 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 20 | 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, Managing Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Friday, 26 September 2014

## **Executive Summary of Audit**

**General Overview**

Elmwood House and Hospital provided residential care for up to 39 residents and occupancy on the first day of the audit was 37. The service provider was certified to provide rest home dementia level care and hospital level care. The facility was currently operated by Elmwood House Partnership. This provisional audit was undertaken to establish the extent to which the existing provider conformed to the requirements of the Health and Disability Services Standards and the District Health Board (DHB) funding contract prior to a change in ownership. This audit also established how well prepared the prospective provider was to provide a health and disability service. A representative for the prospective provider, Napier District Masonic Trust (NDMT) was interviewed prior to this audit. Residents and family members interviewed provided positive feedback on the care provided.

There were three areas identified during this audit that required improvement relating to the development and review of corrective action plans to address shortfalls identified in meeting minutes, the management of complaints, the management of medicines, and the currency of medication competency assessments.

**Outcome 1.1: Consumer Rights**

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

During interview family members confirmed that consent forms were provided to them prior to their relative’s admission to ensure they had time for consultation and that they were fully informed. They also confirmed that time was provided if discussions and explanation was required.

One of the two facility managers/registered nurses who job share was responsible for the management of complaints and a complaints register was maintained. Residents and their family can use the complaints forms or they can raise complaints directly with the managers, the clinical nurse leader, the registered nurses, or with any member of staff. There was no documentation to evidence that complainants were satisfied with the outcome of their complaint and this requires improvement.

**Outcome 1.2: Organisational Management**

Elmwood House Partnership is the current governing body and is responsible for the service provided at Elmwood House and Hospital. Planning documents reviewed included a vision statement, values, quality objectives, quality indicators and quality projects. Systems were in place for monitoring the service provided at Elmwood House and Hospital including regular monthly reporting by the facility managers to the governing body. A business plan for the existing provider and a business plan and transition plan for the prospective provider were reviewed. The prospective provider’s representative advised there will be a review of all systems and processes currently in place at Elmwood House and Hospital following the change of ownership.

The facility is currently being co-managed by two suitably qualified and experienced facility managers who are registered nurses with aged care experience. The facility managers are supported by a clinical leader who is a registered nurse and who is responsible for oversight of clinical care provided in the hospital unit.

The Napier District Masonic Trust is proposing to purchase the facility and assume responsibility for the provision of services from 1 November 2014. The Napier District Masonic Trust has been involved in the aged care sector for the past 20 years. The general manager was interviewed and has been in this position for the last five years. An organisational structure for the prospective provider was reviewed and demonstrated the linkages between the Napier District Masonic Trust and Elmwood House.

There was an internal audit programme in place and there was evidence that corrective action plans were developed, implemented and monitored to address any areas identified as requiring improvement. However, there was no evidence in the quality/staff meetings minutes that other areas identified as requiring improvement have corrective action plans developed and implemented and this requires improvement. Adverse events were documented on accident/incident forms and summary sheets.

There were policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise was occurring. In-service education was provided for staff at least monthly and staff are supported to complete the New Zealand Qualifications Authority Unit Standards to obtain a Certificate in Residential Care. A review of staff records provided evidence that human resource processes was being followed, orientations were being completed and individual education records were maintained.

There was a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. The minimum number of staff was provided during the night shift and consists of one registered nurse and two care givers. The nurse managers were on call after hours. Care staff interviewed report there was adequate staff available and that they are able to get through their work.

Resident information was entered into a register in an accurate and timely manner. Residents' files were integrated and documentation was legible with the name and designation of the person making the entry identifiable.

**Outcome 1.3: Continuum of Service Delivery**

Entry into the service was facilitated in a competent, timely and respectful manner. When entry to the service was declined, immediate risks were identified and monitored. The initial care plan was utilised as a guide for all staff while the long term care plan was developed over the first three weeks. Care plans were individualised and risk assessments were completed. Resident’s response to treatment was evaluated and documented accordingly. Care plans were evaluated six monthly. Tracer methodology was carried out for the hospital and dementia unit.

Assessments were conducted in a timely manner and risk assessment findings were reflected in residents' long term care plans. Documentation and observations made of the provision of services and or interventions demonstrated that consultation and liaison was occurring with other services. Family were notified of changes in resident's condition.  
  
Residents' files sampled demonstrated the individual activity plans were current and demonstrated support was provided within the areas of leisure and recreation, health and well-being. Activities were appropriate to the age, needs and culture of the residents and supported their interests and strengths. The residents and families interviewed expressed satisfaction with the activities provided by the activities coordinator who was training to be a diversional therapist.   
  
Medicine management policies and procedures were documented and residents received medicines in a timely manner. Twenty medication charts were reviewed. There were no residents that self-administer medicines. Controlled drugs were kept in a secure, locked storage area and registered nurses completed weekly checks. The medicines fridge temperature was monitored weekly.   
  
There were two requirements for improvement relating to the general practitioners to consistently complete three monthly medicines reviews, the pharmacy to complete six monthly stock checks and all staff members who administer medicines to complete annual medicines management competencies.

The facility utilised four weekly rotating summer and winter menus and were reviewed by a dietitian. The most recent review was in September 2014.

**Outcome 1.4: Safe and Appropriate Environment**

All bedrooms provided single accommodation. Two bedrooms in the hospital unit had full ensuites and one bedroom in the dementia unit had a wash hand basin. There were also adequate toilet and shower facilities throughout the facility. Residents' rooms were large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. There was an internal court yard in the dementia unit and external areas were also available for sitting and shade is provided. Appropriate call bell systems were available and security systems were in place.

Review of documentation provided evidence there were appropriate systems in place to ensure the residents’ physical environment was safe and that the facilities were fit for their purpose.

There were policies and procedures for waste management, cleaning and laundry, and emergency management and these were known by staff. All laundry was washed on site and the cleaning and laundry systems included appropriate monitoring systems to evaluate the effectiveness of these services. Staff have received training to ensure safe and appropriate handling of waste and hazardous substances.

Visual inspection provided evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing was provided.

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

Restraint approval was obtained and the service maintained a process to ensure restraint use is safe. Restraints were implemented as a last resort to ensure the safety of the resident, verified restraint consents. Restraint responsibilities were clearly defined. The service had six residents using restraints three were bedrails and three were restraint briefs.

The service did not use enablers. Restraints were assessed, consent forms signed, restraints were recorded in the long term care plans, risks were clearly identified, monitoring timeframes documented and evaluations completed at three monthly intervals. The service maintained a restraint register which was up to date.

**Outcome 3: Infection Prevention and Control**

The infection control programme was reviewed annually for its continuing effectiveness and appropriateness for the facility. Staff education in infection prevention and control was conducted according to the in-service training and education programme.   
The type of surveillance undertaken was appropriate to the size and complexity of the organisation. Infections were investigated and appropriate antibiotics were prescribed. The surveillance data were collected monthly for benchmarking and appropriate interventions were in place to address the infections. There were adequate sanitary gels and hand washing facilities for staff, visitors and residents. There was evidence of staff members having completed infection control training as part of the service’ in-service training programme.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 47 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 1 | 3 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Documentation reviewed does not evidence that complainants are satisfied with the outcome of complaints made. | Provide documented evidence that Right 10 of the code is fully complied with. | 90 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Corrective action plans are not being developed following deficits identified in the quality/staff meeting minutes, and are not being documented in the subsequent meeting minutes. | Provide documented evidence that corrective action plans are developed and implemented for issues identified in meeting minutes, and that the actions are reviewed for effectiveness. | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | i)Two of the twenty reviewed medicines charts do not have timely (three monthly) reviews documented and ii) the pharmacist is not currently completing six monthly stock takes of controlled drugs. | i) All medicines charts to be reviewed at least three monthly and ii) controlled drugs stock to be reviewed by the pharmacist at six monthly intervals. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | The two nurse managers and some of the casual registered nurses have not completed annual medicines management competency testing. | All staff members who administer medicines to complete annual medicines management competency testing. | 30 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Staff receive training in the Code of Health and Disability Services Consumers’ Rights’ (the Code of Rights) at least annually and staff education records are sighted. Care staff are observed interacting respectfully and communicating appropriately with residents. Staff encourage residents to make choices demonstrating their knowledge of residents’ rights.

Residents (two hospital) and family members (three hospital and three dementia) are able to verify that services are provided with dignity and respect at all times, privacy is maintained, and individual needs and rights are upheld. These findings are also confirmed during review of the family / friend survey that was completed in June 2014.

Interviews with staff (nurse managers, clinical nurse leader, a registered nurse, four caregivers and the activities coordinator) demonstrate an understanding of resident rights. Education records reviewed indicate that staff attend training in resident rights as part of their orientation as well as part of the ongoing education programme. This education was last provided on three study days in 2013 and two study days in 2014.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.2: Consumer Rights During Service Delivery **(**HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

The general manager for the Napier District Masonic Trust is interviewed and reports they have been in this role since 2009. The general manager is experienced in aged care governance and management and has a thorough knowledge of the consumer rights they must adhere to.

The Code of Rights and information on the advocacy service are displayed and are available at the facility and in the pre-admission enquiry and information packs provided on admission to the facility.

Family members (six) interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to the resident’s admission. The pre-admission enquiry and admission packs are reviewed and contains, but is not limited to, information on the Code, advocacy and complaints processes. Family members interviewed confirm explanations regarding their and their relative’s rights occur on admission and at any time that they may have a query.

The families are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and seven admission agreements are reviewed as part of the review of resident’s files and all are found to contain this level of information.

Residents (two) and family members (six) interviewed confirm they have access to an advocate should one be needed. Family / friend satisfaction survey completed in June 2014 indicates residents and family are aware of their rights.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of family members and during review of family / friend satisfaction survey completed in June 2014.

Staff receive training on abuse / neglect and the last education session for staff was provided over several study days. Staff are observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff demonstrate an awareness of residents’ rights and the maintenance of professional boundaries.

Church services are held on site as part of the activities programme, and residents are taken on outings by their family.

Values, beliefs and cultural aspects of care are recorded in seven residents’ clinical files reviewed.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisation has a Māori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. The Māori Health Plan describes that the holistic view of Māori health is to be incorporated into the delivery of services (whanau, Hinengaro, Tinana and Wairau).

There are currently four residents in the facility that identify as Māori. A cultural assessment is completed as part of the activities/leisure profile and is included in the resident’s care plan. Sighted in the seven resident’s files reviewed.

Access to Māori support and advocacy services is available if required from the local District Health Board. Family are able to be involved in the care of their family members.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that residents who identify as Māori have access to appropriate services. Cultural safety education was last provided in March 2014. There are nine staff members who identify as Maori and all speak Te Reo to varying degrees.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation reviewed during this audit provides evidence that appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Documentation reviewed lists the details on how to access appropriate expertise - for example cultural specialists, and interpreters.

Residents' files reviewed demonstrate that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whanau contact details. All residents have a cultural profile completed as part of the activities assessment and this information is used to complete the cultural section in the resident’s care plan.

Residents and family interviews confirm their and their relative’s culture, values and beliefs are being respected, and their spiritual needs are met. These findings are supported during review of the family / friend satisfaction survey completed in June 2014. Church services are held on site as part of the activities programme and some residents go out to attend church services with the support of family and friends.

Care staff interviewed confirm a very good understanding of cultural safety in relation to care and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures, and house rules that include a code of conduct. These documents also address any conflict of interest issues including the accepting of gifts and personal transactions with residents and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which are reviewed on 10 staff files.

A review of the accident/incident reporting system, complaints register and interview of the managers indicates there have been no allegations made against staff alleging unacceptable behaviour.

Residents and family interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. Documentation reviewed provides evidence that policies and procedures are based on evidence-based rationales.

Education is provided by one of the nurse managers (NM) who is also the facilities nurse educator and ACE assessor. Specialist educators also form part of the in-service education programme and this is confirmed during review of education records and interview of the NM/RN educator, the clinical nurse leader (CNL) and registered nurse (RN) who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. The NM/RN educator, clinical leader and the registered nurse advise the District Health Board (DHB) specialist nurses provide education and support for the clinical staff as needed.

Staff interviewed confirm understanding of professional boundaries and practice.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families and are reviewed. Residents' files reviewed (three hospital and four dementia) provide evidence that communication with family members is being documented in residents' records. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, in family communication sheets, and in the individual resident's files.

Family interviewed confirm that staff communicate very well with them and confirm that they are aware of the staff that are responsible for their relatives care.

The NMs advise access to interpreter services is available if required via the District Health Board, staff members, the local community, family members and interpreter services if required. They also advise there are currently no residents who require interpreter services. There is one resident who is XXXXX and staff have learnt some basis words XXXXXX to enable them to communicate with this resident. Family of this resident act as interpreters as needed.

Family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Seven admission agreements are reviewed and this is clearly communicated in each agreement.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Systems are in place to ensure residents and their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The NM’s report informed consent is discussed and is recorded at the time the resident is admitted to the facility.

Family are provided with various consent forms on admission for completion as appropriate and are reviewed on seven resident’s files. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these are reviewed on resident’s files.

Staff interviewed (four care givers, one RN, clinical nurse leader and the two facility managers) demonstrate a good understanding of informed consent processes.

Family interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.

Residents' files reviewed demonstrate written and verbal discussions on informed consent have occurred and all residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the Code of Rights and was last provided over two session in 2014.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.11: Advocacy And Support **(**HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

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

**Attainment and Risk:** FA

**Evidence:**

There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these are reviewed.

Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they attended education on the Code of Right, advocacy, and complaint management as part of the in-service education programme. This was confirmed during review of staff education records.

Family interviewed confirm that advocacy support is available to them and their relative if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission. Visual inspection provides evidence the nationwide advocate details are displayed along with advocacy information brochures. An admission information pack is reviewed and provides evidence advocacy, complaints and Code of Rights information is included.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service and visitors are required to sign in and out via registers. The activities programme includes access to community groups.

Residents (two) and family members (six) interviewed confirm they or their relative can have access to visitors of their choice, and confirm they are supported to access services within the community. A mobility van is available to take residents on community visits. Some residents go out with family on a regular basis.

Residents' files reviewed demonstrate that activity plans identify support/interest groups. Progress notes and care plans reviewed include regular outings and appointments.

The District Health Board contract requirements are met.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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:** PA Low

**Evidence:**

One of the nurse managers is responsible for managing complaints and there are appropriate systems in place to manage the complaints processes including Right 10 of the Code. Family interviewed demonstrate an understanding and awareness of these processes. A complaints register is maintained that includes six complaints since the last audit. The complaints register is reviewed, and four complaints are reviewed. There is no documented evidence to show that complainants are satisfied with the outcome of the complaint they have made and this requires improvement (See criterion 1.1.13.1).

The NM advises there have been no complaint investigations by the District Health Board, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. There has been one complaint made to the Ministry of Health in August 2013 and was followed by an investigation by the Ministry of Health, HealthCERT, on the 6 August 2013. Documentation reviewed indicates the areas of concern have been addressed.

A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of quality/ staff meeting minutes and the manager’s monthly report provides evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirm this information is reported to them via their staff meetings.

The District Health Board contract requirements are not fully met.

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

**Evidence:**

The complaints policy includes Right 10 of the Code. Review of four complaints provides documented evidence that Right 10 of the Code is being followed in terms of complainants receiving a response to their complaint in a timely manner, including meeting with the complainant. However, documentation does not include evidence that complainants are satisfied with the outcome of their complaint.

**Finding:**

Documentation reviewed does not evidence that complainants are satisfied with the outcome of complaints made.

**Corrective Action:**

Provide documented evidence that Right 10 of the code is fully complied with.

**Timeframe (days):** 90 *(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:**

Elmwood House Partnership is the current service provider and governing body. The Napier District Masonic Trust (NDMT) is proposing to purchase the facility and assume responsibility for the provision of services from 1 November 2014. The general manager for the NDMT is interviewed, is an experienced manager, and has been in this role since 2009. The general manager completed a master’s degree in management from Massey University in 2003, and was the chief executive officer for the Halburg Trust from 2005 to this current position. The Napier District Masonic Trust Board is made up of 12 members, most of whom are retired business people. There is one trustee on the board who is responsible for the aged care arm of the NDMT. This person is a registered nurse with extensive experience in the aged care sector and is currently the quality and operations manager for another company who operates a number of aged care facilities.

'An Elmwood House Facility Business Plan 2014 - 2015' is reviewed and includes a philosophy, mission statement, values, goals, vision and objectives. The general manager for the prospective purchaser is interviewed and a 'Strategic Management Plan 2014-2015’, a ‘Governance Policy’ and a ‘Transition Plan’ is reviewed. An organisational structure for the prospective provider is reviewed and demonstrates linkages between the NDMT and the structure for Elmwood House and Hospital (EHH).

The general manager for NDMT reports they have advised the District Health Board (DHB) concerning transfer of the aged related residential care (ARC) contract to the prospective purchaser. The general manager advises documentation has been completed and a formal letter was sent to the DHB on the 8 September 2014.

The facility is currently being managed by two nurse managers who are suitably qualified and experienced registered nurses with aged care experience. One nurse manager works four days per week and the other nurse manager works two days per week with one of the days as the nurse educator for the facility. The two nurse managers have been co-managing since 2011, and interviews and observation evidences they are very clear on what their responsibilities are and report they work very well together.

The NMs are supported by a clinical nurse leader (CNL) who is a registered nurse and who is responsible for oversight of clinical care provided in the hospital unit.

The general manager for NDMT advises they are not proposing to change any of the key personnel and staffing levels. The general manager advises the organisational structure will be reviewed following the change of ownership and any necessary adjustments will be made as required.

Transition plans for the prospective provider (NDMT) and the existing provider are reviewed and includes a lists of tasks to be undertaken with responsibilities and timeframes identified. The GM for the perspective provider advises that after purchase, the existing policies and procedures and quality and risk management systems will be reviewed with systems the prospective provider is using in their other facility.

The Elmwood House Partnership documented scope, direction, goals and vision are reviewed along with a written quality and risk management plan/policy identifying quality goals, objectives, and scope of service delivery and includes statements about quality activities and review processes. Documented values, mission statement and philosophy are displayed at the main entrance. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

Systems are in place for monitoring the service provided at the facility including regular monthly reporting to the governing body. Reporting includes reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators and is sighted during this audit.

Elmwood House and Hospital is certified to provide rest home dementia level care and hospital level care and has contracts with the District Health Board (DHB) to provide ‘Aged Related Residential Care’ and ‘Long Term Support Chronic Care. On day one of this audit there are 13 residents assessed as requiring rest home dementia level care and 24 residents requiring hospital level care.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are appropriate systems in place to ensure the day-to-day operations of the service continues should the NMs or CNL be absent. The two nurse managers advise they fill in for each other. They are supported by the CNL. Both nurse managers are on call after hours. The NMs handover to each other on Mondays and Fridays. Review of their diaries confirms the handovers are comprehensive and a written handover is also completed each Friday by the NM on duty for care staff who are working on the weekends. An experienced registered nurse was appointed as the clinical nurse leader in April 2014 and is responsible for clinical services provided in the hospital unit.

The facility manager from the NDMT’s other facility nearby is interviewed during this audit and advises their new role as the quality and operations manager will include supporting the NMs at EHH.

Services provided meet the specific needs of the resident group within the facility. Job descriptions and interviews of the NMs and the CNL confirms their responsibility and authority for their roles.

The District health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The general manager for Napier District Masonic Trust (NDMT) advises following purchase of Elmwood House, policies, procedures and quality and risk management systems that are currently being used at Elmwood House will be reviewed with systems the prospective provider is using in their other facility.

The general manager for the NDMT advises that the facility manager for the NDMT’s other facility will be in a new role, that of operations and quality manager, and will be responsible for quality and risk systems at Elmwood House and the NDMT’s other facility. The facility manager for the NDMT’s other facility is interviewed during this audit and advises they are not an RN, and have a master’s degree in Quality systems. The facility manager for the sister facility states they expect their new role of operations and quality manager to start on the 1 November 2014.

There is an internal audit programme in place. Clinical indicators are documented, including graphs for medication, falls and restraint use.

Relevant standards and legislative requirements are identified and are included in the Elmwood House policies and procedures manuals. Policies and procedures reflect current accepted good practice. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff report copies of policies are available in the staff room and that they are advised of updated policies via the staff/quality meetings. Care staff also advise copies of updated policies are available for them to review in the staff room and evidence of this is sighted during this audit. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery

Internal audit schedules and completed audits for 2014 are reviewed during this audit. Any short falls have corrective actions developed and implemented. However, improvements are required as corrective action plans are not being developed to address shortfalls identified in the quality/staff meeting minutes (see criterion 1.2.3.8). The family / friend satisfaction survey was completed in June 2014 and results indicate that families are ‘satisfied’ or ‘very satisfied’ with the service provided. There is one area that family have provided comment on and there is good evidence of a corrective action plan documented to address this concern. The FMs report they have already identified this issue and are addressing it. (See link criterion 1.4.6).

Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. Review of the quality improvement data provides evidence the data is being collected, collated, evaluated and analysed to identify trends and corrective action developed apart from issues raised in meeting minutes. This data is being reported to staff and to the governing body. Quality / staff, health and safety / infection control and RN meetings are held monthly and minutes are reviewed. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff report during interviews that copies of meeting minutes and graphs of medication errors, falls and restraint use are available for them to review in the staff room. This is confirmed during visual observations during this audit.

A three monthly newsletter is reviewed that is sent out to families so that they are kept informed with what is happening at Elmswood House and Hospital. The NMs advise they find the newsletter more effective as there was poor attendance at the family meetings. Family interviewed confirm they find the newsletters informative and enjoy reading them.

The health and safety manual documents health and safety management systems. Risks are identified and there is a hazard register which is reviewed that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Meeting minutes are reviewed and provide evidence of discussion and reporting on accident/ incidents; hazards; health and safety objectives and maintenance.

Chemical safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed: all biomedical equipment has appropriate performance verified stickers in place.

The District Health Board contract requirements are not fully met.

##### **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:** PA Moderate

**Evidence:**

Correction action plans are being developed for deficits identified following audits, surveys and incidents/accidents. The NMs and CNL state deficits identified at the quality/staff meetings are discussed, however, review of the quality/staff meeting minutes evidences corrective actions are not being developed following deficits raised and there is no evidence in subsequent meeting minutes of the issues identified.

**Finding:**

Corrective action plans are not being developed following deficits identified in the quality/staff meeting minutes, and are not being documented in the subsequent meeting minutes.

**Corrective Action:**

Provide documented evidence that corrective action plans are developed and implemented for issues identified in meeting minutes, and that the actions are reviewed for effectiveness.

**Timeframe (days):** 60 *(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:**

The general manager for the NDMT, and facility managers advise during interview that they are not aware of any legislative compliance issues that could affect the service.

There is an adverse event reporting system in place. All accident/incidents are recorded on an ‘Incident/Accident Reporting Form’ and the managers collate this into an incident register. Individual resident accident summaries are sighted in resident’s files. Incidents recorded include but are not limited to incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse.

Documentation is reviewed relating to falls. Falls are analysed and trends are identified and benchmarked against the ‘Indicators for Safe Aged Care and Dementia Care for Consumers SNZ HB 8163: 2005’. Although sensor mats and low beds are used, pull string monitors have been purchased and residents who are experiencing frequent falls are now using these. The FMs state that these devices give out an alarm that alerts staff when a resident tries to get out of a chair unaided.

The GM for the NDMT advises that following purchase, the Elmwood House quality and risk management systems, including adverse event reporting, will be reviewed in line with quality and risk management systems the prospective provider is using in their other facility.

Seven resident files reviewed provide evidence that incident accident forms are completed as well as general observations being recorded in the progress notes for residents following falls.

Communication with families following adverse events, or any change in resident’s condition is evidenced in the residents’ files reviewed. Staff education on communication and documentation was held over several sessions in 2014 as part of core study days. During interviews staff demonstrate an awareness of the adverse event process.

Staff are made aware of their essential notification responsibilities through their job descriptions, policies and procedures and professional codes of conduct.

The District Health Board contract requirements are met

##### **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:**

One of the NMs is responsible for the in-service education programme provided at Elmwood House The NM advises that education inservice is provided at least monthly via three core education training days that are repeated once to make sure all staff receive training. The NM advises that all staff working in the dementia unit are required to complete the ACE dementia specific module first, then ACE core and advanced. The manager advises all staff have either completed the dementia specific module or are currently completing it. Staff files confirm this. The manager is the ACE assessor for Elmwood House. Education records are maintained and are reviewed for 2013 and 2014.

The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority and are reviewed on staff files (10) along with employment agreements, criminal vetting, completed orientations and competency assessments. Individual records of education are maintained for each staff member.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, dietitian, pharmacist, podiatrist and general practitioners (GPs) is occurring. An appraisal schedule is in place and current staff appraisals are sighted on staff files reviewed.

Four of four care givers interviewed, CNL and an RN confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The District Health Board contract requirements are met.

##### **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 general manager for the NDMT is interviewed and reports that they are not proposing to make any changes to the exiting roster and staffing levels. Review and interview of the nurse managers evidences the staffing rationale (‘Skill Mix Policy’) has been reviewed and updated and is based on 'SNZ:HB 8163:2005 Indicators for Safe Aged-care and Dementia-Care for Consumers'.

The rosters for the current service provider are reviewed and the minimum cover is provided on the night shift and consists of one RN and two caregivers (the RN and one caregiver in the hospital unit and one care giver in the dementis unit) plus the two nurse managers share the after-hours on call. Registered nurse cover is provided 24 hours per day, seven days per week. The CNL works Monday to Friday one week and Monday to Thursday the following week. One nurse manager works Tuesday to Friday and the other nurse manager works Mondays and Wednesdays as the nurse educator.

Care staff interviewed report that there is enough staff on duty and they are able to get through the work allocated to them. Residents and family interviewed report there is enough staff on duty to provide them or their relative with adequate care.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Resident information is entered in an accurate and timely manner into a register that is appropriate to the service and is in line with legislative requirements. Interview with the FMs confirms the resident details are entered into a hand copy on the day of admission.

Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. Resident files reviewed provide evidence that an entry into the resident’s clinical record is made on each shift and entries are clear, dated and signed.

A visual inspection of the facility provides evidence that residents' information is stored in staff areas and is held securely and is not on public display. Clinical notes are current and are accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifier.

Staff interviewed confirm they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

#### Standard 1.3.1: Entry To Services **(**HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

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

**Attainment and Risk:** FA

**Evidence:**

The service has policies and procedures for entry criteria, assessment and entry screening. The service’s philosophy is recorded and displayed at the facility, family confirm they are familiar with and receive this as part of the information pack on admission, sighted the admission pack.

The service provides information to referral sources and operates 24/7. The admission agreement defines scope of service and includes the contractual requirement, reviewed seven resident files. The seven residents files (three hospital and four in the dementia unit) sampled evidence signed and dated admission agreements. Access and entry processes are followed, confirmed at the two registered nurse (RN), the clinical nurse leader and caregiver interviews.   
Interviews with two of two residents and six of six family members confirm that staff members discuss care and treatment with residents.

The service has policies and procedures for entry criteria, assessment and entry screening. The service’s philosophy is recorded and displayed at the facility, family confirm they are familiar with and receive this as part of the information pack on admission, sighted the admission pack.   
The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The scope of the service provided by the service is identified and communicated to prospective residents and their families as part of the information pack they receive on admission. The service has a system in place for informing people who are declined to the service, confirmed during the RN, clinical nurse leader and the nurse manager interviews. The nurse manager states resident will be declined entry if not within the scope of the service or if there is no bed available at the time of the enquiry.   
  
Resident files reviewed (three on the hospital and four in the dementia unit) evidence current needs assessments. The risk assessments are reflected in the long term care plans, reviewed seven resident care plans.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Seven resident's files were sampled (three in the hospital and four in the dementia unit). The files evidence the stages of service provision developed by the staff. Services promote continuity of service delivery. Staff interviews confirm residents and/or family members are involved in all stages of service provision, sighted evidence of family signing the long term care plans. Care plans are developed by the clinical nurse leader and registered nurses (confirmed during interviews) and signed by family or the resident (sighted). Residents and family confirm they have input to their care plans.

Sampled files evidence nursing assessments meet appropriate timeframes and demonstrate team approach into reviews and evaluations. Family communication sheets are maintained, sighted in seven residents' files. The general practitioner signs a declaration that the residents are not able to make resuscitation decisions and resident files have general consents signed for treatment, information sharing, photo identification and outings. The District Health Board contract requirements are met.

Tracer Methodology in the hospital

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

Tracer Methodology in the dementia unit

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents' files reviewed evidence risk assessments including continence, balance, pain, falls, mobility, nutrition, and pressure area assessments. Assessments are conducted in a timely manner and risk assessment findings are recorded on residents' long term care plans, reviewed seven care plans. Initial care plans are completed on admission, signed by the RN and by the resident or family, confirmed at staff, resident and family interviews. The long term care plan is developed within three weeks of admission. Outcomes and goals are consistent with the lifestyle plans or short term care plans and the needs of the residents.

The service accesses information through interviews with family members, GP’s, specialists and other referrers. Residents' files sampled evidence discharge and or transfer information from hospitals or NASC assessors. The registered nurse interviews confirm that assessments are conducted in the resident’s bedrooms. Two of two residents and six of six family members interviewed confirm their involvement in assessments, care planning and review of care. Risk assessments are completed as part of the interRAI assessment process on admission and recorded in care plans, sighted risk assessments for all the resident files reviewed.   
  
Seven long term care plans reviewed are evaluated at six monthly intervals or when resident's condition alters, sighted.  
The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The long term care plans are accurate, reflecting the resident's current needs. Specific strategies for challenging behaviour are identified within the care plans, sighted records and confirmed at the RN and nurse manager interviews. Seven of seven resident files sampled evidence long term care plans are individualised and up-to-date. The goals are identified by the residents and or their family members and reviewed at six monthly intervals or when needs change. Family confirm they have input into their care planning and review.   
The seven of seven resident files sampled (three hospital and four in the dementia unit) evidence the clinical interventions, treatment, support and care provided by the staff is current, sighted in the interRAI risk assessments, progress notes, care plans and doctor’s notes. Risk assessments are reflected in the long term care plans. There is written evidence of risk assessments being discussed with and signed off by residents and or family members.  
  
The facility has access to several GPs who attend to residents. Interview with the general practitioner (GP) confirm being satisfied with the levels of care provided by the service. RN and caregiver interviews confirm that care plans are being used for guidance regarding the care of residents. Review of seven resident files (three hospital and four dementia unit residents) evidence of integrated records.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents receive adequate and appropriate services in order to meet their assessed and desired needs. Seven of seven resident files reviewed (three hospital and four in the dementia unit residents) evidence the long term care plans record interventions based on the assessed needs as identified through the InterRAI assessment process. GP records are not current as two of the twenty medicines charts reviewed were not signed after the three monthly reviews, however the service contacted the GP to have the charts signed in order to mitigate the risks (refer to 1.3.12.1).  
Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the service agreement. Interview with the GP, the clinical nurse leader, nurse manager and review of resident files evidence care plans record interventions based on assessed needs, desired outcomes / goals of the residents. The long term care plans include cultural needs, sexuality, spiritual needs and residents or relatives are signing off and demonstrating participation in the care planning process.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The facility has an activity coordinator who is responsible for the activities in the hospital and the dementia unit (working 7.5 hours per day, four days a week) while a part-time activities coordinator works one day a week for 7.5 hours.

Residents, family and staff interviews confirm the activities programme includes input from external agencies, supports ordinary and unplanned / spontaneous activities including festive occasions and celebrations.

Seven of seven residents' files sampled demonstrate the individual activities service plans are current and demonstrate support is provided. Residents' activities assessments are sighted in all seven residents' files sampled.

Interview with the main activities coordinator confirms the activities programme meets the needs of the service group and the service has appropriate equipment, sighted the activities programme. Residents participate in the programme where appropriate, sighted on audit days.

Family interviewed confirm resident’s past activities are considered and confirm their enjoyment of the activities they choose to participate in. Activities attendance records are maintained and are sighted.

The District Health Board contract requirements are met.

##### **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:**

Seven of seven resident files sampled (three hospital and four in the dementia unit) evidence evaluation of care plans are within required timeframes (six monthly) and reviewed when the residents’ condition change. The registered nurses or the clinical nurse leader conduct reviews with input from the resident (where possible) and their family members, confirmed during interview with two of two residents and five of five family members.

Family are notified of changes in resident's condition. The resident files reviewed show evidence of input from and referrals to other services such as specialists and older people mental health services. Multidisciplinary reviews are current, confirmed at the RN, nurse manager and GP interviews and during review of seven of seven (three hospital and four dementia unit) resident’s files.  
The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Review of seven of seven resident files (three hospital and four in the dementia unit) show documentation and records confirming referrals to other health and disability services. Resident files sampled evidence referral forms and letters to medical specialists, and the NASC assessment team and specialist services at the District Health Board. The service maintains effective family communication, confirmed during two of two residents, and six of six family interviews and supported by resident records such as the communication sheets and progress notes.  
The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Seven of seven resident files reviewed, evidence records confirming transition, exit, discharge or transfer plans are communicated to other health and disability service providers, when required. Transitions, exits, discharge and transfers are planned and coordinated by the RN’s or the clinical nurse leader or nurse manager, confirmed during interviews. Letters and plans for transitions, exits, discharge and transfers are located in residents' files, sighted.   
The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Visual inspection of the medication areas in the hospital and dementia unit evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Controlled drugs are stored securely in the hospital. The controlled drug register is maintained and evidences weekly checks on a Tuesday. Six monthly physical stock takes of controlled drugs by Pharmacist are not currently conducted. Residents' medicines charts list all medications a resident is taking (including name, dose, frequency and route to be given). There is evidence staff are signing off, as the dose is administered. Controlled drugs are stored in a secure, locked safe inside the medicines room. The medicines fridge temperatures are recorded at weekly intervals, sighted.

The lunch time medication round is observed during the days of audit in the dementia unit. The correct procedure for administration of medicines is followed. Twenty resident medicines charts are reviewed (10 in the hospital and 10 in the dementia unit). All entries and discontinued medicines are signed and dated by the GPs. Allergies and sensitivities are identified, all medicines charts have photo identification and three monthly medical reviews are conducted, however two of the twenty reviewed medicines charts do not have timely (three monthly) reviews documented. The service immediately acted to mitigate the risks by having the medicines records signed by the GP.

Random review of medicines expiry dates confirm medicines are within the timeframes of safe use. Medicines management training occurred within the previous 12 months and all staff responsible for medicines administration (14 registered nurses and eight caregivers) have annual competencies completed for 2014. The service has no residents who self -administer medicines. All RN and GP’s have annual registration with their regulatory body.

There are two requirements for improvement, relating to medicine reviews, stock take of controlled drugs and annual medicines management competency testing to be completed.  
The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Twenty resident medicines charts are reviewed (10 in the hospital and 10 in the dementia unit). All entries and discontinued medicines are signed and dated by the GPs. Allergies and sensitivities are identified, all medicines charts have photo identification and three monthly medical reviews are conducted, however i) are not current and ii) the pharmacist is not currently completing six monthly stock-takes on the controlled drugs.

**Finding:**

i)Two of the twenty reviewed medicines charts do not have timely (three monthly) reviews documented and ii) the pharmacist is not currently completing six monthly stock takes of controlled drugs.

**Corrective Action:**

i) All medicines charts to be reviewed at least three monthly and ii) controlled drugs stock to be reviewed by the pharmacist at six monthly intervals.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The eight caregivers who administer medicines have completed annual medicines management competencies however the nurse managers and some of the casual registered nurses have not completed medicines management competency testing.

**Finding:**

The two nurse managers and some of the casual registered nurses have not completed annual medicines management competency testing.

**Corrective Action:**

All staff members who administer medicines to complete annual medicines management competency testing.

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

##### **Criterion 1.3.12.5 (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:**

Food services policies and procedures are appropriate to the service setting. There is seasonal four weekly menu being introduced six monthly, confirmed at the cook interview. The menu is developed and was last reviewed by a dietitian in September 2014, sighted and confirmed at the nurse manager interview. Food services staff members have completed food safety training, confirmed during interview with the cook.

There are documented protocols for management of residents with unexplained weight loss or gain, including referral to a dietitian. Food intake and monitoring forms are sighted for residents' requiring to be monitored for identified weight loss. Kitchen staff members are informed when resident's dietary requirements change, confirmed at interview with kitchen staff and cook. Copies of dietary profiles are reviewed in the kitchen and in residents' files sampled. Additional snacks are available for residents when the kitchen is closed. Residents’ nutritional needs and interventions are identified and documented on the care plan. Residents and family members interviewed are satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided.

Food, fridge and freezer temperatures are recorded, sighted. The lunch time meal service was observed in the dementia unit and evidence food is prepared in the kitchen, delivered and served immediately. Staff assist resident with food intake.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and are accessible for staff. A hazard register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided via a number of sessions in 2014. This finding is confirmed during interviews of domestic staff and review of staff education records.

Twice weekly visits are made by the chemical supplier representative who reviews kitchen, cleaning and laundry processes and their reports are reviewed.

Sluice facilities are available in both units for the disposal of waste and hazardous substances. A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example, goggles, gloves, aprons and masks are viewed in the sluice rooms, laundry and cleaners’ room.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Two people are employed as maintenance people and one is interviewed during this audit. The maintenance people are also responsible for maintenance of the lawns and the gardens. During interview the maintenance person confirms there is a maintenance programme in place and maintenance documentation is reviewed. There is an external area with seating and shade as well as an internal area in the dementia unit.

Planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration / performance verified stickers on medical equipment and electrical testing and tagging labels. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 1 January 2015.

A visual inspection of the facility provides evidence of safe storage of medical equipment. Corridors are wider in the hospital unit than in the dementia unit, however, residents are able to pass each other safely in all areas; safety rails are secure and are appropriately located.

Staff report they receive education in the safe use of medical equipment by suitably qualified personnel. Care staff interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

Family interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Family interviewed confirm their relative is able to move freely around the facility and that the accommodation meets their relative’s needs.

The general manager for the NDMT advises there are no plans for environmental changes to the service.

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All bedrooms provide single accommodation and one bedroom in the dementia unit has a wash hand basin. Two of the bedrooms in the hospital unit have full ensuite facilities. There is an adequate number of toilet and shower facilities available throughout the facility.

Visual inspection provides evidence that toilet; shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).

Toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and wash basin facilities that meet specifications for people with disabilities that are large enough for manipulation of mobility aids and where practicable, provide working space for up to two care staff. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Visual inspection provides evidence that the bedrooms allow for access for mobility aids. The bedrooms are larger in the hospital unit then the dementia unit, however, all bedrooms allow residents and staff to move around within the room safely and adequate personal space is provided. Resident’s bedrooms are personalised to varying degrees.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

Visual inspection provides evidence that adequate access is provided to the lounges and dining rooms in both areas. Residents are observed moving freely within these areas. Family interviewed confirm there are alternate areas available to their relative if communal activities are being run in one of these areas and their relative does not want to participate in them.

The District Health Board contract requirement is met.

##### **Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)**

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Cleaning policy and procedures and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons.

All laundry is washed on site and there is a dirty / clean flow. Laundry personnel interviewed describe the management of laundry including transportation, sorting, storage, laundering, and return to residents.

Visual Inspection provides evidence that cleaning and laundry processes are implemented. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and twice weekly visits from the chemical company representative. Completed audits for the laundry and cleaning are reviewed and were last completed on 21 July 2014. Cleaning staff are interviewed and they describe the management of the cleaning processes including the use of personal protective equipment.

Visual inspection of the facility provides evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets are available; appropriate facilities exist for the disposal of soiled water/waste; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Two of six family interviewed report there are times when they find other resident’s clothes in their relative’s bedroom drawers. This finding is confirmed during review of four of the nineteen completed family/friend satisfaction surveys. The NMs at interview state they are aware of the problem, and that this is happening in the dementia unit with residents who wander into other resident’s rooms. The NMs state a corrective action plan has been developed, implemented, and is currently being monitored. Documentation reviewed confirms this.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification are sighted There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

A New Zealand Fire Service (NZFS) letter dated 9 November 2005 is sighted advising the fire evacuation scheme is approved. The last trial evacuation was held on the 25 March 2014. Fire and emergency education was last provided in via several sessions during 2014.

All registered nurses, the activities coordinator and some care givers have current first aid certificates. There is at least one designated staff member on each shift with appropriate first aid training.

Staff interviews and review of files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled provides evidence of current training regarding fire, emergency and security education.

A visual inspection of the facility provides evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.

A visual inspection of the facility provides evidence that emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones are available.

There is a call system in place that is used by the resident, family or staff members to summon assistance if required. Residents and family confirm they or their relative have a call bell system in place which is accessible and staff respond to it in a timely manner. Call bells are accessible / within reach and are available in resident areas.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

There are procedures to ensure the service is responsive to residents and family member’s feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection provides evidence that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Heating is ducted throughout the facility via the ceiling. Residents and family interviewed confirm the facilities are maintained at an appropriate temperature.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint approval is obtained and the service maintains a process to ensure restraint use is safe and implemented as last resort, sighted restraint consents and confirmed at the restraint coordinator, nurse manager and GP interviews. Restraint responsibilities are clearly defined. The service has six residents that currently use restraints. Restraints are in the form of bedrails and pelvic restraints called restraint-briefs.

Restraints are assessed, consent forms signed, restraints are recorded in the long term care plans, restraint risks are identified, monitoring timeframes are documented and restraint evaluations completed at three monthly intervals. The service maintains a restraint register which is up to date, sighted.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service maintains processes for approval of restraints. The responsibility for the restraint processes is recorded in the restraint coordinator’s job description. There are clear lines of accountability identified for the staff members that are involved in the restraint processes. The nurse managers are responsible for restraint. The last restraint and challenging behaviour training was held on 12 September 2013, 5 and 12 November 2013.

Restraint is discussed at the bi-monthly hospital meetings and monthly quality and staff meetings. Staff interviewed understand and are able to describe what restraint is and the process for this to be monitored.  
The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

General assessments and risk are completed via interRAI. Specific restraint assessment and restraint risk templates are available, and included in the restraint documentation, and are evident in the three residents whose files are reviewed for the use of restraints. Staff members confirm that restraint assessments and restraint risks are recorded sighted in the resident files.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

Restraints are in the form of a bedrail and pelvic restraints called restraint-briefs. The service is currently using six restraints in the hospital. Records show that the restraints are used as a last resort in order to assure the resident’s, other resident’s and the staff member’s safety. The service is following an appropriate process to ensure safe use of restraint. The general practitioner confirms being part of the restraint decision making process and has no concerns relating to the use of restraint in the facility. A restraint register is in place with records of current and historic restraints use. The service does not have enablers in use.  
The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

Restraints are being evaluated and reviewed in a timely manner; three of the six restraints in are reviewed for the purpose of this audit. All restraints reviewed evidence monitoring of restraint, with monitoring timeframes and restraint risks identified. Where restraint is on-going the time intervals between evaluations are determined by the nature of the restraint.   
The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service monitors and reviews all restraints. Restraint reviews include the extent of the restraint, strategies to reduce restraint, adverse outcomes, if the approved restraint is necessary, if the restraint is safe and appropriate and current accepted practice.

Evaluation of the restraints occur three-monthly. A monitoring form in the resident file includes documented checks. Restraint monitoring occurs hourly to two hourly while the restraint is in place. Monitoring documentation records when the restraint is removed and how long the restraint is in use.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Interviews with the registered nurses (RN’s) and caregivers confirm they are able to identify the infection control coordinator who is also one of the two nurse managers at the facility.  
Infection control meetings are held as part of the monthly quality and staff meetings and feedback is given to staff members at these meetings, sighted meeting minutes.   
The infection control coordinator (ICC) has a documented job description with responsibilities relating to the role. The responsibilities of the infection control coordinator include monitoring and surveillance of infections on a monthly basis, collating the information and including the data in the monthly report. The infection control program is maintained and updated annually. Alcohol hand sanitizer is available throughout the facility for use.   
The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control meetings are part of the quality and staff meetings and are held monthly, confirmed during interview of the infection control coordinator (ICC) who is also one of the two nurse managers. The infection control coordinator received IC training in June and September 2014. The service has posters and signs throughout the facility to remind residents, their families and staff members of the importance of hand washing and the prevention of infection.

The infection control programme was last reviewed in August 2013.  
The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures for the prevention and control of infection comply with relevant legislation and current accepted good practice. Documented policies and procedures for the prevention and control of infection are current.   
The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The organisation provides relevant education on infection control to service providers and the infection control coordinator last completed infection control training in June and September 2013, verified. Caregivers confirm receiving training relating to infection control and completing hand-washing competency testing. The most recent internal training relating to infection control occurred on 13 April 2014.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. Trends are analysed and discussed at monthly quality and staff meetings (minutes sighted for 2014).

A review of infections for each area shows infections are resolved quickly and the general practitioners are contacted in a timely manner when residents present with symptoms of infections.

All infections are recorded on the notification and progress report and then entered into the monthly infection control summary. The infection control coordinator completes monthly statistics for infection and expresses the information in the form of graphs. The facility participates in the National Standards’ benchmarking programme.

All staff members have access to meeting minutes and infection control data. Caregivers interviewed confirmed that they participate in monthly meetings and that infection is discussed.

##### **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.)*