

The Maples Lifecare (2005) Limited

Current Status: 1 September 2014

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

General overview

The Maples Lifecare is a privately owned rest home and serviced apartment complex in Christchurch. One owner is the manager and the other owner provides maintenance and financial management support. The owners report to a group of shareholders and have implemented a business plan and a quality plan for 2014. The owner/manager (registered nurse) is supported by a full time clinical charge nurse, registered and enrolled nurses and care staff.

The service provides rest home level care for up to 78 residents across a 53 bed rest home area and 25 serviced apartments. Staff turnover is reported as low. The quality and risk management programme is managed by the owner/manager and clinical charge nurse and involves the resident on admission to the service. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required around admission agreements and informed consent, education for staff, aspects of care planning including assessments and plans, aspects of medication management, and calibration of medical equipment.

Audit Summary as at 1 September 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 1 September 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 1 September 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 1 September 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 1 September 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Restraint Minimisation and Safe Practice as at 1 September 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 1 September 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 1 September 2014

Consumer Rights

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

Organisational Management

The Maples Lifecare has an organisational philosophy, which includes a vision, mission statement and strategic objectives.

The owners have owned the facility for the past nine years. The owner/manager is a registered nurse and is supported in her role by one other owner, a clinical charge nurse, registered nurses and care staff. The facility is guided by a comprehensive set of policies and procedures. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Orientation and induction for staff is completed. Improvement is required whereby all aspects of the education and training programmes are completed to ensure staff are competent to provide care. Staffing levels are safe and appropriate.

Continuum of Service Delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by either the clinical charge nurse or the registered nurse who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with

the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Improvements are required around initial nursing care plans and care plan interventions for residents identified needs. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required in relation to completing risk assessments for residents identified needs.

The medication management system includes policy and procedures that follows recognised standards. Improvements are required around medication documentation and safe administration. Staff responsible for medication administration receive training. Improvements are required whereby competency is conducted annually for registered nurses. Resident medications are reviewed by the residents' general practitioner at least three monthly. Self-medicating residents are appropriately supported to do so. Improvements are required around resident's self-medication competency reviews.

A range of activities are available in the rest home and residents provide feedback on the programme. Maples Lifecare has food policies and procedures for food services and menu planning appropriate for this type of service provided by an external contractor. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Kitchen staff complete food safety training.

Safe and Appropriate Environment

Maples Lifecare has a current building warrant of fitness that expires on 1 July 2015. Maintenance is carried out. Chemicals are stored in a locked storage area and in the locked laundry cupboard. Hot water temperatures are monitored and recorded. Improvements are required whereby medical equipment is calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There are lounge and dining areas, and small seating areas throughout the facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise.

There is a designated laundry which includes storage of cleaning and laundry chemicals. There are appropriate emergency and civil defence management plans and resources in place and staff are trained in first aid and fire evacuation. Procedures are in place to protect the safety of residents and visitors. Essential supplies are stored in the event of an emergency. A call bell system operates throughout the building. Communal living areas and resident rooms are appropriately heated and ventilated.

Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service is restraint free and there are no residents assessed as requiring enablers. There is a restraint register and an enabler's register. Restraint minimisation and challenging behaviour education has been provided.

Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and a registered nurse is the infection control coordinator. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The infection control coordinator has attended infection prevention education. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks reported in the past two years.

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 Maples Lifecare (2005) Limited
Certificate name:	The Maples Lifecare (2005) Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
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Types of audit:	Certification Audit
Premises audited:	Maples Lifecare
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 September 2014 End date: 2 September 2014

Proposed changes to current services (if any):	
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Total beds occupied across all premises included in the audit on the first day of the audit:	57
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Audit Team

Lead Auditor	XXXXXXXXX	Hours on site	12	Hours off site	5
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Other Auditors	XXXXXXXX	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	XXXXXXXX			Hours	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	11	Total audit hours	35
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Number of residents interviewed	9	Number of staff interviewed	13	Number of managers interviewed	2
Number of residents' records reviewed	8	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	16	Total number of staff (headcount)	35	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 20 October 2014

Executive Summary of Audit

General Overview

The Maples Lifecare is a privately owned rest home and serviced apartment complex in Christchurch. One owner is the manager and the other owner provides maintenance and financial management support. The owners report to a group of shareholders and have implemented a business plan and a quality plan for 2014. The owner/manager (registered nurse) is supported by a full time clinical charge nurse, registered and enrolled nurses and care staff. The service provides rest home level care for up to 78 residents across a 53 bed rest home area (one double room) and 25 serviced apartments. On the days of audit there were 47 residents in the rest home including two respite residents, and 10 rest home level residents in the serviced apartments. Staff turnover is reported as low. The quality and risk management programme is managed by the owner/manager and clinical charge nurse and involves the resident on admission to the service. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required around admission agreements and informed consent, education for staff, aspects of care planning including assessments and plans, aspects of medication management and calibration of medical equipment.

Outcome 1.1: Consumer Rights

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

Outcome 1.2: Organisational Management

The Maples Lifecare has an organisational philosophy, which includes a vision, mission statement and strategic objectives. The owners have owned the facility for the past nine years. The owner/manager is a registered nurse and is supported in her role by one other owner, a clinical charge nurse, registered nurses and care staff. The facility is guided by a comprehensive set of policies and procedures. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Orientation and induction for staff is completed. Improvement is required whereby all aspects of the education and training programmes are completed to ensure staff are competent to provide care. Staffing levels are safe and appropriate.

Outcome 1.3: Continuum of Service Delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by either the clinical charge nurse or the registered nurse who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Improvements are required around initial nursing care plans and care plan interventions for residents identified needs. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required in relation to completing risk assessments for residents identified needs. The medication management system includes policy and procedures that follows recognised standards. Improvements are required around medication documentation and safe administration. Staff responsible for medication administration receive training. Improvements are required whereby competency is conducted annually for registered nurses. Resident medications are reviewed by the residents' general practitioner at least three monthly. Self-medicating residents are appropriately supported to do so. Improvements are required around resident's self-medication competency reviews. A range of activities are available in the rest home and residents provide feedback on the programme. Maples Lifecare has food policies and procedures for food services and menu planning appropriate for this type of service provided by an external contractor. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Kitchen staff complete food safety training.

Outcome 1.4: Safe and Appropriate Environment

Maples Lifecare has a current building warrant of fitness that expires on 1 July 2015. Maintenance is carried out. Chemicals are stored in a locked storage area and in the locked laundry cupboard. Hot water temperatures are monitored and recorded. Improvements are required whereby medical equipment is calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There are lounge and dining areas, and small seating areas throughout the facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. There is a designated laundry which includes storage of cleaning and laundry chemicals. There are appropriate emergency and civil defence management plans and resources in place and staff are trained in first aid and fire evacuation. Procedures are in place to protect the safety of residents and visitors. Essential supplies are stored in the event of an emergency. A call bell system operates throughout the building. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service is restraint free and there are no residents assessed as requiring enablers. There is a restraint register and an enabler's register. Restraint minimisation and challenging behaviour education has been provided.

Outcome 3: Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and a registered nurse is the infection control coordinator. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The infection control coordinator has attended infection prevention education. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks reported in the past two years.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	38	0	5	2	0	0
Criteria	0	83	0	8	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	5
Criteria	0	0	0	0	0	0	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.2	Service providers demonstrate their ability to provide the	PA Low	Seven of eight files reviewed did not evidence that the admission agreements were signed on the	Ensure that admission agreements are signed on the day of	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.		day of admission (one resident is on respite care).	admission	
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Low	A review of eight files (including one respite) identified that documented informed consent was not obtained on the day of admission.	Ensure that resident informed consent is obtained and documented on the day of admission	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Wound care and pain management education sessions have not been provided in the past two years and attendance at the recent challenging behaviour management session was low (six staff attended). The service currently has a number of residents with challenging behaviours.	Provide wound care and pain management education session and provide evidence that all care staff receive the required education and training.	90
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes,	PA Low	(i) Two residents with identified	(i), (ii), (iii) and (iv)	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.		pain did not have documented evidence of completed pain assessments. (ii) Four residents with identified weight issues (three with weight loss and one recommended to lose weight) did not have documented evidence of completed nutrition assessments. (iii) Five residents with challenging behaviour did not have documented evidence of completed behaviour assessments. (iv) One resident with a wound did not have documented evidence of a completed wound assessment.	Ensure that risk assessments are completed for all resident's identified needs.	
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	1. Interventions were not documented in resident care plans for the following; (i) four residents with weight issues (three with weight loss and one who is recommended to lose weight), (ii) three residents with challenging behaviours, (iii) one resident receiving wound care from a wound care nurse, (iv) two residents who are married (no social or privacy interventions) and (v) one respite resident with no detailed interventions. 2. Updated interventions sighted in the resident care plans was not consistently evidenced as being dated or signed off by a	(i) Ensure that interventions are documented for all identified needs in the resident's long term care plan. (ii) Ensure that updates to resident care plans are signed and dated by a registered nurse.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				registered nurse.		
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	(i)Eight of the nine wound charts reviewed did not show documented evidence of the frequency of wound care required. (ii) Seven of nine wound charts assessments reviewed have not been fully completed (factors which could delay healing).	(i)and (ii) Ensure that all wound charts have documented evidence of frequency of dressing and that all wound assessment charts are fully completed.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	(i)The registered nurse was observed on the day of the audit administering controlled drugs for a respite resident without signing the medication out, and without checking the medication out with another staff member. (ii)The controlled drug register did not show evidence of weekly checks. (iii) One staff member (registered nurse) was observed signing for medications at lunch time before the resident had taken the medication. (iv)The signing sheet for the respite resident had no documented date of administration. (v) Eight of 16 medication charts had no	(i)Ensure that there are always two staff administering and signing for controlled drugs. (ii) Ensure that the controlled drugs are checked weekly and that this is documented in the controlled drug register. (iii) Ensure that medications administered are signed for following administration. (iv) Ensure that dates of administering medications are	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				route of administration documented for prn medications.	documented on the signing sheet. (v) Ensure that the route of medication is documented by the general practitioner.	
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 Low	Competencies for registered nurses were not evidenced as being completed.	Ensure that all staff with responsibilities around medication administration have annual competencies completed.	60
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	Two residents do not show documented evidence that the self-administration assessment competency has been reviewed three monthly.	Ensure that all residents have a competency assessment review three monthly.	60
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Medical/nursing equipment including blood pressure machine and thermometer has not been checked or calibrated.	Ensure all medical equipment is checked and calibrated by an authorised technician annually.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (four caregivers, one activities coordinator, one registered nurse, one owner/manager/owner) confirm their familiarity with the Code. Interviews with nine residents and three relatives confirm the services being provided are in line with the Code of rights.

Code of rights and advocacy training is provided during new staff orientation, as part of ACE care giver training, and as a regular in-service education and training. This was last provided as part of a staff meeting in May 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with nine residents and three relatives identify they are well-informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Two monthly resident/relative meetings (minutes sighted for June 2014) are held providing the opportunity to raise concerns in a group setting. The most recent annual satisfaction survey (May 2014) includes the question relating to privacy, dignity and rights with 100% of the respondents replying they are either satisfied or very satisfied. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.

Discussions with Nine residents and three relatives confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.

D3.1b, d, f, i: the service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

D14.4: there are clear written instructions provided to residents and family on entry regarding responsibilities of personal belongings. Personal belongings are documented and included in residents' files.

Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. All nine residents and three relatives confirm the service is respectful.

A resident satisfaction survey is carried out annually to gain feedback. Survey questions relating to privacy, respect, and satisfaction with care reflect residents and families are 100% satisfied or very satisfied.

D4.1a: Residents' files include their cultural and /or spiritual values when identified by the resident and/or family.

The information pack, provided to residents and their families, includes the home's philosophy of care. Discussions with nine residents confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Eight care plans reviewed identify specific individual likes and dislikes. The abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training on abuse and neglect is a mandatory requirement and last provided in May 2013.

Discussions with the owner/manager, clinical charge nurse and registered nurse report there have been no identified incidents of abuse or neglect.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a cultural safety policy. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.

There were no Maori residents living at the facility at the time of the audit, however there is one resident who identifies with Ngai Tahu. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori healthcare providers.

D20.1: The service utilises a local Maori representatives on an as-needed basis for consultation. These contacts are identified in policy.

Interviews with the clinical charge nurse, four caregivers and one registered nurse confirm they are aware of the need to respond appropriately to maintain cultural safety.

Policies include guidelines about the importance of whānau.

A3.2: There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Care planning includes consideration of spiritual, psychological and social needs. Nine residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Three relatives report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions.

D3.1g: The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the registered nurse.

D4.1c: Eight of eight care plans reviewed include the residents' social, spiritual, cultural and recreational needs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

The staff induction programme includes a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Interviews with four caregivers, one registered nurse, one clinical charge nurse and one owner/manager acknowledge their understanding of professional boundaries.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. Resident satisfaction surveys reflect high levels of satisfaction with the services that are received. The owner/manager and clinical charge nurse are in charge of the internal audit and in-service education programmes. There is access to computer and Internet resources. There are monthly staff meetings and two monthly resident meetings.

Nine residents and three relatives interviewed spoke very positively about the care and support provided. Four caregivers, one registered nurse, one activities coordinator,

one clinical charge nurse and the owner/manager have a sound understanding of principles of aged care.

A2.2: Services are provided at The Maples Lifecare that adheres to the Health & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring.

D1.3: All approved service standards are adhered to.

D17.7c: There are implemented competencies for caregivers and registered nurses (medication competencies require completion link #1.3.12.3). There are clear ethical and professional standards and boundaries within job descriptions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies are in place relating to open disclosure. Nine residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.

A sample of incident reports reviewed, and associated resident files, evidence recording of family notification. Three relatives interviewed confirm they are notified of any changes in their family member's health status. The owner/manager and registered nurses can identify the processes that are in place to support family being kept informed.

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

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

The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.

D11.3 The information pack is available in large print and is read to sight-impaired residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Maples Lifecare has policies and procedures relating to informed consent and advanced directives. Informed consent (permissions granted) is part of the admission process and agreement giving consent for but not limited to; providing/collecting health information, providing names of family members, displaying the residents name on the resident directory board and the resident's bedroom door and the use of residents photographs. A review of eight files (including one respite) identified that documented informed consent was not obtained on the day of admission. This is an area requiring improvement.

There is a resuscitation form and process. Seven of eight files reviewed had completed resuscitation documentation (one resident is on respite care).

There were admission agreements sighted which were signed by the resident or nominated representative however seven of eight files reviewed did not evidence that the admission agreements were signed on the day of admission (one resident is on respite care). This is an area requiring improvement. Discussion with three family identified that the service actively involves them in decisions that affect their relatives' lives.

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

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

Attainment and Risk: PA Low

Evidence:

There were admission agreements sighted which were signed by the resident or nominated representative.

Finding:

Seven of eight files reviewed did not evidence that the admission agreements were signed on the day of admission (one resident is on respite care).

Corrective Action:

Ensure that admission agreements are signed on the day of admission

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

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

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

Attainment and Risk: PA Low

Evidence:

Maples Lifecare has policies and procedures relating to informed consent and advanced directives. Informed consent (permissions granted) is part of the admission process and agreement giving consent for but not limited to; providing/collecting health information, providing names of family members, displaying the residents name on the resident directory board and the resident's bedroom door and the use of residents photographs.

Finding:

A review of eight files (including one respite) identified that documented informed consent was not obtained on the day of admission.

Corrective Action:

Ensure that resident informed consent is obtained and documented on the day of admission

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception.

Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items.

D4.1e; The residents' files include information on residents family/whānau and chosen social networks.

Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.

D4.1d; Discussions with three relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The client information pack informs visiting can occur at any reasonable time. Interviews with nine residents and three relatives confirm that visiting can occur at any time.

Family members and friends were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans.

D3.1.e: Discussions with nine residents and three relatives verify that they are supported and encouraged to remain involved in the community. The Maples Lifecare support

on-going access to community services (e.g. church, and family outings). Entertainers are invited to perform at the facility.
D3.1h: Discussions with three families verify that they are encouraged to be involved with the service and care.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Interviews with nine residents and three relatives are familiar with the complaints procedure and state any concerns or complaints are addressed. The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been two complaints lodged for 2014 and one in 2013. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint. Complaints are discussed at quality management meetings and staff meetings. D13.3h. A complaints procedure is provided to residents within the information pack at entry.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

The Maples Lifecare provides rest home level care for up to 78 residents within a 53 bed rest home area and 25 serviced apartments. There are 57 residents on the days of audit - 47 residents in the rest home area, and 10 rest home residents in the serviced apartments. There are currently two respite residents in the rest home. The facility is owned and operated by a husband and wife team. One owner provides property management, marketing and sales and health and safety oversight. The other owner is responsible for the management of Maples Lifecare and is a registered nurse. The manager is supported by a full time registered nurse (clinical charge nurse), two other registered nurses and care staff. Maples rest home has a quality and risk management programme in place. There is a business plan 2014 that includes a mission statement and operational objectives. A quality plan 2014 is implemented to meet the nine objectives. An annual review of the quality programme is conducted by the owner/manager and registered nursing staff. Objectives are reviewed by the quality and risk committee at the four monthly meetings. There is a risk management schedule and documented quality objectives that align with the identified values and philosophy. The philosophy of care includes 'care without compromise' and endeavouring to create and maintain a high level of service and care for the residents. Residents have a right to live in a clean, safe environment where individual freedom of choice is respected and privacy and security are maintained.

ARC,D17.3di (rest home), the owner/manager has maintained at least either hours annually of professional development activities related to managing a rest home including attending aged care and RVA conference, and local provider meetings. The manager is a registered nurse and has completed a post graduate diploma in health management.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In the manager's absence (owners absence), the clinical charge nurse is in charge. The owner/manager is responsible for the day to day functions of the organisation, including oversight of the quality and risk management programme with support from the other owner and the clinical charge nurse. Formal quality management meetings are

held three monthly between the owner/manager, clinical charge nurse, and senior staff. Daily management meetings are held between the manager, clinical charge nurse, RN and EN with discussion around occupancy, resident issues, and staffing.
D19.1a; A review of the documentation, policies and procedures and from discussions with staff, identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The quality and risk management system is understood and implemented by the owner/manager, owner, clinical charge nurse and staff.

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

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

Key components of service delivery are linked to the quality and risk management programmes. The service has a business plan and current quality and risk management plan for 2014. The business plan includes goals relating to financial management through high occupancy, stabilise and improve capability of the work force, implement the risk management plan and implement the quality plan. The quality plan includes a focus on training, infection prevention, health and safety, internal audits, surveys of residents and relatives, and accident and incident monitoring. There is an internal audit schedule. Audits include a summary, any issues arising and corrective actions when required. These are followed through in monthly quality and risk meetings and monthly staff meetings. The quality and risk meetings incorporate management, quality

improvement, infection control, health and safety and restraint. Full staff meetings are held monthly. Resident satisfaction is obtained through two monthly resident meetings, annual resident relative survey (May 2014), complaints, compliments and suggestions.

Quality indicators are documented for human resource management, health and safety, accidents/incidents, infection control, hospital admissions, and antibiotic prescribing. The service makes comparisons month by month and year by year to track progress at meeting the key performance indicators. The internal audit programme regularly assesses service performance. The resident/relative survey conducted in May 2014 attracted 36 respondents. Comments were overall very positive with residents and families stating they were very satisfied with the provision of care and services. Survey outcomes were communicated to residents via the June 2014 newsletter. Discussions with individual residents also occurred to address any issues that were identified via the survey process. Residents/families were surveyed around likes and dislikes being met, consultation/communication, response to concerns, clothes and laundry, dressing, quality of meals, hygiene/cleanliness, informed re medical care, respect/courtesy, activities, and grounds/facility. Management meetings are held daily. Quality and risk management meetings are held three times per year and general staff meetings are held monthly (minutes sighted for 13 August 2014) with standing agenda items including incident and accident reporting, infection control, complaints and compliments, restraint, health and safety, internal audits and in-service education. Resident and family meetings are held two monthly – minutes sighted for 24 June 2014. Discussion is held at residents meetings around food, activities, concerns or complaints, personal cares, and laundry with minutes posted on the resident notice board.

The internal audit programme involves monitoring areas of quality and risk including care planning, informed consent, admissions, infection control, laundry and cleaning, restraint, continence, wound care, medications, complaints, training, personal privacy/safety, and environment and equipment. A process to measure achievement against the quality and risk management plan is in place with annual review conducted in January 2014. The owner/manager and clinical charge nurse is responsible for ensuring all internal audits are completed. Tasks are delegated to the registered nurse and to staff where appropriate. On review of the completed audits for 2013 and 2014 year-to-date, it is noted that the actual audits are being completed as per the audit schedule.

Data that is collected is analysed, evaluated and communicated to staff. Corrective actions are put into place where opportunities for improvements are identified. Results of the internal audits are discussed in the monthly staff meetings, daily management meetings and four monthly quality and risk management meetings.

The owner/manager oversees all quality initiatives with support from the other owner.

Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register. The register is updated as new hazards are identified. Risks and hazards are monitored through the internal audit programme (sighted).

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

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

D19.2g: Falls prevention strategies include sensor mats and closely observing residents who are at risk of falling, use of mobility aids, correct footwear and exercise and walking groups.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D19.3b; There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

Adverse events (including but not limited to: falls, skin tears, bruising, challenging behaviours, medication errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by a registered nurse. Data is collected and collated on a monthly basis. Results are communicated to staff at the staff meetings (meeting minutes sighted).

Incident reports are collated monthly and trends identified. Incidents for July included 10 falls, two skin tears and four medication errors. A sample of incident report forms were reviewed for July 2014 relating to five residents. Incident reports reviewed included falls (five), skin tear (one), and challenging behaviours (four) and one medication error. Staff advised that they contact family following an incident or accident and this is evident in incident forms or progress notes reviewed. Adverse events include an investigation. Follow up is conducted by the registered nurse and GP is notified if required. The clinical charge nurse investigates all events with further follow up by the owner/manager. Short term care plans are utilised if required. The adverse events form documents the follow-up actions taken. Monthly incident/accident analysis is conducted and results discussed at staff meetings. Annual collation and analysis of reports is conducted.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There are 35 staff employed by The Maples Lifecare which includes a clinical charge nurse, two registered nurses, one enrolled nurse, caregivers, housekeeping and activities staff. Kitchen staff are employed by the contracted food service company. Annual practising certificates, including scope of practice, are validated with copies of certificates held. Current practising certificates were sighted for the registered nurses, general practitioners and the physiotherapist.

Six staff files were randomly selected for review (one clinical charge nurse, one registered nurse, one enrolled nurse, and three caregivers, one housekeeper/caregiver and two caregivers). Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, evidence of a completed orientation programme including evidence of competency. All staff have a current first aid certificate. Staff undergo initial and annual performance appraisals, evident in five of five staff files. One staff member file reviewed commenced employment in the past three months.

The Maples Lifecare has an orientation programme that is specific to worker type. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently (evidenced in the completed orientation checklists for one recently employed caregiver and one registered nurse). Interviews with four caregivers confirm their orientation to the service was thorough. All six staff files reviewed reflected evidence of an orientation programme that had been completed.

Discussion with the registered nurse and caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and year to date for 2014 with a plan in place for the remainder of 2014. The annual training programme exceeds eight hours annually.

Caregivers have completed either the national certificate in care of the elderly or are working towards completion. One registered nurse is a certified trainer and assessor for the ACE programme which all caregivers have either completed or are in the process of completing.

A system is in place to identify, plan, facilitate and record on-going education for staff. All staff are required to attend training for the following: fire safety and evacuation, infection control, restraint minimisation, first aid, manual handling and topics relating to the code of rights including privacy, informed consent, the complaints process and open disclosure. Education is provided either as face to face sessions, self-directed reading and learning or attendance at off-site sessions. The registered nurses have

attended interRAI training. Attendance rates are recorded and evidence good levels of attendance by staff with the exception of challenging behaviour management session provided in May 2014. Improvements are required whereby wound care, and pain management education is provided and attendance rates at challenging behaviour training is improved.

Caregiver competencies available include medication administration knowledge and observed practice, insulin, and controlled drug administration. A tracking process is in place to ensure those who administer medications complete their annual medication competencies. Improvements are required whereby all registered nurses also complete annual medication competencies (link finding #1.3.12.3).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Discussion with the registered nurse and caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and year to date for 2014 with a plan in place for the remainder of 2014. The annual training programme exceeds eight hours annually.

Caregivers have completed either the national certificate in care of the elderly or are working towards completion. One registered nurse is a certified trainer and assessor for the ACE programme which all care givers have either completed or are in the process of completing.

A system is in place to identify, plan, facilitate and record on-going education for staff. All staff are required to attend training for the following: fire safety and evacuation, infection control, restraint minimisation, first aid, manual handling and topics relating to the code of rights including privacy, informed consent, the complaints process and open disclosure. Education is provided either as face to face sessions, self-directed reading and learning or attendance at off-site sessions. The registered nurses have attended interRAI training. Attendance rates are recorded and evidence good levels of attendance by staff with the exception of challenging behaviour management session provided in May 2014. Improvements are required whereby wound care, and pain management education is provided and attendance rates at challenging behaviour training is improved.

Finding:

Wound care and pain management education sessions have not been provided in the past two years and attendance at the recent challenging behaviour management session was low (six staff attended). The service currently has a number of residents with challenging behaviours.

Corrective Action:

Provide wound care and pain management education session and provide evidence that all care staff receive the required education and training.

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

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

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

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:

A human resource manual and associated policies are in place which includes staffing levels and skills mix. Staffing rosters were sighted. Part time and casual staff fill casual shifts and no agency staff are available. The owner/manager works fulltime. The clinical charge nurse works full time. Registered nurses (three) share the after hour's on-call. The owner/manager and other owner are available after hours for clinical and non-clinical service issues. There is further support from general practitioners, and St Johns ambulance service if required. Care staff interviewed advised that they are well supported by owners and the registered nurses. Roster includes one registered nurse, one enrolled nurse and three caregivers on the morning shift in the rest home, and three caregivers on the morning shift in the serviced apartment area. On afternoons there are three caregivers in the rest home and one in the serviced apartment area, and overnight there are three caregivers for rest home and serviced apartment residents. Activities are provided from 9am until 5pm Monday to Friday by either a diversional therapist or an activities coordinator. Both staff work together on Tuesday, Wednesday and Thursday. Housekeeping and laundry staff are employed seven days per week. Staff turnover is reported by the owner/manager as low. Staffing levels are altered according to resident numbers and acuity. One general practitioner was interviewed who confirms that staffing is appropriate to meet the needs of residents. Nine residents and three relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurse's station. Informed consent to display photographs is obtained from residents/family/whanau on admission (with exceptions link #1.1.10.4). Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

D7.1 entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.

Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the code of consumer rights, complaints information, advocacy, and admission agreement. Three family members and nine residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements were not evidence as signed on the day of admission in the files sampled (# link 1.1.10.2). The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission agreement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy and process that describe resident's admission and assessment procedures. Either the clinical charge nurse or the registered nurse undertakes the assessments on admission. An initial nursing assessment and care plan is commenced on admission which is then continued and added to,

to form the long term care plan. It is not clear in the resident files sampled if the initial nursing care plan is completed within 48 hours of admission (# link 1.3.5.2). The long term care plan is developed within three weeks of admission. In all resident files sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Six monthly reviews are conducted or earlier if resident health changes are completed by the registered nurse with input from the care staff, the activities coordinator and any other relevant person. Activities assessments and care plans are developed by the activities coordinator. Handover occurs at the end of each duty that maintains a continuity of service delivery. There is a communication book which staff read that includes reviewed policies. The clinical charge nurse and registered nurses (two) share on-call and after hours and weekends cover.

Medical assessments are completed within two working days of admission by the general practitioner (GP) as evidenced in the medical notes of seven of eight resident files sampled (one resident is on respite care). It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. The GP interviewed stated that the service contacted him in a timely fashion, providing him with information required to assess his residents. The service always carried out any observations and interventions he prescribed.

There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment (# link 1.3.4.2). The clinical charge nurse and the two registered nurses have been trained in InterRAI and will be starting to introduce the assessment tool at the service. Long term care plans reviewed for seven of eight residents' evidence six monthly reviews of goals and interventions (# link 1.3.5.2). All eight files identified integration of allied health including physiotherapy and podiatry.

Tracer Methodology:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

An initial nursing assessment is commenced within 24 hours of admission. The initial assessment includes: communication, mobilisation, nutrition, elimination, skin integrity, personal hygiene, respiratory, sleeping, pain, safety/risks, mental and intellectual status and physiotherapy. Personal needs outcomes and goals of residents are identified.

There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment. Improvements are required whereby all resident risks and care issues are assessed including pain, nutrition and challenging behaviours. Assessments are conducted in an appropriate and private manner. All nine residents interviewed are satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Nine resident interviews and three family members stated they were informed and involved in the assessment process. The assessment tools link to the individual care plans. The care plans are individualised for each resident need such as (but not limited to), mobility aids, food preferences, continence products, skin treatments, personal cares, sleeping times, activities and range of movement, strength and balance. Each aspect of the care plan includes goals, interventions (# link 1.3.5.2) and assistance required and evaluations. The general practitioner completes a medical admission with two working days. Families and residents interviewed confirmed their involvement.

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

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

Attainment and Risk: PA Low

Evidence:

An initial nursing assessment is commenced within 24 hours of admission. The initial assessment includes: communication, mobilisation, nutrition, elimination, skin integrity, personal hygiene, respiratory, sleeping, pain, safety/risks, mental and intellectual status and physiotherapy. Personal needs outcomes and goals of residents are identified. There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment.

Finding:

(i) Two residents with identified pain did not have documented evidence of completed pain assessments. (ii) Four residents with identified weight issues (three with weight loss and one recommended to lose weight) did not have documented evidence of completed nutrition assessments. (iii) Five residents with challenging behaviour did not have documented evidence of completed behaviour assessments. (iv) One resident with a wound did not have documented evidence of a completed wound assessment.

Corrective Action:

(i), (ii), (iii) and (iv) Ensure that risk assessments are completed for all resident's identified needs.

Timeframe (days): 90 (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: PA Moderate

Evidence:

Residents' files include; resident information and family contact sheet, initial nursing assessment, daily progress notes, observations chart, short term care plans, resident comprehensive long term care plans, risk assessments, GP medical notes, lab results, allied health reports, activities, consents (# link 1.1.10.4), advance directives, letters,

discharge summaries, admission agreements (# link 1.1.10.2) and NASC assessments.

The initial care plan is developed from the initial assessment (as advised by the clinical charge nurse) however, it is unclear when the initial care plan is developed as the care plan commenced on admission is then continued to form the long term care plan. This is an area requiring improvement. Resident comprehensive long term care plans are individually developed with the resident and family/whānau who sign to acknowledge their approval of the care plan. Nine residents and three family members interviewed stated they are involved in the care planning process. Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to): night cares, mobilising, food and fluids, continence, activities of daily living, socialisation, safety/risks, cultural beliefs, pain, skin integrity, medical conditions and communication. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. However, documented interventions for all identified care issues were not evidenced in all residents care plans reviewed. Improvement is required in this area.

There is evidence that residents are seen by the GP at least three monthly.

The GP signs a form stating the resident is stable and for three monthly visits. Notes are well maintained.

Short term care plans are in use for changes in health status and the clinical charge nurse keeps a documented record of when short term care plans are commenced and when they are signed off. Examples sighted are cares required for wounds, infections (upper respiratory and throat) and return from acute care. Eight resident files reviewed identified that family were involved.

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

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

Attainment and Risk: PA Moderate

Evidence:

Resident comprehensive long term care plans are individually developed with the resident and family/whānau who sign to acknowledge their approval of the care plan. Nine residents and three family members interviewed stated they are involved in the care planning process. Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to):): night cares, mobilising, food and fluids, continence, activities of daily living, socialisation, safety/risks, cultural beliefs, pain, skin integrity, medical conditions and communication. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.

Finding:

1. Interventions were not documented in resident care plans for the following; (i) four residents with weight issues (three with weight loss and one who is recommended to lose weight), (ii) three residents with challenging behaviours, (iii) one resident receiving wound care from a wound care nurse, (iv) two residents who are married (no social or privacy interventions) and (v) one respite resident with no detailed interventions. 2. Updated interventions sighted in the resident care plans was not consistently evidenced as being dated or signed off by a registered nurse.

Corrective Action:

(i) Ensure that interventions are documented for all identified needs in the resident's long term care plan. (ii) Ensure that updates to resident care plans are signed and dated by a registered nurse.

Timeframe (days): 60 (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: PA Low

Evidence:

Maples Lifecare provides services for residents requiring rest home level of care. Individualised care plans are completed. The four caregivers, one registered nurse, one enrolled nurse and one clinical charge nurse interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment.

Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.

There is currently nine wounds (eight residents) being treated and no pressure injuries. Wound assessment and management plans are completed for the nine wounds and there is evidence of referral to wound and vascular specialists. However eight of the nine wound charts reviewed did not show documented evidence of the frequency of wound care required. Seven of nine wound charts assessments reviewed have not been fully completed (factors which could delay healing). These are areas requiring improvement. One resident file sampled evidenced (as sighted in the progress notes) a right big toe with discharge and a dressing applied. No wound chart assessment was evidence as being completed for this wound (# link 1.3.4.2). Wound care education has not been provided at the service within the last two years (# link 1.2.7.5).

Nine residents and three family members interviewed confirm their current care and treatments they and their family members are receiving meet their needs.

Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed. Continence education has been provided in July 2014.

All falls are reported on the resident accident/incident form and reported to the registered nurse and manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. The service has a physiotherapist that is scheduled to visit the facility weekly. The physiotherapist assesses each resident on admission and then as required. There is a physiotherapist assistant who carries out the physiotherapists plan on Tuesdays and Thursdays, takes group exercises, and is also employed as an assistant activities coordinator.

There are two registered nurses, one enrolled nurse, one clinical charge nurse employed by the service and the manager/owner is a registered nurse. A record of all health practitioners practicing certificates is kept.

Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated

and reviewed at six monthly intervals. Care plans are updated to reflect intervention changes following review or change in health status (# link 1.3.5.2). During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation.

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

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

Attainment and Risk: PA Low

Evidence:

Maples Lifecare provides services for residents requiring rest home level of care. Individualized care plans are completed. The four caregivers, one registered nurse, one enrolled nurse and one clinical charge nurse interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment.

Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. There is currently nine wounds (eight residents) being treated and no pressure injuries. Wound assessment and management plans are completed for the nine wounds and there is evidence of referral to wound and vascular specialists.

Finding:

(i) Eight of the nine wound charts reviewed did not show documented evidence of the frequency of wound care required. (ii) Seven of nine wound charts assessments reviewed have not been fully completed (factors which could delay healing).

Corrective Action:

(i) and (ii) Ensure that all wound charts have documented evidence of frequency of dressing and that all wound assessment charts are fully completed.

Timeframe (days): 90 (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:

There is one diversional therapist (DT) and one activities assistant at Maples Lifecare who are responsible for the planning and delivery of the activities programme. The DT works four days per week (Monday-Thursday) and extra as required. The activities assistant also works four days per week (Tuesday-Friday). The activities assistant acts as a physiotherapy assistant Tuesday and Thursday. The DT has been at the service for four years and has been a qualified DT for one year. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly and every resident has a copy of the programme in their rooms. A copy of the programme is also available in the lounge (large print copies are available if required). Residents have an initial assessment completed over the first few weeks after admission obtaining a complete social history of past and present interests and life events.

The programme includes residents being involved within the community with visits to other facilities, social clubs, café/lunch outings, churches and schools. On or soon after admission, a social history is taken and information from this is added into the long term care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs including but not limited to; baking, flower arranging, exercises, nail pampering, knit and natter, quizzes, newspaper discussion, library and guest speakers. Participation in all activities is voluntary. Maples Lifecare has its own van for transportation. Residents interviewed described weekly liaison with local schools (primary and high school), outings at another facility, weekly van outings and attendance at a variety of community events. The DT and activities assistant have a current first aid certificate. D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review.

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:

All initial care plans are developed by a registered nurse (# link 1.3.5.2) and resident comprehensive long term care plans developed within three weeks of admission. Long term care plans are evaluated six monthly or if there is a change in health status. There is documented evidence that care plan evaluations are up to date in seven of eight resident files sampled (one resident is on respite care). Changes in health status trigger an update on the care plan (# link 1.3.5.2). Care plan reviews are signed as completed by a RN. General practitioners review residents three monthly or when requested if issues arise or health status changes. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out his instructions, giving him full confidence in the management of the residents. Short term care plans were evident for wounds, infections (upper respiratory and throat) and return from acute care.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service facilitates access to other medical and non-medical services. The clinical charge nurse and registered nurse interviewed confirm that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted.

Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records.

There was transfer information available in one of the files reviewed which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

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

The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP. Maples Lifecare uses the medico system of four weekly blister packs; verification is completed by the clinical charge nurse or registered nurse against the drug chart on arrival from the pharmacy. Medication charts record prescribed medications by residents' general practitioners; these are kept in the medication folders. The medication folder includes a list of specimen signatures. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. Education on medication management occurred in March and June 2014. Competencies are conducted annually for staff administering medications however competencies for registered nurses were not evidenced as being completed annually. This is an area requiring improvement. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication. Eight of 16 medication charts had no route of administration documented for prn medications and the signing sheet for the respite resident had no documented date of administration. These are areas requiring improvement. The service has adequate information and supervises the self-administration of medicines. There are three residents self-administering medications and their medications are kept in a locked drawer in the resident's room. Two residents do not show documented evidence that the self-administration competency assessment has been reviewed three monthly. This is an area requiring improvement.

The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded. Sixteen

medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. There are two medication trolleys and two medication folders. Medications are safely stored on the trolleys which are kept in the locked nurse's station/treatment room when not in use. All medications are up to date and eye drops were dated on opening. There is one medication fridge in the treatment room and temperatures are documented daily as sighted. Controlled drugs are kept in a locked safe in a locked cupboard in the treatment room. The controlled drug register did not show evidence of weekly checks and the registered nurse was observed on the day of the audit administering controlled drugs for a respite resident without following correct procedures. These are areas requiring improvement. The rest of the register showed evidence of two signatures when signing out controlled drugs. One staff member (enrolled nurse) was observed safely administration medications at the lunch time medication round. One staff member (registered nurse) was observed signing for medications at lunch time before the resident had taken the medication. This is an area requiring improvement. The service has a current contract with a pharmacy.

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

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

Attainment and Risk: PA Moderate

Evidence:

The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. Education on medication management occurred in March and June 2014. Competencies are conducted annually for staff administration medications. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication. Controlled drugs are kept in a locked safe in a locked cupboard in the treatment room

Finding:

(i)The registered nurse was observed on the day of the audit administering controlled drugs for a respite resident without signing the medication out, and without checking the medication out with another staff member. (ii)The controlled drug register did not show evidence of weekly checks. (iii) One staff member (registered nurse) was observed signing for medications at lunch time before the resident had taken the medication. (iv)The signing sheet for the respite resident had no documented date of administration. (v) Eight of 16 medication charts had no route of administration documented for prn medications.

Corrective Action:

(i)Ensure that there are always two staff administrating and signing for controlled drugs. (ii) Ensure that the controlled drugs are checked weekly and that this is documented in the controlled drug register. (iii) Ensure that medications administered are signed for following administration. (iv) Ensure that dates of administrating medications are documented on the signing sheet. (v) Ensure that the route of medication is documented by the general practitioner.

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 Low

Evidence:

Education on medication management occurred in March and June 2014. Competencies are conducted annually for care giving staff administrating medications.

Finding:

Competencies for registered nurses were not evidenced as being completed.

Corrective Action:

Ensure that all staff with responsibilities around medication administration have annual competencies completed.

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

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

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

Attainment and Risk: PA Low

Evidence:

The service has adequate information and supervises the self-administration of medicines. There are three resident self-administering medications and the medications are kept in a locked drawer in the resident's room.

Finding:

Two residents do not show documented evidence that the self-administration assessment competency has been reviewed three monthly.

Corrective Action:

Ensure that all residents have a competency assessment review three monthly.

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

Criterion 1.3.12.6 (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:

Maples rest home has a large well equipped kitchen with all food cooked on site by external contractors. There is a cook that works from 8am-5.30pm and a kitchen hand who works from 7am-2.30 pm. There is a tea assistant who works from 5pm-7.30pm. The external contractors have a menu (seasonal, four weekly) which is developed by a dietitian, and food services manual that ensures that all stages of food delivery to the resident is noted and documented and complies with standards legislation and guidelines. A tour of the kitchen noted cleanliness and order in the pantry and fridges and freezers complying with guidelines including daily recorded temperatures that were within the recommended range. Hot food temperatures are recorded daily. All food is served directly from the Baine Marie in the rest home dining room and food for the serviced apartments is first transported to the serviced apartment dining room in hot boxes and then served from the Baine Marie. All food in the fridge, freezer and pantry is dated or labelled.

A nutritional profile for each resident is completed on admission and reviewed six monthly in line with the long term care plan review. There is a summary sheet that includes all residents with likes and dislikes individual food requirements. The menu includes alternatives that provide for all current dietary needs to be met. Likes and dislikes are on a board in the kitchen which can only be viewed by kitchen staff. There is a kitchen cleaning roster.

The service gathers information regarding food service through the annual satisfaction survey (May 2014). Nine residents and three relatives interviewed were satisfied with the food provided when taking personal preferences into account.

D19.2 staff have been trained in safe food handling by the external contractor with certificates sighted (2014).

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.

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

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.

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There are policies in place for waste management, waste disposal for general waste and medical waste management. There is an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Laundry/sluice room is locked. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interviews with staff (one laundry and two housekeepers) described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in July 2013.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The service displays a current building warrant of fitness which expires on 1 July 2015. Hot water temperatures checks are conducted and recorded monthly by the owner/maintenance person and are within recommended range as sighted. The service does not have a hoist. Chair scales have been calibrated in June 2014, however other medical equipment (blood pressure machine and thermometer) has not been calibrated by an authorised technician. Improvement is required in this area. Electrical equipment has been tested (9 January 2014). The interior is well maintained with a home-like décor and furnishings. There is a large communal lounge, a dining area and a large internal court yard. There are two other lounges and one other dining area. There is an annual plant and equipment schedule and a building maintenance schedule. All the serviced apartments all have ensuites that include shower/toilet. The majority of the rest home resident's rooms have full ensuites and a third have toilet ensuites only. There are mobility shower/toilets available. There are small seating nooks available for residents and visitors. Residents were observed to safely mobilise throughout the facility. There is an external designated smoking area. There is easy access to the outdoors. Outdoor ramps have handrails. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with four caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. The service has a van with a current warrant of fitness (expires April 2015).

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low

Evidence:

The service displays a current building warrant of fitness which expires on 1 July 2015. Hot water temperatures checks are conducted and recorded monthly by the owner/maintenance person. Chair scales have been calibrated June 2014.

Finding:

Medical/nursing equipment including blood pressure machine and thermometer has not been checked or calibrated.

Corrective Action:

Ensure all medical equipment is checked and calibrated by an authorised technician annually.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

All the serviced apartments have ensuites that include shower/toilet. The majority of the rest home resident's rooms have full ensuites and a third have toilet ensuites only. There are mobility shower/toilets available. There are communal toilets available near main communal areas. The number of toilets and showers provided is adequate.

Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Nine rest home residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs.

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:

The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised.

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: The service has three lounges and two dining areas. The main dining room is spacious, located directly off the kitchen/serverly area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit and nine residents interviewed report they can move around the facility and staff assist them if required.

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:

Maples Lifecare has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Sheets and towels are laundered by an external contractor on a daily basis. Staff attend infection control education and there is appropriate protective clothing available. There are dedicated laundry and cleaning staff. Care staff complete laundry tasks in the evening. Manufacturer's data safety charts are available. There is a sluice in the dirty side of the laundry which includes a sanitizer. Nine residents and three family interviewed report satisfaction with the laundry service and cleanliness of the room/facility. Resident satisfaction survey conducted in May 2014 included questions around laundry with satisfaction with the service. Laundry and housekeeping audits have been conducted in August 2014. Chemical training has been provided in July 2013.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has policies and procedures and training for civil defence, other emergencies and security. Emergency training is included in all new staff orientation. All shifts have a trained first-aider. The New Zealand Fire Service approved the fire evacuation scheme on the 23 April 2007. Fire evacuation drills have occurred six monthly - last conducted on 19 June 2014. A civil defence emergency kit is readily available in the reception office area and there is sufficient water stored in case of emergency. Battery operated emergency lighting, extra torches and gas cooking and gas bbq and is in use/available. The service is able to obtain a generator from within the community if required in an emergency. Fire alarms and hose reels are checked by a contracted company. Call bells are evident in resident's rooms, dining and living areas, corridors and toilets/bathrooms. Security policies and procedures are in place. There is a procedure for additional resident supervision to maintain safety. The service has extra food and water available should the need arise.

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.

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

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.

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

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p>
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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:

All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated (some under floor and some ceiling) and ventilated. Nine residents and three family interviewed state the environment is warm and comfortable.

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:

Maples Lifecare has comprehensive policies and procedures on restraint minimisation and safe practice. The clinical charge nurse is the restraint coordinator and confirms that the service promotes a restraint-free environment and has done so for a number of years.

Policy states that enablers are voluntary. There are no residents using enablers and no residents assessed as requiring restraint. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers.

Documentation includes restraint register, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms. Restraint education last provided for staff in January 2014 with associated questionnaire.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

A registered nurse is the infection control (IC) nurse. She is supported by the clinical charge nurse, owner/manager and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The registered nurse has attended infection control training. The IC nurse and staff have good external support from the local laboratory infection control team, the GP's and an IC nurse consultant. The infection control team is representative of the facility.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are infection control policy and procedures appropriate to for the size and complexity of the service.

D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed and updated by the owner/manager and registered nurse to ensure best practice information is included. The policies and procedures were last updated and reviewed in November 2013. The Maples Lifecare infection control policies include (but not limited to): hand hygiene, standard/transmission based precautions; prevention and management of staff infection, antibiotic and antimicrobial agents, infectious outbreaks management, cleaning and disinfecting, single use items, personal protective equipment, medical waste and sharps and spills management.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse (RN). All infection control training is documented and a record of attendance is maintained. Infection control education was provided in September 2013 in relation to hand washing and hand hygiene. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Residents are informed of infection prevention matters that are appropriate to their needs and this is documented in medical records. The registered nurse has attended infection control and outbreak management education session in May 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Infection surveillance is an integral part of the infection control programme and is described in The Maples Lifecare infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual short term care plan is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Infections are reported on a monthly running summary which details the resident name, type of infection, organism, treatment, effectiveness and resolution. Surveillance of all infections are entered on to an annual running infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the management meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. There has been no outbreaks in the past two years.

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.)*