

The Ultimate Care Group Limited - Karadean Court Lifecare

Current Status: 9 October 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

Karadean Court Lifecare situated in Oxford Canterbury provides residential care for up to 53 residents who require hospital, rest home and younger peoples' disability (YPD) level care. Occupancy on the day of the audit is 52 residents. The facility is operated by The Ultimate Care Group Limited. Staffing is stable with minimal turnover. Residents and family interviewed give very positive feedback on the care and services provided by the facility. The facility manager has been appointed since the previous audit, has been in the position for two years, and is well supported by the organisation's quality management team, who are on site during the audit.

Two areas have been rated as continuous improvement relating to a quality initiative implemented in the garden activities and another in relation to choices of cooked breakfast on Saturdays.

Integration of residents' notes, care plan interventions and faxed medication records are three areas identified as requiring improvement.

Audit Summary as at 9 October 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Indicator	Description	Definition
	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 9 October 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 9 October 2014

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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 9 October 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 9 October 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 9 October 2014

Consumer Rights

The facility ensures information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the facility's complaints process and the Nationwide Health and Disability Advocacy Service is accessible and brought to the attention of residents and their families on admission to the facility. This is verified during interviews with residents and family members. Information relating to the Code is on display at the entry foyer, in the communal lounge and is provided in the admission package. All residents and family members interviewed verify that residents' rights are met at all times during service delivery, all staff are respectful of their needs, communication is appropriate, and they have a clear understanding of their rights, and the facility's processes if these are not met.

Residents and family members verify that consent forms are provided prior to admission to ensure they have time for consultation and are fully informed. Time is provided by the facility manager if discussions and explanation is required. An older persons' advocate is available if required confirming the facility's encouragement of external support agencies.

There is evidence in documentation and observation on the days of the audit of consideration of residents' rights during service delivery to allow for personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence.

An effective complaints and compliments system is in place and all response timeframes are being met in line with the policy. All issues raised in the current year are low level with all resolved satisfactorily.

Organisational Management

Karadean is managed by an experienced and well qualified manager who oversees the day to day running of the facility. She is supported by a regional operations manager and the executive team at The Ultimate Care Group Ltd national office. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A comprehensive quality and risk management system is in place with robust reporting. There is a quality improvement plan which includes an annual calendar of internal audit activity, including monitoring of the activities programme, administration functions, human resources, health and safety, infection control, medication, resident care, 'releasing time to care', and the monitoring of a number of quality initiatives that are in place. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective actions

planning, feed into the quality improvement cycle to manage any further risk and ensure a continuous quality improvement occurs.

Records reviewed are complete and current and include identifiable signatures and staff identification. All current and archived records are secured.

A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme is evident to maintain a high level of competence of all staff. Staff report high job satisfaction and enjoy the supportive environment they work in.

Continuum of Service Delivery

The facility's registered nurse (RN) or clinical nurse completes a range of assessments and develops detailed and comprehensive life style care plans or short term care plans for isolated events, to guide care staff in service provision. However not all care plans include recommendations of allied health and this requires improvement. The RN reviews these within recommended timeframes. Observation of staff, review of integrated residents' notes, and resident and family interviews, confirms that all staff provides individualised care that reflects desired goals and outcomes.

A general practitioner (GP) is interviewed during the audit and confirms the facility RNs assessments are accurate and appropriate, that he is notified in a timely manner of any issues, his recommendations and treatments are carried out, and he is very complimentary of the facility and the environment.

An activities programme is planned and implemented by the diversional therapist and the activities person, and these meet the identified activities wishes of the residents. An individual resident's activity plan is developed that reflects their individual interests, and are reviewed in line with lifestyle care plans. A garden initiative including a worm farm is a quality project that has enhanced the quality of life for some residents, and this is an area identified as continuous improvement.

Policies and procedures are in place for all stages of medication management. A blister pack medication system is in place for the facility. The medication administration process is observed during the audit confirming safe practice occurs. Documented medication records are completed by the residents' GPs, however faxed records are not transferred onto the original medication form, some changes are not identifiable and are not signed and dated when discontinued and these areas require improvement.

A dietary profile is completed for each resident on admission and updated as required. Special dietary requirements are met and personal likes and dislikes are catered for. Kitchen processes, including food preparation, transport, storage and removal of kitchen waste is appropriately managed by the kitchen staff including the chef. A nutritional review of the menu has occurred this year, and observation of the meals provided reflects the facility's menu. Food, fridge and freezer temperatures are recorded daily, and observed to be within recommended levels.

A quality initiative implemented by the kitchen relates to cooked breakfast choices. Feedback from residents has been implemented by all staff with improved benefits for residents and this reflects a continuous improvement.

Safe and Appropriate Environment

The facility is very well maintained with a full time maintenance position on staff. The residents' rooms and the communal areas are spacious, clean, well ventilated and kept at a comfortable temperature for residents. A number of rooms are apartment style with their own kitchenettes. There are adequate shower and toilet facilities with most rooms having their own, or access to, an ensuite. Well maintained and safe outside areas are easily accessed for all residents.

The building has a current building warrant of fitness.

The management of waste and hazardous substances is safely managed by staff who are trained in these processes.

Emergency procedures are well documented for ease of use and instructions located in a number of places around the facility. Regular fire drills are held and sprinkler systems are installed in case of fire.

Access to a temporary emergency power source is in place. Adequate back up supplies and food are kept on site in case of an emergency and an active civil defence service in the area prioritises this facility to ensure the ongoing safety of all residents should an emergency occur.

Restraint Minimisation and Safe Practice

The philosophy of the facility is that it will be restraint free and that they will manage all behaviour in a way that promotes this. This is reflected in the restraint free environment that the service currently operates in. Staff have ongoing training in the management of any challenging behaviours. Policies and procedures that meet all the requirements of the standard are in place and are followed for the use of enablers. The use of enablers is for the safety of residents in response to individual requests. These are monitored and reviewed regularly.

Infection Prevention and Control

A documented and implemented infection control (IC) programme which meets the infection control Standards includes policies and procedures to guide all staff. Records sighted, observation and interviews with care staff provides evidence that all staff have a clear understanding of what is required for prevention of infections.

The clinical nurse manager (CNM) and the facility manager (FM) ensure the programme is implemented, collate and analyses IC data, and reports findings to the quality committee and at staff meetings.

The facility's RNs, CNM and FM gain expert external advice as required, and the residents' GPs are also consulted regarding individual resident's infections.

All staff receive IC education as part of the induction process and at least annually. There is evidence that residents and family are educated in IC for specific practices.

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 Ultimate Care Group Limited		
Certificate name:	The Ultimate Care Group Limited - Karadean Court Lifecare		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Certification Audit		
Premises audited:	Karadean Court Lifecare		
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical		
Dates of audit:	Start date: 9 October 2014	End date: 10 October 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			52

Audit Team

Lead Auditor	XXXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXXX	Total hours on site	16	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXX			Hours	4

Sample Totals

Total audit hours on site	32	Total audit hours off site	20	Total audit hours	52
Number of residents interviewed	5	Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed	8	Number of staff records reviewed	9	Total number of managers (headcount)	2
Number of medication records reviewed	18	Total number of staff (headcount)	76	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXXX, Managing Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group 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)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Tuesday, 4 November 2014

Executive Summary of Audit

General Overview

Karadean Court Lifecare situated in Oxford Canterbury provides residential care for up to 53 residents who require hospital, rest home and younger peoples' disability (YPD) level care. Occupancy on the day of the audit is 52 residents; 31 at hospital level, 21 rest home level and four YPD care. The facility is operated by The Ultimate Care Group Limited. Staffing is stable with minimal turnover. Residents and family interviewed give very positive feedback on the care and services provided by the facility. The facility manager has been appointed since the previous audit, has been in the position for two years, and is well supported by the organisation's quality management team, who are on site during the audit.

Two areas have been rated as continuous improvement (beyond the standard normally expected) relating to a quality initiative implemented in the garden activities and another in relation to choices of cooked breakfast on Saturdays.

Integration of residents' notes, care plan interventions and faxed medication records are three areas identified as requiring improvement.

Outcome 1.1: Consumer Rights

The facility ensures information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the facility's complaints process and the Nationwide Health and Disability Advocacy Service is accessible and brought to the attention of residents and their families on admission to the facility. This is verified during interviews with residents and family members. Information relating to the Code is on display at the entry foyer, in the communal lounge and is provided in the admission package. All residents and family members interviewed verify that residents' rights are met at all times during service delivery, all staff are respectful of their needs, communication is appropriate, and they have a clear understanding of their rights, and the facility's processes if these are not met.

Residents and family members verify that consent forms are provided prior to admission to ensure they have time for consultation and are fully informed. Time is provided by the facility manager if discussions and explanation is required. An older persons' advocate is available if required confirming the facility's encouragement of external support agencies.

There is evidence in documentation and observation on the days of the audit of consideration of residents' rights during service delivery to allow for personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence.

An effective complaints and compliments system is in place and all response timeframes are being met in line with the policy. All issues raised in the current year are low level with all resolved satisfactorily.

Outcome 1.2: Organisational Management

Karadean is managed by an experienced and well qualified manager who oversees the day to day running of the facility. She is supported by a regional operations manager and the executive team at The Ultimate Care Group Ltd national office. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A comprehensive quality and risk management system is in place with robust reporting. There is a quality improvement plan which includes an annual calendar of internal audit activity, including monitoring of the activities programme, administration functions, human resources, health and safety, infection control, medication, resident care, 'releasing time to care', and the monitoring of a number of quality initiatives that are in place. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective actions planning, feed into the quality improvement cycle to manage any further risk and ensure a continuous quality improvement occurs.

Records reviewed are complete and current and include identifiable signatures and staff identification. All current and archived records are secured.

A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme is evident to maintain a high level of competence of all staff. Staff report high job satisfaction and enjoy the supportive environment they work in.

Outcome 1.3: Continuum of Service Delivery

The facility's registered nurse (RN) or clinical nurse completes a range of assessments and develops detailed and comprehensive life style care plans or short term care plans for isolated events, to guide care staff in service provision. However not all care plans include recommendations of allied health and this requires improvement. The RN reviews these within recommended timeframes. Observation of staff, review of integrated residents' notes, and resident and family interviews, confirms that all staff provides individualised care that reflects desired goals and outcomes.

A general practitioner (GP) is interviewed during the audit and confirms the facility RNs assessments are accurate and appropriate, that he is notified in a timely manner of any issues, his recommendations and treatments are carried out, and he is very complimentary of the facility and the environment.

An activities programme is planned and implemented by the diversional therapist and the activities person, and these meet the identified activities wishes of the residents. An individual resident's activity plan is developed that reflects their individual interests, and are reviewed in line with lifestyle care plans. A garden initiative including a worm farm is a quality project that has enhanced the quality of life for some residents, and this is an area identified as continuous improvement.

Policies and procedures are in place for all stages of medication management. A blister pack medication system is in place for the facility. The medication administration process is observed during the audit confirming safe practice occurs. Documented medication records are completed by the residents' GPs, however faxed records are not transferred onto the original medication form, some changes are not identifiable and are not signed and dated when discontinued and these areas require improvement.

A dietary profile is completed for each resident on admission and updated as required. Special dietary requirements are met and personal likes and dislikes are catered for. Kitchen processes, including food preparation, transport, storage and removal of kitchen waste is appropriately managed by the kitchen staff including the chef. A nutritional review of the menu has occurred this year, and observation of the meals provided reflects the facility's menu. Food, fridge and freezer temperatures are recorded daily, and observed to be within recommended levels.

A quality initiative implemented by the kitchen relates to cooked breakfast choices. Feedback from residents has been implemented by all staff with improved benefits for residents and this reflects a continuous improvement.

Outcome 1.4: Safe and Appropriate Environment

The facility is very well maintained with a full time maintenance position on staff. The residents' rooms and the communal areas are spacious, clean, well ventilated and kept at a comfortable temperature for residents. A number of rooms are apartment style with their own kitchenettes. There are adequate shower and toilet facilities with most rooms having their own, or access, an ensuite. Well maintained and safe outside areas are easily accessed for all residents.

The building has a current building warrant of fitness.

The management of waste and hazardous substances is safely managed by staff who are trained in these processes.

Emergency procedures are well documented for ease of use and instructions located in a number of places around the facility. Regular fire drills are held and sprinkler systems are installed in case of fire.

Access to a temporary emergency power source is in place. Adequate back up supplies and food are kept on site in case of an emergency and an active civil defence service in the area prioritises this facility to ensure the ongoing safety of all residents should an emergency occur.

Outcome 2: Restraint Minimisation and Safe Practice

The philosophy of the facility is that it will be restraint free and that they will manage all behaviour in a way that promotes this. This is reflected in the restraint free environment that the service currently operates in. Staff have ongoing training in the management of any challenging behaviours. Policies and procedures that meet all the requirements of the standard are in place and are followed for the use of enablers. The use of enablers is for the safety of residents in response to individual requests. These are monitored and reviewed regularly.

Outcome 3: Infection Prevention and Control

A documented and implemented infection control (IC) programme which meets the infection control Standards includes policies and procedures to guide all staff. Records sighted, observation and interviews with care staff provides evidence that all staff have a clear understanding of what is required for prevention of infections.

The clinical nurse manager (CNM) and the facility manager (FM) ensure the programme is implemented, collate and analyses IC data, and reports findings to the quality committee and at staff meetings.

The facility's RNs, CNM and FM gain expert external advice as required, and the residents' GPs are also consulted regarding individual resident's infections.

All staff receive IC education as part of the induction process and at least annually. There is evidence that residents and family are educated in IC for specific practices.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	1	42	0	1	1	0	0
Criteria	2	89	0	1	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	4	0	1
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 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			
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 Low	The lifestyle plan content in two of eight files reviewed does not have the recommendations from the health professional's assessment (dietitian and physiotherapist) included as interventions. The dietitian's recommendations have not been provided to kitchen staff and food serving staff. For example, a change in a resident's breakfast to porridge with milk and sugar for a slight weight loss, and to assist with feeding due to fatigue has not been included. The physiotherapist's recommendations are occurring, but have not been included in the lifestyle plan.	Lifestyle care plans describe the required support as indicated in on-going assessments, including those of allied health professionals.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	Eighteen medication files are reviewed. Ten of eighteen files reviewed are either not signed or dated when they are discontinued. Three medication records have the item scribbled out, rather than a single line, so the written medication is not identifiable. Fourteen files reviewed are faxed forms, and the original document has not been updated as required in medication care guidelines, or is not in the medication folder but archived.	Medication management is implement to ensure safe prescribing and in line with the residential aged care medication guidelines.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Residents were asked for improvements and suggestions for the external environment. The outcome and analyses of the information showed the residents interest in developing garden pots, a rose competition from the potted roses, a vegetable garden with raised beds and a worm farm. The worm farm has provided increased resident activity for two residents in particular who had not shown any interest in activities and had become less involved and more compromised as a result of inactivity. The residents are now involved in the garden, in maintaining the worms and have improved functioning and engagement in conversation as a result of the worm farm. Two residents and one family member are interviewed,

Code	Name	Description	Attainment	Finding
				and verify they now have a purpose in life and the worm farm has improved their overall wellbeing and functioning. This positive outcome for the residents exemplifies continuous improvement principles.
HDS(C)S.2008	Criterion 1.3.13.1	Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	CI	Residents and family members interviewed confirm there is variety in the food provided and this meets their needs. The facility has recently introduced breakfast choices on a daily basis, which is an initiative introduced by the chef. This initiative led to a survey provided to all residents on what they would like as a choice for a cooked Saturday breakfast menu. Each resident or their family member completed the survey, and the chef commenced residents' cooked choice breakfasts on every second Saturday. Off duty kitchen staff came into help with the cooked choices of bacon and eggs, pancakes, waffles, sausages and mushrooms. The cooked breakfast initiative was analysed through a further survey, with all those receiving the cooked breakfast giving feedback on whether this should continue and be increased to occur every Saturday. The results confirmed over 90% approval of the breakfast initiative, with improved health benefits

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:

Records sighted verify that staff receive training in the Code of Health and Disability Services Consumers' Rights' (the Code) at least annually. Registered nurses (RNs) and care staff are observed interacting respectfully and communicating appropriately with residents. Staff encourage residents to make choices demonstrating their knowledge of residents' rights. The three residents reviewed using tracer methodology and who were interviewed provided examples of individual choices, and confirm that this is supported by staff.

Five residents (one disability, three rest home and one hospital) and four family members (three hospital and one rest home) are able to confirm that services are provided with dignity and respect at all times, privacy is maintained, and individual needs and rights are upheld. Observation during the audit confirms doors are closed and staff always knock and wait before entering residents' bedrooms.

The ARRC requirements D1.1c; D3.1 are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

Karadean Court Lifecare ensures information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the facility's complaints process and the Nationwide Health and Disability Advocacy Service is accessible and brought to the attention of residents and their families on admission to the facility. This is verified during interviews with residents and family members. Information relating to the Code is on display at the entry foyer, in the communal lounges and is provided in the admission package. Time is allowed for explanation and discussion.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are guidelines in place for staff to follow to ensure residents' privacy and dignity is maintained throughout all service provision activities, and this is reflected in observed practice. For example staff knock before entering a person's bedroom, assist residents to have private conversations in private, residents' religious and cultural values and beliefs are documented and it is confirmed by residents and family members that these are respected.

There is a privacy and dignity policy to guide all staff and the facility manager is the appointed privacy officer.

A policy on elder abuse and neglect describes how staff will ensure that no resident is subjected to abuse or neglect. Staff interviewed demonstrate knowledge in the elder abuse and neglect prevention policy and describe how they would report any suspected abuse. None of those interviewed have had need to report. Families interviewed have not at any time witnessed any untoward situation or possible abuse or neglect of any resident.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The Ultimate Care Group organisation has a Maori Health Plan, a Maori Health policy and a Maori perspective on health, and cultural safety policy. The Maori Health Plan is personalised to Karadean Court and includes the three principals: Partnership, Participation and Protection, describing how the holistic view of Maori health is to be incorporated into the delivery of services (whanau, hinengaro, tinana and wairua).

The clinical nurse manager (CNM) is interviewed and confirms that on the days of the audit there is not a resident in the facility who identifies as Maori.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The Recognition of Individual beliefs and values policy is sighted. This policy describes the process of documenting each person's own values and beliefs in their care plan in consultation with family members / whanau and the resident on admission to the facility, and ensuring these needs are met through staff training. An historical view is

recorded including culture, spirituality, family commitments and community involvement. Discussion with the CNM, RNs and care staff confirm their knowledge and respect of residents' beliefs and values.

Feedback is obtained through regular surveys. A satisfaction survey has recently been sent out to families (confirmed in family interviews).

Access to interpreters, translators and cultural representatives are available on request. Information on how to access these services is included in the Resident Information document which enables privacy of access if required.

Residents and family members interviewed report their satisfaction with their individual needs and wishes being accommodated and met. One resident who is a practising Catholic stated she has weekly communion in her room and attends Mass every month. One resident reports attending the monthly church meetings. Their family member states that staff will always offer to take the resident to church services at the facility, even if he does not wish to attend which has happened over recent months. Staff remain very respectful of his wishes and do not push him to go.

Four of four family members and five of five residents interviewed report their satisfaction with the care carried out with regards to individual needs. One resident enjoys watching sport on TV in his room and staff ensure the TV is turned on to the sports channel every morning.

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 Guidelines for Privacy and Dignity and Guidelines for Communicating with Residents / Relatives and Visitors describe expected behaviours of staff when providing support to residents and communicating with families/whānau. These include speaking respectfully to people. Staff induction and orientation covers non-gifting and

descriptions relating to freedom from discrimination, coercion, harassment, sexual, financial and other exploitation. Staff also receive training annually in the Code (records sighted).

Residents are given the brochure on the Code which fully explains their right to freedom from discrimination, coercion, harassment and exploitation, on admission. These brochures are also available at the front entrance to the facility.

There is a section documented on sexuality and intimacy in the resident's individual lifestyle care plans.

Five of five residents and four of four family members reported satisfaction with staff approaches to residents with comments such as "always speak nicely"; "can't fault the staff approach"; and "very good care". The general practitioner interviewed GP stated residents are "always clean and tidy and well looked after".

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:

Policies sighted that reflect good practice include: assessing and monitoring challenging conditions; management of challenging behaviours; open disclosure and informed consent. An advance directive form which documents the resident's wishes on their resuscitative status, and who they have discussed these wishes with, is available for completion on admission. There is an option on the advance directive form for the resident to document they do not wish to make these decisions at that time. All documentation sighted included the residents' choices and these are reviewed with the GP at least six monthly.

Clinical procedures sighted which are relevant to the resident's care are continence assessment and management, infection prevention and control, smoke free policy, medication management, pain assessment and management, personal grooming and hygiene, personal privacy and dignity, providing culturally safe care, recognition of people's rights, restraint minimisation and safe practice, advance directives, spirituality, skin management, transportation of residents and wound care.

Resident's notes include recognised and validated clinical assessment forms for continence, pain, mobility and falls risk, pressure area risk and nutrition. The facility RNs are trained in the use of the interRAI electronic assessment tool, but are using paper based assessments as well until all staff are familiar with the tool. The organisation's quality manager is interviewed and reports that UCG is 'championing' the interRAI tool as a special project.

Staff are observed to carry out good practice. Resident and family report that the staff are: "very good at what they do"; and are "obviously well trained".

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An Open Disclosure Policy is sighted. The policy advocates that disclosure to the resident should generally be made when an adverse resident event has occurred. Typically disclosure should be within 24 hours of the event depending on the specific circumstances of the event. An incident report relating to a skin tear is reviewed and verifies the facility has notified the resident's family within 24 hours of the incident, the treatment provided and a follow-up of when the resident was seen by the GP. This is also verified in the family communication form in the resident's hardcopy records.

Interpreter and Translation Services Policy provides contact details for services. The interpreter policy identifies interpreter availability with braille, sign language, dictation, te reo Maori and other languages. The policy states those residents with hearing and visual deficits are accorded the degree of explanation or repetition necessary to establish recognition. Staff name badges are in large print.

The Code of Rights pamphlet provided to residents on admission, displayed on walls, and available at the facility entrance, confirms the residents' right to effective communication.

Active family communication sheets are sighted in four residents' files reviewed. These include all communication with family members, by phone or during a visit to the facility.

Staff are observed explaining and giving information to residents. Resident meetings are held regularly to enable residents to be informed, ask questions and discuss issues. The minutes of these (sighted) are documented and detailed.

Four of four family members confirm they are kept up to date with matters relating to their family member. All report the staff to be friendly and approachable and state they feel able to discuss freely.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a lengthy policy and procedure document 'Policy on Informed Consent' covering informed consent for residents in UCG facilities. There is evidence of procedural steps of informed consent that includes each residents signed Informed Consent Form for Care and Treatment, Permission to Collect, Store and Release Information form, taking and display of photographs, flu vaccinations, and outings. There is also sighted a range of consent forms relating to each individual's choice for resuscitation (CPR) / Do not Resuscitate, that complies with the Code; serious injury; a generic training / procedure consent form. Eight of eight files reviewed contain signatures for the various consent forms.

Residents and family members interviewed verify that consent is an on-going practice at the facility and provide examples how this occurs. Staff are observed providing choices and gaining consent for day to day activities, going to the dining room or to activities, food preferences for breakfast.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: There is a Resident Advocacy Policy which describes a process of identifying a new resident's support people, including family/whanau / next of kin and any welfare guardian or enduring power of attorney (EPOA). If a situation arises when a resident needs independent support and there are no formal or informal representatives for them, an

advocate will be sought for them from either Age Concern, Public Trust, or a legal or religious representative. The contact details for advocacy services and the Health and Disability Commissioner are included in the policy document. In discussion with the facility manager there has not been any instance where this has been required.

Family and residents interviewed confirm they are provided with information on the advocacy services on admission to the facility, and have not needed to use this service.

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 facility's admission form collects details of the resident's primary contact, secondary contact and any other family members. The social profile completed by the activities person collects information on residents' interests and hobbies and the care plan links these to community resources, such as the library, the 'men's shed', care and craft groups, local churches.

Staff were observed to greet family members and visitors in a friendly and welcoming manner, and all family members interviewed verify this is the norm.

Residents have a choice of two lounges, and other small seating alcoves or their bedrooms to entertain their visitors. A residents' portable phone is also available, as well as the ability to have a phone in their own room if they choose.

Three residents interviewed report they are actively assisted to maintain outside links with transport and staff available to accompany them to outside activities if required. One resident has a mobility scooter and is able to freely go to town as she wishes. She states that the facility is "great".

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: There is a complaint / concern policy and associated forms. All residents are given a copy of the complaint form is given to residents on admission and forms are available in all facilities at all times. Facility managers are responsible for investigating and managing complaints. All complaints are recorded in the complaint register. A risk rating is applied to each complaint/concern and a risk matrix has been developed to guide staff. Any of a serious nature are immediately notified to the quality and audit manager who

then provides support to ensure the process is followed and support given as required. Every complaint is then entered into the electronic quality system (GOSH) and becomes a part of the quality process.

The complaints register is reviewed and all compliments and complaints are well documented with copies of all responses made. All meet the required timeframes as per the organisational policy which meets all the requirements of Right 10 of the Code. Seven recent complaints are reviewed and all are resolved satisfactorily. In all written communications with complainants, the contact details for the Nationwide Health and Disability Advocacy Service are given. This year to date a total of 12 complaints have been received with all of these rated low risk. The manager in interview confirms all complaints/concerns are responded to in writing within the required timeframes and if possible a written response is provided within 48 hours. An investigation is undertaken as required and updates are completed every ten days until resolution and sign off. Corrective actions are initiated as appropriate.

Three of three caregivers interviewed confirm a sound understanding of the complaint process and when formal action is required.

A similar number of compliments have been received so far this year congratulating staff on the level of service received in a number of areas.

ARCC requirements are met.

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

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

Attainment and Risk: FA

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:

This Ultimate Care Group (UCG) facility, Karadean, is owned by Windhaven Investments, who have a chief executive officer (CEO) to manage an executive team to support their business activity. A General Manager (GM) leads a team of national managers to support the 16 aged care facilities. Each facility has its own business plan which is written by the manager of the facility and approved by the regional operational manager. The vision and goals of the organisation are on display at the main entrance and these are integrated into the planning at each facility. The vision and core values are reviewed by the GM annually. A comprehensive suite of policy and procedure documents is sighted with the focus on quality aged care provision. These form a basis for the facility business plan which details the planned goals and actions for the current year with the manager completing weekly reports to the regional operational manager with whom regular weekly or fortnightly meetings are held.

The manager has been in the role for two years and was employed at Karadean for two and a half years prior to her appointment as manager. She is a qualified RN who has also had experience in aged care in Scotland before coming to New Zealand.

ARCC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

During any leave by the manager the role is managed in her absence by the clinical services manager (CSM) who is available to step in as required. The regional operational manager also steps up her support if the manager is taking leave. Both the CSM and the manager have management experience in the aged care sector with both maintaining RN registration. The manager took leave in July and the role was covered by the CSM.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a detailed quality and risk management plan which is reviewed annually. The current plan is for 2014-2015. The organisation's quality policy states they will provide 'service excellence without compromise through all levels of our organisation'. The plan details the responsibilities for quality in each facility specifically the facility manager and the senior clinical staff.

The manager and clinical services manager run the quality improvement programme in each facility. Feedback from residents / family / whanau and staff are invited regularly throughout the year and there will be annual resident / relative and staff surveys. There is a quality governance group which includes consultation with the regional operations manager and each facility manager. The QGG is made up of the executive team, audit & compliance manager, HR manager, project manager and the southern and northern operations managers.

A range of quality indicators will be monitored throughout 2014. These include a comprehensive range of both clinical and non-clinical indicators.

Appendix A in the quality and risk management plan includes terms of reference for the following committees: restraint approval; quality; health & safety; resident care review; resident and family; staff meetings; registered nurse meetings; quality governance team and clinical advisory group.

There is a quality improvement plan which includes an annual calendar of internal audit activity and the month when each audit is completed.

Appendix C is the organisational risk management plan. The plan has risk factors, risk categories, impact and probability scales and impact of each after controls are applied, actions to be taken to control each risk and the people (positions and committees) responsible for them. Most risks are reviewed continuously.

The manager in interview confirms reporting is done on a weekly basis and this involves data around staffing levels, financial reporting and occupancy. Monthly reports are also completed with results from internal audits and resulting corrective actions which are monitored regularly.

Policies sighted are all current with staged reviews occurring on a two year cycle. A document control system is in place. Any policies that change are sent to the facilities for updating. The manager has a set of policies as well as another set kept in the nurse's station. All staff must read all new and revised policies and sign when this has been completed.

The quality management system is informed by regular reporting and analysis of data collected from all adverse events, complaints, infection control, health and safety and restraint minimisation. Health and safety meetings are held monthly with data collected reviewed and corrective actions put in place and monitored. All information is fed into the national 'GOSH' quality system to enable national benchmarking and data analysis to be done at both facility and national levels.

Staff meetings are held monthly with quality indicators and issues are discussed and new initiatives introduced. Staff that are unable to attend must read and sign off the meeting minutes. The minutes of the 2 September 2014 meeting are sighted and the agenda covers all the relevant quality and risk reports. A newsletter is also sent out with all payslips that details relevant information for staff.

Internal audits are scheduled six months in advance. The results of these are graphed and relevant corrective actions raised if needed. The monthly reporting summarises activity in this area. The September reports are reviewed with corrective actions raised and outcomes from previous actions recorded.

The manager also completes a three monthly overview of all quality initiatives and corrective actions which are shared as appropriate at residents and family meetings and all staff forums.

All new hazards are entered into the GOSH system and each facilities hazard register is then automatically updated.

Staff interviewed all report they are involved in and kept informed of all quality activity at the facility.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

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:

Within the quality management system folder there is a detailed national policy on incident management and reporting. This states that all staff are responsible for reporting and responding to incidents and the place of analysis of incident data to assist in learning from those incidents. There is a process for escalating serious harm incidents to head office and relevant senior managers. This policy also states it is to compliment the systems for reporting and recording incidents / complaints / accidents in each facility, through reporting to head office.

In the Health and Safety policies and procedures there is a guidelines document for reporting incidents / accidents. This describes the process for completing the incident / accident report form and what action staff take once they have completed the form. There is monthly analysis of incident / accident reports and individual events are to be followed up by the staff nurse on duty daily. The policy on incident / accident reporting states that each facility will ensure that the quality committee analyses collated data

and that any serious incidents / accidents are reported to head office. There are a range of other documents (policies, procedures and guidelines) to assist staff in investigating incidents and accidents and taking appropriate action.

The UCG template quality plan includes the clinical and non-clinical indicators which are monitored and these include a range of incidents and accidents, including falls, skin tears and bruises, a range of infections (eg, skin, respiratory, urinary tract infections (UTIs)), incidents and accidents, near misses, serious and sentinel events. Non-clinical indicators include complaints, staff injuries and accidents, staff training, completion of appraisals, property / security or emergency incidents. In the infection control suite of policies there is a notifiable diseases policy which describes those diseases which are notifiable and the process to be followed for reporting them.

All incident forms are completed by the person involved and these are given to the duty RN, signed off by the CSM, given a risk rating and then they are forwarded to the manager. The manager enters them into the GOSH system and raises any corrective actions. All those with a high risk rating are immediately notified to the national audit and compliance manager who follows up the incident.

The manager confirms she reports any incidents that require essential notification to the relevant authority at the DHB or to the Occupational Safety and Health authority.

Three completed incident forms are reviewed and all required actions are taken including notification of families, GPs, police or pharmacy as appropriate. All relevant corrective actions raised are communicated to staff, reviewed, progress tracked and preventative measures implemented.

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:

ARRC requirements are met.

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In the policies provided for review there are three human resource policies: procedures for managers dealing with harassment; policy on implementing procedures; and allocation of staff duty rosters. There are two forms, a staff register and a file note form. There is another folder (Staff & Education) which has a range of documents covering staff recruitment, orientation and on-going education. There is a policy on police vetting which states that all new staff will have a police check prior to commencement of employment. Staff members working within a professional scope of practice will have their qualifications verified to ensure there are no restrictions on their scope of practice.

All recruitment is currently managed by the manager, with support from the CSM for all clinical appointments. The manager reports that when a vacancy occurs, head office manage the initial advertising then the responsibility for shortlisting, interview, reference checks and police checks is done internally by the facility. Competency checks are completed prior to any appointments. Professional qualifications are verified and filed. Other professionals who are independent of the facility also have relevant checks completed. All APCs are current and securely filed. The GP's relevant qualifications are sighted.

Nine of nine staff files reviewed have all the required documentation including police checks, reference checks, job descriptions, individual employment contracts, curriculum vitae (CVs), orientation sheets and current performance appraisals. Also included are training certificates for individuals.

All new staff receive a comprehensive orientation. For caregivers an initial session is held with the EN who takes responsibility for all training. This covers the introduction to the facility and the policies. New staff are also given an orientation pack. This has a checklist of all activity required to be completed by the person and is expected to be completed in a timely way. New staff are then paired up with a more experienced staff member for at least two days of duties. A review is completed, and then as they are able to perform required duties, they are given more responsibility. Before the end of the three month trial period a report is given to the manager with a recommendation around full employment. All staff interviewed confirm the orientation was completed and they felt competent to carry out their duties as required.

A comprehensive annual training programme is in place. A large spreadsheet detailing all the training completed by each staff member is sighted. It also has details of training sessions for the last six month period of 2014. The manager also reports she keeps individual attendance records. The CSM is responsible for the clinical training programme and facilitates outside presenters as needed. All staff are required to attend training sessions directly associated with their role as well as full staff attendance at emergency evacuations training. There are a number of modules that are compulsory for all staff and this includes training about the Code, infection prevention and control, manual handling, challenging behaviour, complaints and informed consent. All care staff must complete Aged Care Education (ACE) training and the EN is a qualified assessor and manages this programme. She has four hours a week dedicated to staff training and records reviewed evidence comprehensive training occurs for all staff at the facility.

Any staff unable to attend particular sessions have follow up on line training to complete.

An externally contracted service conduct regular training sessions for all staff on handling of chemicals and waste products. People unable to attend particular sessions will have one on one training or another opportunity in the next planning cycle. All twelve staff in interview report the training programme is relevant and they attend as required. They also confirm management are very encouraging to staff to upskill themselves.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy / guideline document in the HR policies sighted entitled 'Allocation of staff duty rosters'. This describes the process for developing rosters in each facility which provides for 'staff designations and hours will be set according to the needs of the client groups, individuals and numbers. This will take into consideration the age, gender, safety, response times, ethnic requirements, cultural mix and equipment availability (ie, hoists and hydraulic beds). Staff hours will be set to ensure that they are sufficient to provide safe care in a timely manner. This will take into account the dependency levels (NASC Assessments), time required to provide care according to the individual's lifestyle plans, infection surveillance results, incident/accident results including medication errors, staff injury and internal audit results.'

All rosters are maintained by the manager and are prepared weekly in advance using the organisational tool. The tool is able to ensure safe staffing levels as levels of need change.

The rosters are sighted for the current week of the audit and these confirm adequate cover for the acuity needs of current residents. The manager reports any absences are able to be covered internally as there is a number of 'casuals' able to be called on.

For most day shifts there are sufficient staff to have one person who is able to 'float' and assist in areas where duties may get particularly busy at certain times. Staff report this is very helpful and assists to manage workloads evenly.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Eight residents' files are reviewed and show evidence that information is entered in a timely and accurate manner in the integrated files. Staff interviewed are aware of the need to keep information confidential, and observation on the days of the audit verifies that this occurs.

Resident notes on the whole are integrated into one file. Medication records are in folders in the secure medication trolley.

Archived records are secure and retained according to legislation, and observed to be easily retrievable.

Entries on residents' files having the name and designation of the staff member included, and all clinical notes are dated. There is a register of staff signatures and designation to verify staff initials and signatures, including general practitioners.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility's entry criteria includes details about the facility, type of residents the facility is suited to, needs most able to be met, business location, full time residential and hospital services, prioritising of residents where adequate bed numbers are not available, criteria around referral processes, self-referrals, timeframes for referrers, out of hours contact if applicable, cost of services, review of service and feedback process and when the facility may ask a resident to leave the facility. The criteria are distributed to needs assessment and service coordination (NASC) agencies, other private referral agencies, the local DHB, GP practices, and on request from the general public.

The Admission Agreement was sighted and details all relevant information as required. The clinical nurse manager (CNM) and facility manager (interviewed) undertake a pre-entry risk assessment of each prospective resident in the form of a NASC assessment, and interview with resident and family to determine the suitability of the admission to the facility (records sighted).

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 clinical nurse manager (CNM) and facility manager (interviewed) undertake a pre-entry risk assessment of each prospective resident in the form of a NASC assessment, and interview with resident and family to determine the suitability of the admission to the facility. A record is retained (sighted) and referral back to the referring agency of those residents not suitable and declined.

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:

Four hospital residents' files, three rest home residents' files and one YPD resident's file are reviewed, including three residents identified for tracer methodology (hospital resident, rest home resident, disability resident). All files reviewed have an interRAI assessment completed prior to admission to the facility.

Lifestyle plans are developed within the required timeframes based on the NASC, general practitioner (GP) and detailed registered nurse (RN) assessments. The long term lifestyle care plan identifies needs/problems, goals and timeframes, and interventions in all service areas, including personal care/hygiene, skin integrity, elimination/ bowels and bladder, respiration, cardiovascular, communication and sensory, mobility, pain and comfort, safety, social/cultural needs, sexuality/intimacy, spiritual, nutrition, grief/loss/end of life, and behaviour needs.

A short term care plan has been developed if required for skin tears, wounds, infections, constipation, loose bowel motions and mobility issues, as sighted in the front of the resident's file.

Discussion with the RNs and care staff and observation during the audit provide evidence that consultation with the RN relating to service provision occurs regularly. Care staff (interviewed) are observed consulting the care plan to verify the residents' care needs. Interview with one carer verifies she provides services reflective of the care plan content for T3, who verifies that the staff are "great" and they know her unique needs.

A handover from RN to care staff in the morning shift is observed during the audit and confirms staff refer to handover notes as a reference and the content is consistent with the progress notes written for each shift (records sighted).

The facility has several GPs that visit the facility, but one who visits the majority of the residents. One GP is interviewed and confirms the facility provides a good level of care and assessments and he is always notified in a timely manner of any issue. He is advised by fax or telephone of patient/residents needs prior to his three times a week visit. He is very complimentary of the facility RNs and service provision and care provided.

Family members interviewed confirm that contact with them occurs regularly, either verbally on site or by phone, and is recorded in the family communication form and as part of the multidisciplinary team (MDT) meeting record form (records sighted).

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

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

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

The relevant ARRC requirements D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c.i; D16.5c.ii; D16.5e are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Prior to admission the NASC agency completes an interRAI assessment to ensure that the placement is appropriate, as verified in files. The CNM or the RN completes appropriate resident assessments (records sighted) on admission to the facility. Falls risks, pressure area risk, continence and nutritional assessments are completed initially and at least six monthly, but usually every three months for all residents. Information gained in the assessment tools are transferred to the resident's lifestyle plan. If required a wound assessment is completed. Goals are developed based on the nursing diagnosis and those reviewed are individualised and specific to the issue identified during the assessment process. Lifestyle care plans reviewed are detailed and easy to read for care staff, as verified in staff interviews.

The facility is using both the electronic interRAI and paper based tools for assessments, until all RNs are trained and familiar with the electronic version.

Resident files reviewed are completed in a timely manner by the RN. If an issue arises at any time, an appropriate assessment tool is completed prior to the development of a short term care plan. For example, a wound assessment and a short term care plan are developed. The short term care plan is reviewed weekly or longer depending on the issue, and closed. But if the issue continues for three months, it is transferred to the long term lifestyle care plan, including the increased risk.

The ARRC requirements D16.2 are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The FM, CNM and RNs are interviewed. Four hospital residents, three rest home residents and one YPD residents' files are reviewed. There is a comprehensive initial assessment undertaken for all patients and residents on admission to the facility, including individual assessments for pressure area risk, falls risk and nutrition (documentation sighted). On-going assessments are occurring by the RNs and allied health professionals. The information gathered from assessments is sighted to be transferred to either short term care plans, or lifestyle care plans by the resident's RN.

GP assessments and recommendations are included in both short term care plans and lifestyle care plans in files reviewed. The GP interviewed verifies that his treatment recommendations are included in short term care plans.

Residents and family members interviewed verify care provision is occurring in line with the patient and resident's identified needs, and they have on-going care plan development. Care staff interviewed confirm they refer to the short term care plans, and lifestyle plans, particularly after days off to ensure there is no change in interventions. However they are also kept fully informed by the RN on duty.

The lifestyle plan content in two of eight files reviewed does not have the recommendations from the health professional's assessment (dietitian and physiotherapist) included as interventions on the resident's lifestyle care plans and this requires improvement.

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 Low

Evidence:

There is a comprehensive initial assessment undertaken for all patients and residents on admission to the facility, including individual assessments for pressure area risk, falls risk and nutrition (documentation sighted). On-going assessments are occurring by the RNs and allied health professionals, and information is usually transferred to the resident's short term or lifestyle care plan.

The lifestyle plan content in two of eight files reviewed does not have the recommendations from the health professional's assessment (dietitian and physiotherapist) included as interventions. The dietitian's recommendations have not been provided to kitchen staff and food serving staff. For example a change in a resident's breakfast to porridge with milk and sugar for a slight weight loss, and to assist with feeding due to fatigue has not been included.

The physiotherapist's recommendations are occurring, but have not been included in the lifestyle plan.

Finding:

The lifestyle plan content in two of eight files reviewed does not have the recommendations from the health professional's assessment (dietitian and physiotherapist) included as interventions. The dietitian's recommendations have not been provided to kitchen staff and food serving staff. For example, a change in a resident's breakfast to porridge with milk and sugar for a slight weight loss, and to assist with feeding due to fatigue has not been included.

The physiotherapist's recommendations are occurring, but have not been included in the lifestyle plan.

Corrective Action:

Lifestyle care plans describe the required support as indicated in on-going assessments, including those of allied health professionals.

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility's CNM or RN documents appropriate interventions on the resident's short term or long term care plan, based on prior assessments. Lifestyle care plans reviewed are consistent with meeting the resident's identified needs and outcomes are evaluated regularly and the care plan is either updated or a short term care plan is developed. Progress notes are written by care staff and those sighted confirm residents' needs are met and service delivery is provided in a timely manner. Staff are observed providing care to residents based on the care plan intervention. For example, a resident has strategies to manage her behaviour, and this is observed occurring during the audit.

GP assessments sighted are detailed on the medical clinical form in the integrated resident's file and the subsequent intervention is included on the resident's short term care plan (sighted). For example, a resident GP recommendations and interventions to treat a wound is included on the patient's short term care plan.

Residents and family interviewed confirm service delivery is consistent with meeting the resident's desired outcomes and they are involved in the review process, as evidenced in the family communication form and residents' MDT team meetings (records sighted).

The ARRC requirements D16.1a; D16.1b.i; D16.5a; D18.3; D18.4 are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: CI

Evidence:

Eight resident files are reviewed (four hospital, three rest home and one disability resident). The activities person, a diversional therapist (DT) is interviewed. The DT develops the activity programme each month following an activities meeting (minutes sighted).

The DT implements activities for residents Monday to Sunday. There are two activities staff job sharing the role. A social profile is developed on admission to the facility in all those files that are reviewed. An activity plan is developed following the completion of the resident's long term care plan. Activity plans are reviewed three monthly in line with the lifestyle care plan, identifying progresses and attendance at either group or individual activities. Lifestyle plans reviewed are detailed, individualised and specific to the resident's interests from their social profile.

The general activity programme includes local shopping, church services, bowls, men's shed activities and visit, reading, quizzes, puzzles, housie, entertainers, movies, outings, sing a longs, exercises, stories and word games.

Residents and family members interviewed confirm there is always something to do at the facility and five residents interviewed are very complimentary of the recent project of the worm farm. This project commenced about one year ago, to create an alternative activity to give residents more choice with the ability to take personal ownership with skill sets they had prior to entering the facility. This is identified as a continuous improvement activity.

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: CI

Evidence:

Residents and family members interviewed confirm there is always something to do at the facility and five residents interviewed are very complimentary of the recent project of the worm farm. This project commenced about one year ago, to create an alternative activity to give residents more choice with the ability to take personal ownership with skill sets they had prior to entering the facility.

With the rural setting and large unused areas of the garden, many residents had previously worked outside, and this was recognised during a meeting with the residents, and a survey to gain information on how best to utilise the grounds and the resident's skills. Residents were asked for improvements and suggestions for the external environment.

The outcome and analyses of the information showed the residents interest in developing garden pots, a rose competition from the potted roses, a vegetable garden with raised beds and a worm farm.

The worm farm has provided increased resident activity for two residents in particular who had not shown any interest in activities and had become less involved and more compromised as a result of inactivity. The residents are now involved in the garden, in maintaining the worms and have improved functioning and engagement in conversation as a result of the worm farm. The residents and one family member are interviewed, and verify they now have a purpose in life and the worm farm has improved their overall wellbeing and functioning. This positive outcome for the residents exemplifies continuous improvement principles.

Finding:

Residents were asked for improvements and suggestions for the external environment. The outcome and analyses of the information showed the residents interest in developing garden pots, a rose competition from the potted roses, a vegetable garden with raised beds and a worm farm. The worm farm has provided increased resident activity for two residents in particular who had not shown any interest in activities and had become less involved and more compromised as a result of inactivity. The residents are now involved in the garden, in maintaining the worms and have improved functioning and engagement in conversation as a result of the worm farm. Two residents and one family member are interviewed, and verify they now have a purpose in life and the worm farm has improved their overall wellbeing and functioning. This positive outcome for the residents exemplifies continuous improvement principles.

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:

The facility's CNM is interviewed along with the RN regarding care plan evaluations. Eight residents' files are reviewed (four hospital, three rest home and one YPD) and all are evaluated three monthly in line with required timeframes and the facility's policies. Assessments are completed prior to the review of the care plan. The facility also evaluates residents' care if progress is less than expected, using the relevant assessment tools. A short term plan is then developed indicative of the resident's changed needs. Records were sighted include short term care plans reflective of their changed needs, and evaluations are included following resolution of these.

Residents and family members interviewed verify they are included in care plan evaluations as part of the MDT process (records sighted) and there is evidence of this also documented in the residents' progress notes, and the family communication form (records sighted). Care staff interviewed are able to demonstrate knowledge in following short term care plans and evaluations when needs change. Observed during the audit, the RN and care staff discussing a short term care plan developed as a result of an updated evaluation.

The ARRC requirements D16.3c; D16.3d; D16.4a are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Eight residents' integrated files are reviewed and the CNM and the RN are interviewed. Six of six files, were reviewed have evidence of referral to other health and disability services. For example, two residents have been referred to the physiotherapist. Five residents' referral is to a dietitian. Referrals are included in the integrated notes (sighted). The physiotherapist, podiatrist and dietitian documents their assessments and recommendations in the residents' integrated notes (records sighted).

The CNM (interviewed) confirms that, if required, the facility will accompany residents on appointments if the family member is unavailable. This is verified in family member interviews.

The ARRC requirements D16.4c; D16.4d; D20.4 are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

One discharged resident's file is reviewed, and one transfer to and from hospital. The FM and the CNM are interviewed and verify that all discharges include the involvement of the resident, the family and GP and this is confirmed in documentation sighted. A discharge or transfer form is completed (sighted) and details any persons involved, any risks and measures to minimise the risk. A 'yellow transfer folder' is prepared for all transfers to hospital, with all appropriate documentation included (sighted). This is completed by the hospital on transfer back to the facility and retained in the residents' integrated notes.

The discharge file reviewed is completed with evidence of family and GP involvement prior to the discharge and ensuring the resident's medications are available following discharge.

The ARRC requirements D21 are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Within the clinical procedures there is a suite of medication related documents. Policies and procedures for medication management include each health professional's responsibility in relation to medicine prescribing, administration, reconciliation, dispensing, storage and disposal.

The facility has a blister pack medication system in place for all residents requiring medication assistance. The blister packs are reconciled into the facility by the CNM monthly. Discontinued medications are returned to the pharmacy at least daily if required, including controlled medications as sighted in records signed by the RN and the pharmacist.

The resident's prescription medication record is completed by the resident's GP and administered by the facility care staff. The initial record is legible and each record signed individually by the GP although not always when discontinued and this requires improvement. Some records are scribbled out when discontinued and this also needs improvement. If there are changes in the medication record, the prescriber faxes medication prescriptions to the facility, and the original is archived, but not updated at his next visit and this also needs addressing.

Two RNs are observed administering medications on the days of the audit. Both have medication competencies sighted. The medication trolley holds all current medication, blister packs and medication records and is observed to be locked and securely stored when not in use.

Controlled drugs are reviewed and storage is in line with guidelines. There is a separate medication fridge and temperatures are recorded (observed) and within recommended guidelines.

Eighteen medication files are reviewed. The sample has been extended to provide conformity. PRN (pro re nata) medication is recorded to a level of detail to indicate the intended use, for example for nausea, chest pain, coughing and pain.

There is one resident who self-medicates, and this occurs in line with policies, procedures and resources provided (observed and documents sighted).

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 facility has a blister pack medication system in place for all residents requiring medication assistance. The blister packs are reconciled into the facility by the CNM monthly. Discontinued medications are returned to the pharmacy at least daily if required, including controlled medications as sighted in records signed by the RN and the pharmacist.

The resident's prescription medication record is completed by the resident's GP and administered by the facility care staff. The initial record is legible and each record signed and dated individually by the GP, although not always in ten of eighteen files reviewed, when discontinued and this requires improvement. Three records are scribbled out when discontinued and this needs improvement. If there are changes in the medication record, the prescriber faxes medication prescriptions to the facility and the original is archived, but not updated at his next visit.

Fourteen files reviewed are faxed forms, and the original document has not been updated as required in medication care guidelines, or is not in the medication folder but archived

Finding:

Eighteen medication files are reviewed. Ten of eighteen files reviewed are either not signed or dated when they are discontinued. Three medication records have the item scribbled out, rather than a single line, so the written medication is not identifiable.

Fourteen files reviewed are faxed forms, and the original document has not been updated as required in medication care guidelines, or is not in the medication folder but archived.

Corrective Action:

Medication management is implement to ensure safe prescribing and in line with the residential aged care medication guidelines.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures are reviewed and in place for all aspects of food service, delivery, preparation, service, storage and disposal and cleaning.

A nutritional audit of the menus has been undertaken by a dietitian in September 2014 (sighted). The menu content on the day of the audit reflects the version in use by the facility, and the dietitian's recommendations have been implemented. One chef (interviewed) manages the kitchen and shares the food preparation responsibilities with another cook. Kitchen duties are shared among other care and kitchen staff, depending on who is on duty at the time.

Dietary profiles are written on admission (eight of eight dietary profiles are reviewed), and these include likes and dislikes, preferences for beverages, and any other special dietary instructions. The RN or CNM will usually inform the kitchen if there are any changes in dietary requirements (refer criteria 1.3.5.2). Residents' preferences are listed and catered for and sighted on the kitchen notice board. This is verified in resident and family interviews.

Residents and family members interviewed also confirm there is variety in the food provided, and meets their needs. The facility has recently introduced breakfast choices on a daily basis, which is an initiative introduced by the chef. This initiative led to a survey provided to all residents on what they would like as a choice for a cooked Saturday breakfast menu. Each resident or their family member completed the survey, and the chef commenced residents' cooked choice breakfasts on every second Saturday. Off duty kitchen staff came into help with the cooked choices of bacon and eggs, pancakes, waffles, sausages and mushrooms.

The cooked breakfast initiative was analysed through a further survey, with all those receiving the cooked breakfast giving feedback on whether this should continue and be increased to occur every Saturday. The results confirmed over 90% approval of the breakfast initiative, with improved health benefits identified for the residents, increased weight for those who had previously been identified as losing weight, and overall liked by all. This initiative exemplifies continuous improvement principles.

There are some weight issues with residents, however these are being managed appropriately with supplements, GP and dietitian intervention. Observation of meal service confirms that residents enjoy the meals provided. A review of residents' meetings minutes and survey results verifies that discussion regarding food are complimentary, particularly in relation to the cooked breakfast initiative.

Food and fridge temperatures are recorded and those reviewed are within recommended guidelines.

The ARRC requirements D1.1a; D15.2b; D19.2c are met.

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

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

Attainment and Risk: CI

Evidence:

Residents and family members interviewed confirm there is variety in the food provided and this meets their needs. The facility has recently introduced breakfast choices on a daily basis, which is an initiative introduced by the chef. This initiative led to a survey provided to all residents on what they would like as a choice for a cooked Saturday breakfast menu. Each resident or their family member completed the survey, and the chef commenced residents' cooked choice breakfasts on every second Saturday. Off duty kitchen staff came into help with the cooked choices of bacon and eggs, pancakes, waffles, sausages and mushrooms.

The cooked breakfast initiative was analysed through a further survey, with all those receiving the cooked breakfast giving feedback on whether this should continue and be increased to occur every Saturday. The results confirmed over 90% approval of the breakfast initiative, with improved health benefits

Finding:

Residents and family members interviewed confirm there is variety in the food provided and this meets their needs. The facility has recently introduced breakfast choices on a daily basis, which is an initiative introduced by the chef. This initiative led to a survey provided to all residents on what they would like as a choice for a cooked Saturday breakfast menu. Each resident or their family member completed the survey, and the chef commenced residents' cooked choice breakfasts on every second Saturday. Off duty kitchen staff came into help with the cooked choices of bacon and eggs, pancakes, waffles, sausages and mushrooms.

The cooked breakfast initiative was analysed through a further survey, with all those receiving the cooked breakfast giving feedback on whether this should continue and be increased to occur every Saturday. The results confirmed over 90% approval of the breakfast initiative, with improved health benefits

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a 'chemicals / hazardous substances' protocol which provides a number of instructions around handling chemicals, storage of chemicals / hazardous substances and procedure to be followed after chemical / hazardous substance spill. There are references to chemicals and cleaning products provided by an externally contracted service and material safety data sheets for their use.

The waste management policy requires adequate training, the use of data safety sheets, special considerations for Maori residents and the use of protective clothing. It has guidelines for handling and disposal of all chemicals and hazardous substances.

Within the infection control documentation is a waste management section which includes policy and procedures for waste (blood and bodily fluids) management and disposal. In the waste management policy staff are instructed to report any exposure to waste / substances or needle stick injuries using the incident / accident reporting procedures.

The door to the cleaning store is locked as is the door to the laundry where cleaning products are in use. An outside storage shed is also used to store chemicals and this is locked at all times. A contracted service supplies all chemicals and cleaning products with relevant training. In the laundry, notices are displayed detailing all chemicals in use, instructions for safe use and what to do if there is a spill. Cleaning products are all colour coded for ease of identification. The cleaner's trolleys have a limited amount of labelled cleaning products on them. These are securely stored when not in use.

The person who manages the laundry for the facility was able to detail process and procedures required for the safe use of any chemicals. Care staff demonstrated the process for the safe disposal of waste products and the colour coded waste disposal bags clearly marked.

Aprons, gloves and masks are provided in the sluice rooms and in all areas where personal cares are involved, the laundry and the cleaning stores. Staff are observed using these throughout the facility as appropriate. Large 'outbreak bins' are located the emergency storage areas.

All incidents are reported and documented, then entered into the GOSH quality management system. Both clinical and non-clinical staff report they are clear about the process for incident reporting in this area.

ARRC requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The building warrant of fitness (WOF) is sighted and expires on 15 June 2015. The facility has a building certificate of compliance with maintenance and reporting procedures dated 29 June 2014. All electrical equipment is checked and calibrated regularly with records kept by the facility maintenance manager.

The access ways are wide enough that any mobility aids are able to be stored without impeding access. A specific area is available for the storing and charging of mobility vehicles.

The outside areas are easily accessed and very well maintained. There is a variety of areas for residents to use and a new area which is currently being completed will have raised vegetable gardens for the residents to grow fresh vegetables. A number of residents are observed making the most of the sunny weather and sitting outside in the fresh air during the audit.

ARRC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

The facility has adequate accessible shower and toilet facilities. There are only two rooms without their own ensuite or access to a shared ensuite. These two have easy access to toilet and shower facilities close by. All the facilities are hygienic and well maintained with privacy locks installed. There are also a number of toilets for all residents to use in various parts of the facility. Clear labels are used to identify all facilities as appropriate with one fully compliant disabled toilet available.

Hand sanitizers are sighted in all areas of the facility including all communal areas, entrances, residents' rooms, hallways and staff areas.

ARRC requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a range of rooms available to suit resident's needs. These range from seven spacious apartments with kitchenettes to large single rooms to cater for those who require the use of hoists and wheelchairs easily. While the facility is an older one, the rooms are very clean with well-maintained fixtures and residents personalising their own environments according to their tastes.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Karadean has three separate dining areas and a number of areas where residents can gather if they wish. The main lounge is very spacious and a number of activities are held there. There are two smaller conservatories, a library and a lounge area to cater for the area where the apartments are located. All areas are available for use by all residents and families with good sunlight.

ARRC requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a specific laundry policy which outlines the aims and outcomes expected from the laundry services. There are procedures for the key tasks, times and frequency when these are carried out. Treatment and cleaning of soiled laundry procedures are clearly documented and clear definitions of the process for clean and dirty areas. Stained and/or damaged laundry and transportation of infectious linen is all detailed. There are three audit tools for laundry services: condition of linen; handling of linen and laundry cleanliness; and laundry services audit.

The laundry chemicals are all supplied by an externally contracted service. They are all colour coded and well labelled. Training is given regularly to personnel involved in the laundry and cleaning. This is confirmed by relevant staff interviewed. The laundry manager is aware of all procedures should a spill occur and she reports all chemicals are maintained by the contracted service on a monthly or as required basis if this is needed more frequently. All laundry is sorted into colour coded bags which separates the soiled and dirty linen and personal clothing. Any soiled laundry has been through the sluice room process prior to arrival at the laundry. The process for washing linen is observed and follows the policy requirements.

Product data sheets are displayed in the laundry area, which has the required doors for dirty and clean laundry, with well-marked areas for management of this. The door is kept locked and accessed via keypad.

An externally contracted service manages all the cleaning supplies. They also ensure relevant training occurs. In the quality management / audit documents there is a selection of internal audit tools, under 'household' for cleanliness, cleanliness of rooms and cleaning services. The standard of cleanliness throughout the facility during the audit is of a very high standard. All staff are observed using protective clothing during their work. Their trolleys are locked away when not in use and all cleaners are stored securely.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are policies / procedures and guidelines for emergency planning, preparation and response. There is a civil defence plan template document which is drafted and requires each facility to enter in their own local information (eg, telephone numbers and addresses for the civil defence centre and emergency response centre, where and how much emergency water is held on site, the location of fire suppression equipment in the facility, the evacuation plan and assembly point).

There are disaster planning guides which direct the facility in their preparation for disasters and describe the procedures to be followed for fire evacuations and regular practices. There is a list of what supplies are to be in the emergency pack.

The last fire evacuation drill attended by the fire department was held on 9 September 2014 and these are held six monthly. The dedicated fire warden is the health and safety representative who has completed stage one to three health and safety qualifications. The RN's take this role outside of normal working hours. The fire warden reports regular training is provided for all staff and is a compulsory part of the orientation programme. The manager has also completed stage one and two of the health and safety qualification.

The health and safety committee meet monthly and discuss all incidents and accidents and ensure hazards are eliminated or controlled across the facility.

The approved evacuation plan was approved by the Transalpine Fire Region in April 1999. Annual testing of the sprinkler system is undertaken and the alarm system is observed being tested on the day of audit.

If there is a power failure there is an emergency system that will run for two hours. All residents on oxygen use bottled oxygen so there is no risk should an outage occur. If there is a prolonged failure, civil defence in the area will be contacted to provide a back-up generator. The emergency supplies are sighted in three different areas of the facility and they contain torches, batteries, glo sticks, blankets, beanies and continence supplies. Pandemic boxes are also stored in the different areas as well as the nurses' station. Cooking facilities include both gas and electricity.

The electronic call system is linked to the emergency signal with continuous ringing. The call system has identifying signs along all corridors and in the nurses' station to alert staff as to which resident is requiring attention. The manager does informal audits to ensure calls are answered in a timely way. During the audit bells were observed to be answered very quickly.

Due to the rural nature of the service there is no need for a formal security arrangement with an outside contractor. The doors are locked at dusk and every room is checked to ensure it is secure at night. The only way in after dark is through the front door. This is monitored by a call bell connected to the system to alert staff someone is at the door.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: The facility is spacious, light and well ventilated. As the audit is conducted during a cooler month, the heating is fully operational and the environment is warm and comfortable. Heat pumps are used to supplement heating in larger areas if required. All residents and communal rooms are bright and airy with outside opening windows or sliding doors.

ARRC requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The organisation has a suite of policies, procedures and forms in relation to the use of restraints and enablers. There is a definition of restraint which is consistent with these standards, as is the definition of enabler. There is a flow chart to guide the decision making before any restraint is considered and a consent process for residents / family / whanau or EPOA. There are forms for consent, application, approval group recommendations, monitoring and review.

Each facility will have a restraint coordinator and a restraint approval group. The approval group must approve the use of any restraint for a resident before it is utilised with that person.

The facility has a philosophy of no restraint use and there are no episodes of restraint being used at the time of audit.

There is a restraint register which is to be maintained in each facility. This includes a 'key' for the purpose of the restraint; whether the person is at risk of falls, a risk to themselves or a risk to others.

Education is provided to all staff as a compulsory module at orientation and includes reading the restraint and enabler policies and procedures, and watching a video on restraint minimisation and safe practice from the ACE education dementia series. There is a questionnaire for ancillary staff and caregivers / hospital staff. There is a competency assessment which is reviewed and assessed by the training coordinator at the facility.

Annual training is also provided and the range of people with expertise in gerontology are invited to present that training as well as the availability of an on line module as required. Staff interviewed confirm regular training in the use of restraints and enablers occurs along with modules on working with people with challenging behaviours.

The only use of an enabler currently in place is used by a person who comes to the facility for respite care and has requested the use of bedrails for personal safety. The register is sighted for the last visit and all relevant consents, assessments, approvals and reviews are in place. Regular monitoring is undertaken and records of these are sighted as completed as required.

The restraint / enabler committee meets at least three monthly to review the use of enablers and to ensure all processes have been followed. All records from the previous meeting in August 2014 are documented and reflect a sound process being followed.

ARRC requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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:

Infection control policies and procedures are reviewed and include the role and responsibility for infection control, the link to the quality meetings and organisational management. The infection control (IC) programme is sighted and reviewed annually. There are distinct lines of accountability and this is approved by the FM. All requirements of the IC standard are included. The CNM (interviewed) is the IC co-ordinator. The CNM collects all data monthly and documentation is provided to the FM for review and analysis, providing a summarised report at the quality meeting (meeting records sighted). A report is developed and provided to staff at their monthly meeting (records sighted). Care staff interviewed are able to demonstrate their knowledge on observing, reporting and documenting infections.

The facility's front entrance notice requests persons with 'flu' not to visit and hand gel is available at the front door and throughout the facility for any visitor or resident to use. The facility has recently increased the number of hand gel dispensers in a trial to decrease urinary tract infections (UTI's), and initial results show this has been successful.

If there are any internal infections, the facility has processes in place to prevent visitors and to isolate the infection. There has been no internal infections in recent years.

The ARRC requirements D5.4e are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The CNM is the IC co-ordinator and with the FM share responsibilities implementing the infection prevention programme. The CNM and the FM have experience and have attended relevant on-going training in IC (records sighted). The CNM documents resident specific IC information, including treatments and conclusions, and provides monthly reports to the FM who analyses the data and tables a summary to the quality meeting monthly (records sighted). A report is included in the agenda for monthly staff meetings (minutes sighted).

Expert advice is gained from the IC specialist and microbiologist at the Christchurch DHB and the resident's GP as required for any resident with an infection (confirmed in GP interview).

Residents and family interviewed verify they are advised of infections and treatments. Observed throughout the facility is hand gel and soap dispensers and education on hand hygiene on walls above hand basins. The facility has an up to date outbreak kit (sighted). There have been no reported recent outbreaks of infections.

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:

Infection control is included in the organisation's quality plan and clinical indicators which the facility and the wider organisation monitors. There is an infection control manual with sections: infection and management, infection control, quality and risk management, infection control staff and health practices, policies and procedures, waste management and public health fact sheets.

Within the quality management system there are a range of documents / guidelines/ policies and procedures relating to infection prevention and control practice, staff responsibilities, surveillance of infections and actions to be taken to both prevent and respond to infections when they occur. The CNM has IC co-ordinator sighted as included in her job description.

The FM interviewed states that as a reference the facility uses an expert external infection control organisation's guide to ensure policies and procedures remain current.

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 CNM and the FM are experienced in IC and documents sighted verify that they provide relevant initial and on-going education for staff. IC education is provided initially on induction (eight staff files reviewed), and then annually as part of the internal education programme (records sighted). A record is sighted of the past two IC education sessions content. Staff attendance records sighted are also retained.

Care staff interviewed confirm their participation in IC training and are observed to demonstrate IC practices. A notice at the front entrance and above communal hand basins provides visual aid in the correct hand hygiene methods. One of one family member interviewed confirms that staff have advised him of IC practices to undertake prior to attending, and assisting with his mother.

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:

A form sighted for the purpose of collecting monthly data on all infections is maintained by the RN in the facility's office. The CNM collects the monthly report sheets and the information is transferred to an organisation wide electronic data analyses sheet (sighted), listing specific infections of urinary tract, skin and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections. This gives an up to date analyses of trends and patterns.

Documentation sighted includes the collection, collation and analysis of information on infections and the measurement of incidence and recommendations for minimising infections.

Evidence in the last two quality meeting minutes and staff meeting minutes verify that IC surveillance, analyses, conclusions and specific recommendations to minimise reduction in infection have been documented and reported to the organisation. The facility has implemented increased hand hygiene initiatives in an initiative to reduce infections, and preliminary data shows this has had an effect.

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.)*