

Mission Rest Home Limited

Current Status: 29 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

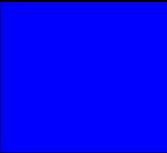
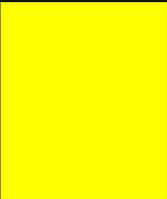
Mission Rest Home provided residential care for up to 31 residents who required rest home level care. The facility also provided accommodation for up to six boarders in independent living units on the first and second floors of the facility. The company is owned by a charitable trust, namely the Institute De Notre Dame Des Missions Trust Board.

Five areas were identified as requiring improvement during this audit relating to residents documentation, care planning and completion of corrective action plans.

Audit Summary as at 29 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
	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 29 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 29 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.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 29 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 29 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 29 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 29 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 29 October 2014

Consumer Rights

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, was accessible and was brought to the attention of residents' (if able) and their families on admission to the facility. Residents and family members interviewed confirmed that their rights were met during service delivery, that staff were respectful of their needs and communication was appropriate.

During interview residents and family confirmed that consent forms are provided and they are informed. Residents and family also advised that time was provided if discussions and explanation were required. Residents and family interviewed provided positive feedback on the care provided.

The facility manager was responsible for management of complaints and a complaints register is maintained.

Organisational Management

Mission Rest Home Limited was the governing body and was responsible for the service provided at Mission Rest Home. Planning documents reviewed included a business plan, a mission statement, values, and philosophy. An organisational chart was also reviewed.

A facility manager, who is a registered nurse, was responsible for the management of the facility, including oversight of clinical care. The facility manager was supported by two other registered nurses and registered nurse cover was provided seven days a week.

There was evidence that quality improvement data had been collected, collated, and analysed to identify trends and improve service delivery and that this information had been reported to the governing body and to staff. There was an internal audit programme in place and internal audits had been completed. Improvements are required as corrective action plans had not been consistently developed to address areas identified as requiring improvement. Risks had been identified and the hazard register had identified health and safety risks documented as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events had been documented on accident/incident forms.

There were policies and procedures on human resources management and the validation of current annual practising certificates for health professionals who required them to practice had occurred. In-service education had been provided for staff at least monthly. Staff were also supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care. Review of staff records provided evidence human resources processes had been followed and individual education records had been maintained.

There was a documented rationale for determining staffing levels and skill mix and the minimum number of staff was provided during the night shift and consisted of two care givers. The facility manager and the registered nurses share the after-hours on call and were available if required. Care staff interviewed reported there was adequate staff available and that they were able to get through their work.

Resident information was entered into a register in an accurate and timely manner although improvements are required as staff writing in all of the care plans was not always easy to decipher.

Continuum of Service Delivery

The systems were implemented that evidenced each stage of service provision had been developed with resident and/or family input and was coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. The residents interviewed confirmed that interventions noted in their care plans were consistent with meeting their needs.

A sampling of residents' clinical files validated the service delivery to the residents. Where progress was different from expected, the service responded by initiating changes to the care plan or recording the changes on a short term care plan.

There are areas identified as requiring improvement around completion of risk assessments, NASC reassessments, weight monitoring, care plan interventions and care plan reviews.

Planned activities were appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. The residents' files sampled evidenced individual activities were provided either within group settings or on a one-on-one basis.

There was an appropriate medicine management system in place. Policies and procedures clearly detailed service provider's responsibilities. Staff responsible for medicine management had attended in-service education for medication management and had current medication competencies. The resident who self-administers medicines did so according to policy.

Food, fluid, and nutritional needs of residents were provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There was a central kitchen and on site staff that provided the food service. The kitchen staff had completed food safety training.

Safe and Appropriate Environment

With one exception, accommodation for residents was provided in single bedrooms and all bedrooms had wash hand basins. Residents' rooms were observed to be of varying sizes and adequate personal space was provided in bedrooms.

Lounge, activities room and a large dining area were available, as well as a chapel and additional areas for residents to sit. External areas were available for sitting and shading was provided in these areas. An appropriate call bell system was available and security systems were in place.

Visual inspection provided evidence of sluice facilities, safe storage of chemicals, soiled linen and equipment, and that protective equipment and clothing was provided and was used by staff. Review of documentation provided evidence there were appropriate systems in place to ensure the residents' physical environment was safe, and facilities were fit for their purpose.

There were policies and procedures for waste management, cleaning and laundry, and emergency management and these were known by staff. All laundry was washed on site and cleaning and laundry systems included appropriate monitoring systems in place that evaluated the effectiveness of these services.

Restraint Minimisation and Safe Practice

The restraint policy, procedures and the definitions of restraint and enabler were congruent with the restraint minimisation and safe practice standard. The approval process for enabler use was activated when a resident voluntarily requested an enabler to assist them to maintain independence and/or safety. There was one resident using restraint and one resident using an enabler on audit days.

There was evidence the restraint was applied as last resort and recorded consent by family for the restraint use was obtained. The service provider's documentation evidenced a restraint register that recorded sufficient information to provide an auditable record of restraint use. Staff education in restraint, de-escalation and challenging behaviour had been provided.

Infection Prevention and Control

The infection prevention and control policies included guidelines on prevention and minimisation of infection and cross infection, and contained all requirements in the standard. The policies and procedures guide staff in all areas of infection control practice. New employees were provided with training in infection control practices and there was on-going infection control education available for all staff.

Infection control was a standard agenda item at facility's meetings. Staff interviews confirmed staff were familiar with infection control measures at the facility.

The infection control surveillance data was sampled through resident records and collated infection reports. The information sampled confirmed that the surveillance programme was appropriate and fully implemented. Surveillance for residents who develop infection were collated at the end of each month and reported to staff at meetings.

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:	Mission Rest Home Limited
Certificate name:	Mission Rest Home Limited
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Certification Audit
Premises audited:	Mission Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 October 2014 End date: 30 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:

20

Audit Team

Lead Auditor	XXXXXXXX	Hours on site	13	Hours off site	10
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Other Auditors	XXXXXXXX	Total hours on site	13	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXX			Hours	3

Sample Totals

Total audit hours on site	26	Total audit hours off site	17	Total audit hours	43
Number of residents interviewed	4	Number of staff interviewed	11	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	22	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	0

Declaration

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

I confirm that:

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

Dated Wednesday, 5 November 2014

Executive Summary of Audit

General Overview

Mission Rest Home provides residential care for up to 31 residents who require rest home level care. The facility also provides accommodation for up to six boarders in independent living units on the first and second floors of the facility. The facility is operated by Mission Rest Home Limited, a charitable trust.

Five areas were identified as requiring improvement during this audit relating to residents documentation and completion of corrective action plans.

Outcome 1.1: Consumer Rights

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, was accessible and was brought to the attention of residents' (if able) and their families on admission to the facility. Residents and family members interviewed confirmed that their rights were met during service delivery, that staff were respectful of their needs and communication was appropriate.

During interview residents and family confirmed that consent forms are provided and they are informed. Residents and family also advised that time was provided if discussions and explanation were required. Residents and family interviewed provided positive feedback on the care provided.

The facility manager was responsible for management of complaints and a complaints register is maintained.

Outcome 1.2: Organisational Management

Mission Rest Home Limited was the governing body and was responsible for the service provided at Mission Rest Home. Planning documents reviewed included a business plan, a mission statement, values, and philosophy. An organisational chart was also reviewed.

A facility manager, who is a registered nurse, was responsible for the management of the facility, including oversight of clinical care. The facility manager was supported by two other registered nurses and registered nurse cover was provided seven days a week.

There was evidence that quality improvement data had been collected, collated, and analysed to identify trends and improve service delivery and that this information had been reported to the governing body and to staff. There was an internal audit programme in place and internal audits had been completed. Improvements are required as corrective action plans had not been consistently developed to address areas identified as requiring improvement. Risks had been identified and the hazard register had identified health and safety risks documented as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events had been documented on accident/incident forms.

There were policies and procedures on human resources management and the validation of current annual practising certificates for health professionals who required them to practice had occurred. In-service education had been provided for staff at least monthly. Staff were also

supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care. Review of staff records provided evidence human resources processes had been followed and individual education records had been maintained.

There was a documented rationale for determining staffing levels and skill mix and the minimum number of staff was provided during the night shift and consisted of two care givers. The facility manager and the registered nurses share the after-hours on call and were available if required. Care staff interviewed reported there was adequate staff available and that they were able to get through their work.

Resident information was entered into a register in an accurate and timely manner although improvements are required as staff writing in all of the care plans was not always easy to decipher.

Outcome 1.3: Continuum of Service Delivery

The systems were implemented that evidenced each stage of service provision had been developed with resident and/or family input and was coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. The residents interviewed confirmed that interventions noted in their care plans were consistent with meeting their needs.

A sampling of residents' clinical files validated the service delivery to the residents. Where progress was different from expected, the service responded by initiating changes to the care plan or recording the changes on a short term care plan.

There are areas identified as requiring improvement around completion of risk assessments, NASC reassessments, weight monitoring, care plan interventions and care plan reviews.

Planned activities were appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. The residents' files sampled evidenced individual activities were provided either within group settings or on a one-on-one basis.

There was an appropriate medicine management system in place. Policies and procedures clearly detailed service provider's responsibilities. Staff responsible for medicine management had attended in-service education for medication management and had current medication competencies. The resident who self-administers medicines did so according to policy.

Food, fluid, and nutritional needs of residents were provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There was a central kitchen and on site staff that provided the food service. The kitchen staff had completed food safety training.

Outcome 1.4: Safe and Appropriate Environment

With one exception, accommodation for residents was provided in single bedrooms and all bedrooms had wash hand basins. Residents' rooms were observed to be of varying sizes and adequate personal space was provided in bedrooms.

Lounge, activities room and a large dining area were available, as well as a chapel and additional areas for residents to sit. External areas were available for sitting and shading was provided in these areas. An appropriate call bell system was available and security systems were in place.

Visual inspection provided evidence of sluice facilities, safe storage of chemicals, soiled linen and equipment, and that protective equipment and clothing was provided and was used by staff. Review of documentation provided evidence there were appropriate systems in place to ensure the residents' physical environment was safe, and facilities were fit for their purpose.

There were policies and procedures for waste management, cleaning and laundry, and emergency management and these were known by staff. All laundry was washed on site and cleaning and laundry systems included appropriate monitoring systems in place that evaluated the effectiveness of these services.

Outcome 2: Restraint Minimisation and Safe Practice

The restraint policy, procedures and the definitions of restraint and enabler were congruent with the restraint minimisation and safe practice standard. The approval process for enabler use was activated when a resident voluntarily requested an enabler to assist them to maintain independence and/or safety. There was one resident using restraint and one resident using an enabler on audit days.

There was evidence the restraint was applied as last resort and recorded consent by family for the restraint use was obtained. The service provider's documentation evidenced a restraint register that recorded sufficient information to provide an auditable record of restraint use. Staff education in restraint, de-escalation and challenging behaviour had been provided.

Outcome 3: Infection Prevention and Control

The infection prevention and control policies included guidelines on prevention and minimisation of infection and cross infection, and contained all requirements in the standard. The policies and procedures guide staff in all areas of infection control practice. New employees were provided with training in infection control practices and there was on-going infection control education available for all staff.

Infection control was a standard agenda item at facility's meetings. Staff interviews confirmed staff were familiar with infection control measures at the facility.

The infection control surveillance data was sampled through resident records and collated infection reports. The information sampled confirmed that the surveillance programme was appropriate and fully implemented. Surveillance for residents who develop infection were collated at the end of each month and reported to staff at meetings.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	45	0	2	3	0	0
Criteria	0	96	0	2	3	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Corrective action plans are not being consistently documented to address shortfalls identified in internal audits.	Provide documented evidence that corrective action plans are being consistently developed and monitored to address any shortfalls identified.	90
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.9	All records are legible and the name and designation of the service provider is identifiable.	PA Low	Hand written care plans in two of five resident files reviewed are difficult to read.	Provide confirmation that care plans are legible.	60
HDS(C)S.2008	Standard 1.3.4:	Consumers' needs, support	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Assessment	requirements, and preferences are gathered and recorded in a timely manner.				
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Risk assessments are not consistently completed, one resident's reassessment by the NASC team has not been conducted and one resident's weight has not been monitored for over four months.	Provide evidence the risk assessments, NASC reassessments and weight monitoring are conducted in timely manner.	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	There is inconsistent documentation of residents' care plan interventions consistent with meeting residents' needs.	Provide evidence the care plans record detailed interventions that contribute to meeting the residents' needs.	90
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	Three of five residents' care plans have not been evaluated six monthly. The restraint (one of one) and enabler (one of one) reviews do not include all the criteria of the restraint minimisation criterion 2.2.4.1.	Provide evidence care plans are reviewed six monthly and restraint and enabler evaluations include all items in the restraint criterion 2.2.4.1.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

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

Residents (four rest home) and family members (two) are able to verify that services are provided with dignity and respect, privacy is maintained, and individual needs and rights are upheld. These findings are also confirmed during review of the responses in the completed resident and family survey questionnaires that were completed in July 2014. The collated results indicate the majority of the respondents are 'satisfied' or 'very satisfied' with service delivery.

Interviews with staff (the facility manager, one registered nurse, five care givers working morning, afternoon and night shifts, one activities co-ordinator, the chaplain and the advocate) demonstrate an understanding of resident rights. Education records reviewed indicate that staff attend training in resident rights as part of their orientation as well as part of the ongoing education programme. This education was last provided in September 2014 by the Health and Disability Advocate.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

The Code of Rights and information on the advocacy service are displayed and are available at the facility. This information is provided as part of the pre-admission and information packs.

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

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

Residents interviewed confirm they have access to an advocate and one may be appointed if needed. Residents' meetings are held monthly and review of these meeting minutes indicates residents are aware of their rights. A resident survey and a relative survey were completed in July 2014 and the collated results and completed questionnaires reviewed indicate residents and family are aware of their rights and are satisfied with this aspect of service delivery.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of residents and a family member and during review of the collated results of the completed satisfaction surveys for residents and family completed in July 2014.

Staff receive training on abuse / neglect as part of the annual in-service education day that was last provided in June 2014. Staff are observed knocking before entering residents' rooms and keeping doors closed or drawing the privacy screen while attending to residents. Care staff demonstrate an awareness of residents' rights and the maintenance of professional boundaries.

With one exception, all bedrooms provide single accommodation. This room is currently empty. (See link 1.4.4)

Activities in the community are encouraged and the facility manager advises during interview that some of the residents attend community events independently. Church services are held on site as part of the activities programme. A chaplain is employed for 10 hours a week and is interviewed during this audit. The chaplain advises they are on site four days a week as well as every second Sunday and that a priest is on site twice a week to conduct services in the on-site chapel.

Values, beliefs and cultural aspects of care are recorded in residents' clinical files reviewed (five rest home).

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

There are currently no residents in the facility that identify as Māori. A cultural assessment is completed as part of the care plan for residents.

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

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education was last provided as part of the in-service education day that was last provided in May 2014.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

Residents' files reviewed demonstrate that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whanau contact details. Residents have a cultural assessment completed as part of the care planning process.

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. These findings are supported during review of the completed questionnaires for the resident survey and the relative survey completed in July 2014. Church services are held on site daily in the chapel.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

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

During interview the facility manager describes the process for managing residents' 'comfort account' funds.

A review of the accident/incident reporting system, complaints register and interview of the facility manager indicates there has been one allegation made alleging unacceptable behaviour that has been referred to the Police. The staff member involved is no longer working at the facility.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

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

Education is provided by specialist educators and District Health Board (DHB) education programmes as part of the in-service education programme which is overseen by the facility manager. This is confirmed during review of education records and interviews of the facility manager and a registered nurse who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. The facility manager advises that the registered nurses (RNs) attend education at the DHB and this is confirmed during review of two registered nurses and the facility manager's files.

Staff interviewed confirm understanding of professional boundaries and practice.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

Residents and family interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care.

The facility manager advises access to interpreter services is available if required via the District Health Board and the local community if required. They also advise there are currently no residents who require interpreter services.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The facility manager, as well as the registered nurse (RN) report informed consent is discussed and is recorded at the time the resident is admitted to the facility.

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

Staff interviewed (five care givers, one RN, one activities co-ordinator and the facility manager) demonstrate a good understanding of informed consent processes.

Residents (four rest home) and family (two) interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.

Residents' files reviewed demonstrate written and verbal discussions on informed consent have occurred and residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education on the Code of Rights, which included advocacy and consent, was provided in September 2014 by the advocate from the Nationwide Advocacy Services.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these are reviewed. A resident advocate visits most days and is interviewed during this audit. The chaplain is also interviewed and advises they also provide advocacy services for residents if requested.

Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they have attended education on the Code of Rights, advocacy, and complaint management.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service (for example, visitors are required to sign in and out via registers). The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs.

Residents and family members interviewed confirm they can have access to visitors of their choice, and confirm they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a van is available to take residents on community visits. Some residents go out independently on a regular basis.

Residents' files reviewed demonstrate that progress notes and the content of care plans include regular outings and appointments (records sighted).

The District Health Board contract requirements are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes one complaint for 2014 (one staff member complaining about another staff member). There are two complaints entered for 2013. The current facility manager has entered a complaint that was received in September 2013 but not entered in to the complaints register by the then facility manager. The complaint that was not entered in September 2013 alleges theft by a staff member of resident's money and was referred to the Police for investigation. This staff member is no longer working in the facility and has left New Zealand. The complaints register is reviewed during this audit.

The facility manager advises there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board (DHB), Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents (four) and family (two) interviewed demonstrate an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues they have during these meetings. This is confirmed during interview of residents and family and review of resident meeting minutes.

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

The District Health Board contract requirements are 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:

A business plan and a quality risk management plan are reviewed and include goals. Also reviewed is a mission statement, values, vision and objectives. An organisational chart is also reviewed during interview of the general manager / facility manager. The general manager (GM) is a registered nurse (RN) and was appointed as the GM in October 2013. The GM assumed the facility manager's (FM) role in December 2013 when the previous facility manager left. The general manager / facility manager has worked in the aged care sector for the last 17 years and has extensive aged care management experience. The general manager / facility manager advises they are proposing to interview for a new facility manager in 2015 at which point the current general manager / facility manager will revert back to being the general manager. This is confirmed during interview of one of the directors.

The FM is supported by two registered nurses (RNs) as well as by a nurse consultant. There is an RN on site seven days a week between 8.30am and 3.00pm as well as after-hours. The FM works Monday to Friday between 9am and 5pm. The personal files and annual practising certificates for these three RNs are reviewed and are current.

The GM/FM provides monthly reports to the director and a selection of these are reviewed during this audit.

The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.

Mission Rest Home is currently certified to provide 31 rest home level beds and there are 20 residents assessed as requiring rest home level care during this audit. There are also four independent residents living / boarding on the first and second floors who receive meals, laundry and housekeeping services.

There is one resident who was referred for reassessment in March 2014 as this resident's acuity had increased. This assessment has not been completed and the facility manager contacted the assessment team during this audit for follow-up. A discussion was had with the FM concerning the need to seek an exemption from the Ministry of Health to continue to care for this resident if their reassessment confirms they are a hospital level resident. (See link criterion 1.3.4.2 and Standard 1.3.3).

Mission Rest Home Limited is certified to provide rest home level care. The service provider has contracts with the DHB to provide aged related residential care (rest home), residential respite services - rehabilitation and support services, and residential - non aged, long term support - chronic health conditions. There are 20 rest home residents and four boarders aged over 65 years on day one of this audit.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager be absent. One of the two registered nurses fills in for the facility manager with support from one of the directors and a nurse consultant. Administrative support is also available from the organisation that provides administrative and financial support to Mission Rest Home. Interview of one of the registered nurses (RN) confirms their responsibility and authority for this role.

Services provided meet the specific needs of the resident group within the facility. There are 20 residents assessed as requiring rest home level care during this audit. There are also four independent residents living / boarding on the first and second floor who receive meals, laundry and housekeeping services.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

A business plan and quality and risk management plan/policy are reviewed and are used to guide the quality programme and include goals and objectives. There is an internal audit programme in place and completed internal audits for 2014 are reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A Health and Safety manual is available that includes relevant policies and procedures.

Also reviewed are documented values, mission statement and philosophy, which are displayed. Monthly quality and staff meetings are held along with monthly resident meetings. Meeting minutes reviewed and are available for review by staff. The facility manager's monthly reports are reviewed and includes but is not limited to information on updates for any policies and procedures, complaints, resident admissions and discharges, internal audits completed, meetings held, goals for the next month as well as information on any issues or areas of concern. The facility manager also provides copies of these reports to the directors as well as reports to the quarterly directors meetings. This is confirmed during interview of one of the directors.

The facility manager is responsible for ensuring the organisations quality and risk management systems are maintained. Monthly quality and staff meetings are held and meeting minutes reviewed provide evidence of reporting / feedback on completion of internal audits, health and safety, infection control, accidents and incidents, restraints, complaints and compliments, privacy and confidentiality, activities and staff issues. Minutes for 2014 are reviewed.

Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. There is documented evidence quality improvement data is being collected, collated, analysed, and evaluated, including reporting on numbers of various clinical indicators and quality and risk issues to staff and the directors. Meeting minutes and reports reviewed also provide evidence of discussion of any trends identified, as well as reporting on infection control and health and safety. Staff interviewed report they are kept well informed of quality and risk management issues including clinical indicators. Quality improvement data reviewed, including adverse event forms and meeting minutes provide evidence that corrective action plans are being developed, implemented and signed off as being completed to address the issue/s that require/s improvement. However, improvements are required as internal audits do not consistently have corrective action plans developed to address all shortfalls identified (see criterion 1.2.3.8).

Copies of meeting minutes and graphs of clinical indicators are available in the staff room and graphs of clinical indicators are reviewed attached to meeting minutes.

Adverse events are documented on accident/incident forms and copies of these are retained in the resident's files.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service reflects current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed during interviews that they are advised of updated policies and they confirm the policies and procedures provide appropriate guidance for the service delivery.

A Health and Safety Manual is available that includes relevant policies and procedures and there is a hazard reporting system available and a hazard register. Chemical Safety data sheets are available that identify the potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed. All biomedical equipment has appropriate performance verified stickers in place. Electrical safety stickers are observed in place.

Not all of the District Health Board contract 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: PA Low

Evidence:

Completed audits for 2014 are reviewed and although a corrective action plan is not always documented to address shortfalls identified, there is evidence that the shortfall has been corrected.

Audit tool templates have sections at the end of each audit tool to record a summary of audit findings and corrective action plan.

Meeting minutes are reviewed with corrective actions, responsibilities and timeframes. There is evidence of follow-up at the next meeting

Finding:

Corrective action plans are not being consistently documented to address shortfalls identified in internal audits.

Corrective Action:

Provide documented evidence that corrective action plans are being consistently developed and monitored to address any shortfalls identified.

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

Criterion 1.2.3.9 (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:

Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Registered nurses (RN) are advised of all adverse events and are responsible for investigating the event as well as for documenting any corrective actions required. The facility manager or the one of the other RNs visits the facility and assesses any resident if there is an injury or if the staff are concerned if the adverse event occurs when there is no RN on duty. There is an RN on site seven days a week between 8.30am and 3.00pm, plus the facility manager, who is also a registered nurse, is available Monday to Friday between 9am and 5pm and they assess all incidents that occur during these hours.

The provider has recently reviewed their processes following unwitnessed falls when there is a risk of head injury, or any other event where a head injury is likely and has implemented a system where neurological observations are taken. Education has been provided for staff on recording of accidents and incidents in September 2014.

Resident files reviewed (five rest home) provides documented evidence of communication with family and GP on the accident/incident form, in resident progress notes, and in whānau/family communication sheets. All residents also have an untoward event log in their file. There is also evidence reviewed during this audit of notification to family of any change in the resident's condition. This finding is confirmed during interviews of residents and family member. There is an open disclosure policy.

Corrective action plans to address areas requiring improvement are documented on accident/incident form and there is evidence of monitoring of this.

Staff confirm during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions; policies and procedures; and staff education, which is confirmed via review of documentation. Staff also confirm they are completing accident / incident forms for adverse events. Policy and Procedures comply with essential notification reporting (e.g. health and safety, human resources, infection control).

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Written policies and procedures in relation to human resource management are available and are reviewed during this audit. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (five of five) along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments (as appropriate). Copies of annual practising certificates are reviewed for all staff that require them to practice and are current.

The facility manager is responsible for the inservice education programme and there is evidence available indicating in-service education is provided for staff at least once a month. The education planner for 2014, individual staff attendance records and attendance records for each education session are reviewed and provides evidence ongoing education is provided. A suite of competency assessments are available and competencies are reviewed during this audit and indicate staff have current competencies in place as appropriate.

Although there is currently no on-site Aged Care Education (ACE) assessor available, staff are supported to complete the ACE learning modules. The facility manager has enrolled to complete the on-site ACE Assessor training programme and plans to complete this in 2015. Approximately 80% of care staff has completed the ACE modules or an equivalent. New staff are encouraged to complete this education programme at the end of their orientation and there are currently two staff members completing the Ace modules. An appraisal schedule is in place and current staff appraisals are sighted on all staff files reviewed.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The facility manager advises that staff are orientated for at least two to four shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided including the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values and philosophy.

Care staff interviewed (five caregivers working all shifts and one RN), one activities co-ordinator and the housekeeper confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and the currency of their performance appraisals.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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: <p>There is a documented rationale (Rostering Policy) in place for determining service provider levels and skill mixes in order to provide safe service delivery at Mission Rest Home. Registered nurse (RN) cover is provided seven days a week between 8.30am and 3.00pm. The facility manager, who is a registered nurse, works Monday to Friday between 9am to 5pm. On call after hours registered nurse support and advice is provided by the facility manager or one of the other registered nurses. The minimum amount of staff on duty is between 12 midnight and 6.45am and consists of two caregivers.</p> <p>Care staff interviewed report there is adequate staff available and that they are able to get through their work. There is at least one staff member with a current first aid certificate on each shift although all staff received first aid education in September 2014.</p> <p>Residents and family interviewed report staff provide them with adequate care.</p> <p>The District Health Board contract requirements are met.</p>

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: PA Low

Evidence:

Resident information is entered in an accurate and timely manner into a register (hard backed book) on the day of admission. Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. Resident files reviewed provide evidence that an entry into the residents' clinical record is made on each shift and entries are dated, signed and the time of entry documented. Improvements are required as two of the five care plans that were written by a registered nurse, who is no longer employed at the facility, are difficult to read (see criterion 1.2.9.9)

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

Clinical staff interviewed including caregivers, an RN, an activities co-ordinator and the facility manager confirm they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible.

Not all the District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Two of the five care plans reviewed has hand writing that is difficult to read. New care plans that have been completed are legible.

The facility manager and one of the of the registered nurses advise they are currently rewriting all care plans.

Finding:

Hand written care plans in two of five resident files reviewed are difficult to read. The registered nurse who wrote these care plans is no longer employed at the facility.

Corrective Action:

Provide confirmation that care plans are legible.

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

There are recorded entry and assessment processes. The service's philosophy is recorded, displayed at the facility and communicated to residents, family, relevant agencies and staff. This facility operates 24 hours a day, seven days a week. The facility information pack is available for residents and their family and contain all relevant information.

Five of five residents' files sampled, include five of five residents' admission agreements. All residents' admission agreements sampled evidence residents' and /or family and facility representative sign off. The admission agreement defines the scope of service and includes all the contractual requirements. The residents' files sampled demonstrate the needs assessments are completed for rest home level of care (refer to 1.3.4.2).

Interviews with four of four residents and two of two family members confirm the admission process is completed by staff in timely manner, all relevant admission information is provided and discussion held with staff in respect of resident care have been conducted.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The scope of the service provided by the facility is identified and communicated to all concerned. A process to inform residents in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the facility manager (RN). The residents will be declined entry if not within the scope of the service or if a bed is not available at the time, the resident will be referred back to the NASC service.

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:

In the five of five resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with resident and/or family input and the service is coordinated to promote continuity of service delivery. The four of four residents and two of two family interviewed confirm they receive timely and appropriate services. The registered nurses, under the guidance of the facility manager, registered nurse (RN) are responsible for each stage of service provision inclusive of the assessment, care planning, and provision of care, evaluations and review. Care givers support and assist residents with day to day personal cares. All staff files sampled confirm that staff have the required skills, experience and competencies. The clinical staff interviewed (one RN and five care givers) state they are updated and skilled to care for residents and also confirm residents and/or family members are involved in all stages of service provision. One registered nurse and five care givers at interview state they enjoy working in the rest home and verify educational opportunities are encouraged.

The initial care plan is developed on admission to guide clinical staff in the resident's care for the first three weeks of admission to the facility. The long term care plan is developed and implemented within the required timeframe of three weeks. The risk assessments are not consistently completed (refer to 1.3.4.2) and the evaluation of care plans are not consistently completed within the six months timeframe (refer to 1.3.8.2).The general practitioners (GP) record an entry on medical progress notes at every contact with the resident to ensure the records are current. The GP was not available for interview on days of the audit.

The four of four residents and two of two family member interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews. The residents' files sampled evidence handovers at beginning of each shift and progress notes entries ensure continuity of care. The auditor evidenced verbal briefing /hand over from am to pm shift. Staff attend a handover between each shift and staff interviewed demonstrate an awareness of the current needs of the residents (as identified in the files sampled and resident interviews).

The District Health Board contract requirements are met.

Tracer methodology;

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The residents' needs, outcomes and goals are identified via the assessment process and are recorded. The facility has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.

The residents' files sampled evidence residents' discharge/transfer information from DHB (where required) are available. The facility has appropriate resources and equipment, confirmed at staff interviews. The RN interview confirms that assessments are conducted in a safe and appropriate setting including visits from the doctor. The four of four rest home residents and two of two family interviews confirm their involvement in assessments; care planning, review, treatment and evaluations of care.

There are areas identified as requiring improvement around risk assessments, NASC reassessments and weight monitoring to be completed in timely manner.

The District Health Board contract requirements are not fully 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: PA Moderate

Evidence:

Five of five residents' files reviewed. All five files evidence NASC assessments for rest home level of care.

i) One of the five files evidences an increase in the resident's acuity and the service referring the resident for NASC re assessment in March 2014, sighted records of the request. There is no recorded evidence of the reassessment being completed. The facility manager contacted the NASC service on audit days, however they were unable to speak to anyone at the service. The service is awaiting the NASC reassessment of this resident and if this resident is assessed at hospital level of care then the service plan to apply to Ministry of Health to grant a dispensation for this resident.

ii) Two of five files evidence the RN assessment has not been completed in the last six months.

iii) Four of five files evidence the pressure area care risk assessment has not been completed.

iv) One of one restraint and one of one enabler assessments do not record the risks associated with the restraint and enabler use (refer to 2.2.2.1).

v) One of five resident's files evidences no recorded weight monitoring for four month period from June to September 2014.

Finding:

Risk assessments are not consistently completed, one resident's reassessment by the NASC team has not been conducted and one resident's weight has not been monitored for over four months.

Corrective Action:

Provide evidence the risk assessments, NASC reassessments and weight monitoring are conducted in timely manner.

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

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

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

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

Attainment and Risk: FA

Evidence:

The five of five residents' care plans reviewed are individualised and the records reviewed demonstrate integration inclusive of input from RNs, care givers, activities, GP and allied health services. Short term care plans are developed when required and when fully actioned the short term care plans are signed off by the RN. The five of five care givers at interview report they receive adequate information to assist the continuity of care for residents. The handover observed includes updates of all residents and changes in residents observed.

The residents' files sampled evidence the residents' care plans are up-to-date, however the care plans have not been reviewed six monthly prior to current reviews (refer to 1.3.8.2). The interventions sighted do not consistently reflect the assessments (refer to 1.3.4.2) and the clinical care/treatment/support or interventions that are to be provided by the staff are not always detailed/recorded to provide the level of required care (refer to 1.3.6.1). The two of five care plans sighted evidence the RN handwriting is difficult to read (refer to 1.2.9.9).

The residents have input into their care planning and review, confirmed at four of four resident interviews and also confirmed at the two of two family interviews. The facility ensures access to regular GP care, sighted in current GP progress reports.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:**Finding:****Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The residents' files sampled evidence the GP documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement. The four of four residents and two of two family interviews confirm their and their relatives' current care and treatments they are receiving meet their needs. The family communication sheets record family communications, sighted in all residents' files sampled.

Nursing progress notes and observations charts are maintained. Five of five care givers interviewed are familiar with the current interventions of the resident they are allocated and residents interviewed confirm involvement in the care planning process.

The resident care audit was completed in January 2014 with 91% compliance with corrective actions addressed and re-audited in June and July 2014 with 100% compliance.

The residents' files sampled evidence the care plans do not consistently record detailed interventions based on the assessed needs, desired outcomes or goals of the residents and this requires improvement.

The District Health Board contract requirements are not fully 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: PA Moderate

Evidence:

Five of five residents' files sampled.

- i) One of one resident's care plan for a resident using restraint does not record the detail of interventions relating to restraint use.
- ii) One of one resident's care plan for a resident using an enabler does not record the detail of interventions relating to the enabler use.
- iii) One of five resident's care plan for a resident with high risk of pressure areas does not record the detail of interventions relating to this.
- iv) One of five resident's care plan for a resident with change of medical condition does not record the detail of interventions relating to this.
- v) There are two residents using 'wander trackers' at the facility and the front door of the facility has a controlled exit by a key pad that has been approved by the DHB. There is no evidence on the two residents' care plans of clinical justification of the environmental restraint and use of wander trackers.

Finding:

There is inconsistent documentation of residents' care plan interventions consistent with meeting residents' needs.

Corrective Action:

Provide evidence the care plans record detailed interventions that contribute to meeting the residents' needs.

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

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

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

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

Attainment and Risk: FA

Evidence:

An interview with the activities officer (AO) confirms the activities programme meets the needs of the service group and the service has appropriate equipment.

Residents, family and staff interviews confirm the activities programme includes input from external agencies (sighted at audit) and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. Regular exercises and outings are provided for those residents able to partake.

The activities officer is responsible for conducting residents' activities assessments, activities care planning and evaluation and implementation of the activities programme. The residents' activities attendance records are maintained, sighted. The residents' meetings are held monthly, minutes of the meetings are sighted for 2014. The resident meeting minute's folder is held in the residents' lounge.

The residents' files sampled demonstrate the individual activities care plans are current and record support is provided within the areas of leisure and recreation, health and well-being. The activities resident care plan includes resident's needs relating to physical ability; cognitive; emotional; social; spiritual and cultural needs. The activities officer enters the residents' participation in activities weekly into the residents' progress notes, sighted in all five residents' files sampled.

Resident diversionary therapy programme audit was last conducted in July 2014 with 100% compliance.

The District Health Board contract requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The clinical staff interviewed (one RN and five care givers) report that residents' progress records are entered at each shift, sighted. The family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews. The care plan evaluations are conducted by the RN with input from the resident, family, care givers, activities officer and GPs. The resident and family interviews confirm their participation in care plan evaluations and this is evidenced in the files reviewed. The multidisciplinary reviews sighted are current.

When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans are in some of the residents' files sampled, used when required.

Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. The residents' files evidence referral letters to specialists and other health professional when this is required.

The residents' files sampled evidence the residents' care plans are up-to-date, however not all care plans have not been reviewed six monthly prior to current reviews.

The District Health Board contract requirements are not fully 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: PA Moderate

Evidence:

Five of five residents' files reviewed evidence all care plans are current, however three of five care plan were not evaluated within the six month period. The restraint management plan for a resident using restraint has not been evaluated since June 2013. The evaluation of restraint and enabler use are completed monthly, however the evaluations do not record the detail of review as required in criterion 2.2.4.1.

Finding:

Three of five residents' care plans have not been evaluated six monthly. The restraint (one of one) and enabler (one of one) reviews do not include all the criteria of the restraint minimisation criterion 2.2.4.1.

Corrective Action:

Provide evidence care plans are reviewed six monthly and restraint and enabler evaluations include all items in the restraint criterion 2.2.4.1.

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

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

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

Attainment and Risk: FA

Evidence:**Finding:****Corrective Action:**

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

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

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

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

Attainment and Risk: FA

Evidence:

The service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services (refer to 1.3.4.2).

The residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required including DHB specialists. In all of the residents' files sampled there is evidence of family communication sheets that document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented.

The District Health Board contract requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

The residents' files evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files, where this is required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Evidence gathered confirms that the medicine management system meets guidelines and current legislative requirements. The registered nurse interviewed reports that prescribed medications are delivered to the facility and checked (on entry). The medication area in the facility evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. There is one controlled drugs storage in the facility and this is secure. The controlled drug register is maintained and evidences weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded.

All staff authorised to administer medicines have current competencies. The medication round is observed and evidences the staff member is knowledgeable about the medicine administered and signs off, as the dose is administered. Administration records are maintained, as are specimen signatures.

Staff education in medicine management was conducted in June 2014 by a pharmacist and attended by 11 staff.

Ten medicine charts are sampled and all medicine charts evidence residents' photo identification, medicine charts are legible, PRN medication is identified for individual residents and correctly prescribed, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. The residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given). There is one resident who self-administer medicines and does so according to policy.

Resident self- medicating audit conducted in January 2014, April, July and August 2014 with 100% compliance. Medication procedure audit conducted in January and July 2014 with 98% compliance.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The food service policies and procedures are appropriate to the service setting with a six weekly menu reviewed by the dietitian in April 2013.

An interview with the cook confirms they are aware of the residents' individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review (refer to 1.3.4.2 and 1.3.8.2). There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the cook.

The residents' files sampled demonstrate monthly monitoring of individual resident's weight, except one resident (refer to 1.3.4.2). The residents interviewed are satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided.

Staff education in food safety was last conducted in September 2014.

The food temperatures are recorded, sighted. The fridge, chiller and freezer temperatures are recorded, sighted. All decanted food is dated.

A kitchen audit was conducted in January 2014 with 100% compliance. Kitchen services audit conducted in January 2014 with 94.7 % with corrective actions addressed and also audited in July 2014 with 92 % compliance. Nutritional compliance audit conducted in February 2014 with 92.7% compliance and in April 2014 with 98 % compliance and in August 2014 with 99% compliance.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There are documented processes in place for the management of waste and hazardous substances. Policies and procedures specify labelling requirements. Material safety data sheets provided by the chemical representative are available and are accessible for staff. Education was last provided on chemical safety for all staff in October 2014. Staff interviewed report they receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. A sluice facility is provided for the disposal of waste, and protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substances being handled are provided and are being used by staff. For example, gloves, aprons, and masks are sighted in the sluice room.

The District Health Board contract 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:

A maintenance person is employed for 12 hours a week and is interviewed during this audit. The maintenance person advises that external contractors are used for plumbing, electrical and other specialist areas. During interview the maintenance person and the facility manager confirm there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. This finding is confirmed during visual inspection and review of maintenance documentation.

Planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration/performance verified stickers in place on medical equipment and electrical safety tags are viewed on electrical items. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 2 August 2014.

A visual inspection of the facility provides evidence of safe storage of medical equipment. Corridors are narrow in parts and residents are observed safely passing each other; safety rails are secure and are appropriately located.

The door at the main entrance has as electronic lock that is high on a wall behind a curtain that is activated when touched and the door then opens. The facility manager advises the District Health Board have sanctioned the locking of the front door. The external areas are safely maintained and are appropriate to the resident groups and setting. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating; provision of shade; and ensuring a safe area is available for recreation or evacuation purposes).

Care staff interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. This finding is confirmed during review of the relatives and family satisfaction surveys completed in July 2014. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

All bedrooms have wash hand basins and there are an adequate number of communal toilets and wash hand basins for residents. Toilets and showers are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are 45 degrees Celsius or below.

Toilets have appropriate access for residents based on their needs and abilities. Communal toilets and showers have a system that indicates if it is vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.

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:

With one exception, all bedrooms provide single accommodation. The facility manager advises the double bedroom is only used by couples or residents who are happy to share. Adequate privacy is provided in this double bedroom if more than one resident occupies the bedroom. Bedrooms also have privacy curtains at the bedroom doors that can be drawn to enhance resident privacy if the bedroom doors are open.

Visual inspection provides evidence that bedrooms are of various sizes and adequate personal space is provided in bedrooms to allow residents and staff to move.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Visual inspection evidences adequate access is provided to the lounge, activities room, chapel, sitting areas and dining room area. There are other alcoves/ communal areas throughout the facility where residents are able to sit. Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

All linen is washed on site and there is adequate dirty / clean flow. The housekeeper is responsible for laundry during the week and care staff at the weekend. Night staff also undertake some cleaning duties. The housekeeper is interviewed in the laundry and describes the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.

Visual inspection of the facility provides evidence of implementation of appropriate cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning are reviewed. The chemical representative also provides reports during their visits.

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

Residents and family interviewed state they are satisfied with the cleaning and laundry service and this finding is confirmed during review of the collated satisfaction survey results.

The District Health Board contract requirements are met.

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

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

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

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

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 D15.3j; D19.6

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

The door at the main entrance has an electronic lock that is linked to the fire system.

New Zealand Fire Service letters dated 28 April 1999 and an amendment dated 28 September 2011 are reviewed that advise the evacuation scheme is approved, are sighted during this audit. The last trial evacuation was held on 11 September 2014.

All staff have a current first aid certificate and there is at least one staff member on duty with a current first aid certificate. Emergency and security management education is provided as part of the annual in-service education programme and staff interviewed confirm this.

Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.

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

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

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Air temperatures are monitored monthly and these are reviewed during this audit. Residents and family interviewed confirm the facility is maintained at an appropriate temperature.

Visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

The District Health Board contract 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 definition of restraint and enabler is congruent with the definition in NZS 8134.0. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded (refer to 1.3.4.2, 1.3.6.1 and 1.3.8.2). The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

There is one resident using restraint and one resident using an enabler at the facility on audit days. The staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. The staff education in challenging behaviour, de-escalation and restraint use was last conducted in September 2014. The staff restraint competencies are current.

Staff and management interviews confirm there are two residents with 'wander trackers'. The facility manager states the front door of the facility has a controlled exit by a key pad. To exit the facility a person must activate a key pad (by touch) for the front door to unlock. The facility manager advises the DHB have approved this key pad exit lock. Visual observation evidences staff, visitors and residents are exiting the facility freely.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

The service has systems in place for determining the restraint approval processes. The staff interviewed confirm responsibilities relating to restraint and enabler use are identified and known. There is one resident using restraint and one resident using an enabler. One of one resident's file sampled evidences the family input into the restraint approval process. An enabler was implemented following a resident's voluntarily request for an enabler to assist them to maintain safety. There is a documented, formal process for the approval of specific restraint processes at the policy/procedure level.

The restraint coordinator position is delegated to suitably skilled and experienced service provider, the registered nurse who has been in this position since March 2014. An interview with the restraint co-ordinator and the facility manager is conducted.

The clinical staff interviewed are aware of the restraint co-ordinator's responsibilities. RMSP policy/procedures define approved restraints and alternatives to restraint. There are policies relating to strategies to minimise the use of restraint and management of disturbed behaviour in accordance with the requirements of the service agreement. The orientation/induction programme includes overview of RMSP policies/procedures. The staff education programme includes on-going RMSP training, conducted in September 2014.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The RMSP policies relate to strategies to minimise the use of restraint and management of disturbed behaviour in accordance with the requirements of the service agreement. The policies record details of required assessment of the resident to be undertaken prior to restraint and enabler use being implemented. The two of two residents' files sampled (one using restraint and one using enabler) demonstrate the restraint and enabler assessment process is not fully completed. There is evidence of an assessment recorded for one resident using restraint and one resident using an enabler, however both assessments do not record the risks associated with restraint and the enabler use (refer to 1.3.4.2).

The District Health Board contract requirement is met.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

Appropriate systems are in place to ensure the service is using restraint safely. The one of one resident's file using restraint demonstrates the restraint is applied as a last resort and there is recorded consent by family for the restraint use. The service provider's documentation evidences a restraint register is established that records sufficient information to provide an auditable record of restraint use. On the days of the audit there was one resident using restraint and one resident using an enabler.

The two of two residents' care plan interventions (one for restraint and one for enabler) record the restraint and enabler use, however the interventions do not record the details of the required interventions for restraint and enabler use (refer to 1.3.6.1).

The resident restraint and enabler policy compliance audit was completed in February 2014 with 88.8 % compliance and in April 2014 with 84% compliance (refer to 1.2.3.8) and in August 2014 with 100% compliance. Management of challenging behaviour audit was conducted in April 2014 with 92 % compliance.

The District Health Board contract requirement is met.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The restraint evaluation processes are documented in the restraint minimisation and safe practice policy. The resident's file sampled evidences that the restraint is being evaluated, however the evaluation does not consider all items from (a) to (k) of the criterion 2.2.4.1 (refer to 1.3.8.2). The restraint reviews /evaluations evidence current reviews. The residents' files sampled demonstrate residents' care plan evaluations and multidisciplinary meetings are current (refer to 1.3.8.2).

Evaluation of restraint is conducted monthly, sighted.

The District Health Board contract requirement is met.

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The RMSP policies and procedures include monitoring and quality review processes. The restraint approval group meeting minutes are sighted for October 2014. The review meeting is attended by the facility manager (RN), the restraint co-ordinator (RN) and the GP and the restraint review records all the necessary components.

The District Health Board contract requirement is met.

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control (IC) policy meets the needs of the service and provides information and resources to inform staff on infection prevention and control, confirmed at staff interviews. The delegation of infection control matters is documented in policies, along with an infection control co-ordinator's (ICC) job description, sighted. The infection control co-ordinator is the registered nurse, supported in their IC role by the facility manager (RN). Interviews are conducted with both the ICC and the facility manager

relating to IC matters. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The IC policy/ programme is reviewed annually. Infection prevention and control programme is sighted for 2013 -2014 recording objectives relating to: IC policy; outbreak management; staff training and education in IC; surveillances practices; staff health and environmental issues relating to IC. The IC programme is signed off by the director in June 2014.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control programme meets the needs of the service and provides information and resources to inform and guide staff. The IC co-ordinator has access to relevant and current information which is appropriate to the size and complexity of the service, including but not limited to; IC manual, internet, access to experts (DHB and Lab), and on-going in-service education. The IC is an agenda item at the facility's meetings, evidenced during review of meeting minutes and interviews with staff. Hand washing audit was completed in January and June 2014, with 100% compliance.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures on the prevention and control of infection include written material that is relevant to the service and reflects current accepted good practice and relevant legislative requirements. The policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interview.

The IC policies and procedures are developed and reviewed regularly in consultation and input from relevant staff, last review occurred in June 2014. IC policies and procedures identify links to other documentation in the organisation e.g. health & safety, quality and risk.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The service provider's documentation evidences that infection control education is provided to all staff, as part of their orientation and is provided as part of the on-going in-service education programme. Staff interviewed advice that clinical staff identify situations where IC education is required for a resident such as; hand hygiene, cough etiquette and one on one education is conducted.

The IC staff education was last provided in October 2014 by the facility manager (RN), who attended an external education IC study day by IC specialist in 2013. All education sessions have evidence of staff attendance and content of the presentations.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The IC programme, policy and procedures detail surveillance objectives and processes. The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. The infection control monthly data is completed for each resident and includes type of infection, lab results, antibiotics prescribed, review and outcome. An infection log is maintained, sighted.

The numbers of infections are collated at the end of each month, analysed, graphed and reported to staff at meetings. The care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers at commencement of each shift, handover sheets, short term care plans and progress notes. This is evidenced during attendance at the staff handover from am to pm shift and review of the residents' files.

The infection control surveillance data is sampled through resident records and collated infection reports. The information sampled confirms that the surveillance programme is appropriate and fully implemented. Surveillance monitoring audit was last conducted in October 2014 with 96% compliance.

An interview with the ICC and the facility manager confirm there have been no outbreaks at the facility since the last audit.

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.)*