

# G J & J M Bellaney Limited

---

Current Status: 11 September 2014

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

## General overview

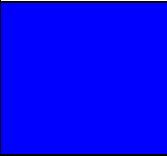
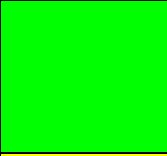
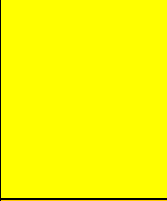


Wimbledon Villa is certified to provide dementia level care for up to 38 residents. On the day of the audit there were 25 residents. Wimbledon Villa's business facility manager and clinical nurse manager are qualified for their roles.

There are developed and implemented systems and policies to guide appropriate care for residents. A quality programme is being implemented. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. There are ten improvements required around corrective action planning, incident reporting, training, aspects of care planning including assessment, interventions and evaluation, medication management and equipment calibration.

## Audit Summary as at 11 September 2014

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	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 11 September 2014

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

## Organisational Management as at 11 September 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
---	--	---

## Continuum of Service Delivery as at 11 September 2014

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

## Safe and Appropriate Environment as at 11 September 2014

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

## Restraint Minimisation and Safe Practice as at 11 September 2014

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

## Infection Prevention and Control as at 11 September 2014

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

# Audit Results as at 11 September 2014

## **Consumer Rights**

Wimbledon Villa provides care in a way that focuses on the individual resident. There is a Maori Health Plan and ethnicity awareness policy/procedure supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are in place and documented. Residents and family interviewed reported satisfaction with the service being provided.

## **Organisational Management**

Wimbledon Villa is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly staff meetings. An annual resident satisfaction survey is completed and there are regular resident/family meetings. Quality performance is reported to staff at monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around corrective action planning, incident reporting and staff education.

## **Continuum of Service Delivery**

There are pre-entry and admission procedures in place. The service is pro-active in the community and meets with groups such as Alzheimer's Society. There is a well presented information booklet for residents/families/whanau at entry that includes information on the service philosophy and practices particular to the secure wings. Care plans are developed by the registered nurses and are reviewed six monthly. Improvements are required around six monthly review of the resident's long term care plan. Families are involved in the development and review of the care plan. All staff are qualified in their roles and complete on-going training around the specific needs of people with dementia. All assessments linked into the comprehensive care plan. Improvements are required around completing risks assessments and six monthly risk assessment reviews. Care plans are individually developed, holistic and meet resident's needs. Improvements are required round interventions for residents identified needs. Other specific needs of residents such as medical conditions are also included. There is at least a three monthly review by the general practitioner of the resident. Improvements are required around general practitioner three monthly reviews and providing medical information for respite residents. On-going nursing evaluations occur daily/as indicated and are included within the progress notes. There is a planned seven days activities programme that is developed by activity staff and daily household activities are completed. The medication management system includes medication policy and procedures and there is on-going education and training of staff in relation to medicine

management. Improvements are required around three monthly reviews of medications by the medical practitioner, and ensuring there is a medical prescription chart for a respite resident. The main kitchen provides food to each wing. The service also has access to a dietitian for review of resident nutritional status. Improvement is required around referral to the dietitian.

### **Safe and Appropriate Environment**

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Improvements are required around calibration of medical equipment. The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness displayed in the foyer. Residents were able to move freely inside and within the secure outside environments off the dementia wings. Wimbledon Villa is divided into two smaller wings. Staff described how they get to know their residents well and family described getting to know staff well. Each wing is well maintained with easy access to the secure gardens and paths. Each wing has their own dining/lounge areas. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. Communal service areas are separate and activities can occur in the lounges and/or the dining area. The service has in place policies and procedures for effective management of laundry and cleaning practices. General living areas and resident rooms are appropriately heated and ventilated.

### **Restraint Minimisation and Safe Practice**

There is a Restraint Minimisation and Safe Practice Policy and Procedure applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint training is provided at orientation and is completed as part of the services training schedule. This includes restraint a self-directed learning and competency for restraint minimisation. The service currently has no residents using enablers and no residents requiring restraint. The service has been restraint free for over 12 months. The register shows a monthly review by the restraint coordinator and the register is updated each month. There is a restraint approval group and process in place that meet six monthly.

### **Infection Prevention and Control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical nurse manager) is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

# 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

<b>Legal entity name:</b>	G J & J M Bellaney Limited
<b>Certificate name:</b>	G J & J M Bellaney Limited

<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
------------------------------------	--

<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Wimbledon Villa
<b>Services audited:</b>	Dementia care
<b>Dates of audit:</b>	<b>Start date:</b> 11 September 2014 <b>End date:</b> 12 September 2014

<b>Proposed changes to current services (if any):</b>	
---	--

<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	25
---	----

## Audit Team

<b>Lead Auditor</b>	XXXXXXX	<b>Hours on site</b>	12.5	<b>Hours off site</b>	8
---------------------	---------	----------------------	------	-----------------------	---

<b>Other Auditors</b>	XXXXXXXX	<b>Total hours on site</b>	12.5	<b>Total hours off site</b>	8
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	25	Total audit hours off site	18	Total audit hours	43
---------------------------	----	----------------------------	----	-------------------	----

Number of residents interviewed	6	Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	27	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

## Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	
d)	this audit report has been approved by the lead auditor named above	
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	

Dated

## Executive Summary of Audit

### General Overview

Wimbledon Villa is certified to provide dementia level care for up to 38 residents. On the day of the audit there were 25 residents including one respite resident. Wimbledon Villa's business facility manager and clinical nurse manager are well qualified for their roles.

There are developed and implemented systems and policies to guide appropriate quality care for residents. A quality programme is being implemented. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. There are ten improvements required around corrective action planning, incident reporting, training, aspects of care planning including assessment, interventions and evaluation, medication management and equipment calibration.

### Outcome 1.1: Consumer Rights

Wimbledon Villa provides care in a way that focuses on the individual resident. There is a Maori Health Plan and ethnicity awareness policy/procedure supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are in place and documented. Residents and family interviewed reported satisfaction with the service being provided.

### Outcome 1.2: Organisational Management

Wimbledon Villa is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly staff meetings. An annual resident satisfaction survey is completed and there are regular resident/family meetings. Quality performance is reported to staff at monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around corrective action planning, incident reporting and staff education.

### Outcome 1.3: Continuum of Service Delivery

There are pre-entry and admission procedures in place. The service is pro-active in the community and meets with groups such as Alzheimer's Society. There is a well presented information booklet for residents/families/whanau at entry that includes information on the service philosophy and practices particular to the secure wings. Care plans are developed by the registered nurses and are reviewed six monthly. Improvements are required around six monthly review of the resident's long term care plan. Families are involved in the development and review of the care



plan. All staff are qualified in their roles and complete on-going training around the specific needs of people with dementia. All assessments linked into the comprehensive care plan. Improvements are required around completing risks assessments and six monthly risk assessment reviews. Care plans are individually developed, holistic and meet resident's needs. Improvements are required round interventions for residents identified needs. Other specific needs of residents such as medical conditions are also included. There is at least a three monthly review by the general practitioner of the resident. Improvements are required around general practitioner three monthly reviews and providing medical information for respite residents. On-going nursing evaluations occur daily/as indicated and are included within the progress notes. There is a planned seven days activities programme that is developed by activity staff and daily household activities are completed. The medication management system includes medication policy and procedures and there is on-going education and training of staff in relation to medicine management. Improvements are required around three monthly reviews of medications by the medical practitioner, and ensuring there is a medical prescription chart for a respite resident. The main kitchen provides food to each wing. The service also has access to a dietitian for review of resident nutritional status. Improvement is required around referral to the dietitian.

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

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Improvements are required around calibration of medical equipment. The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness displayed in the foyer. Residents were able to move freely inside and within the secure outside environments off the dementia wings. Wimbledon Villa is divided into two smaller wings. Staff described how they get to know their residents well and family described getting to know staff well. Each wing is well maintained with easy access to the secure gardens and paths. Each wing has their own dining/lounge areas. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. Communal service areas are separate and activities can occur in the lounges and/or the dining area. The service has in place policies and procedures for effective management of laundry and cleaning practices. General living areas and resident rooms are appropriately heated and ventilated.

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

There is a Restraint Minimisation and Safe Practice Policy and Procedure applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint training is provided at orientation and is completed as part of the services training schedule. This includes restraint a self-directed learning and competency for restraint minimisation. The service currently has no residents using enablers and no residents requiring restraint. The service has been restraint free for over 12 months. The register shows a monthly review by the restraint coordinator and the register is updated each month. There is a restraint approval group and process in place that meet six monthly.

#### **Outcome 3: Infection Prevention and Control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical nurse manager) is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through

surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	36	0	8	1	0	0
<b>Criteria</b>	0	83	0	9	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	5
<b>Criteria</b>	0	0	0	0	0	0	0	8

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: 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	On the corrective action plan summary sheet there are outstanding actions across the majority of months January to August. While it is acknowledged there are corrective actions that are still in progress, there is no evidence that recording progress towards the corrective action is completed – such as a corrective action plan.	Corrective actions from internal audit are signed out as completed.	180
HDS(C)S.2008	Standard 1.2.4: Adverse Event	All adverse, unplanned, or untoward events are	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Reporting	systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.				
HDS(C)S.2008	Criterion 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.	PA Low	<p>This finding relates to appropriate internal and external notification following events:</p> <p>a) Early September a resident inappropriately left the service (incident form reviewed) and police were notified. There was no notification to other relevant authorities such as the DHB and/or MoH.</p> <p>b) The internal incident reporting process is that non-injury resident incidents that occur after 2200 hours are reported to the registered nurse/clinical nurse manager at 0700 the following morning. Of the ten incident forms reviewed two did not record escalation to the registered nurse either at the time or the next day. Interview with the clinical nurse manager confirmed this is an area of improvement. There is no evidence resident care has been compromised and the risk is therefore considered to be low.</p>	Appropriate notification – internal and external - is made following resident incidents. Following the draft report the provider identified that they have been addressing this prior to audit by coaching staff.	180
HDS(C)S.2008	Criterion 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.	PA Low	Four (of four) resident files were reviewed and there was one reported incident of bruising that did not have an associated incident form (since the draft report the manager forwarded a copy of this form). There was an incident form attached to a complaint (received April) that had not been reviewed and signed out by the clinical nurse	Changes in resident health status are reported through the incident reporting process.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				manager, and potentially did not get included in the monthly clinical indicator reporting. The incident was a resident fall.		
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The following was noted: a) Approximately two shifts across the week's roster reviewed did not have a first aid trained member of staff on every shift. First aid training has been booked for staff who do not hold a current certificate. b) RN's do not have an insulin competency and there are three insulin dependent diabetics at the facility. These were completed during the audit. Care assistants do not administer insulin. (since the draft the provider has confirmed the RNs have completed the insulin competencies). c) Chemical safety training was last delivered August 2012, and while it was scheduled for August this year did not get delivered. It is noted the session has been rescheduled for October 2014.	Required training is completed.	90
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.4	The service is coordinated in a manner that promotes continuity in service delivery and promotes	PA Low	Three residents with documented weight loss do not show evidence of referral to a dietitian for	Ensure residents with weight loss are referred to a dietitian for specialist input.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		a team approach where appropriate.		specialist input.		
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	Two residents do not show documented evidence that risks assessment were reviewed six monthly.	Ensure that all residents have risks assessments reviewed at least six monthly.	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 Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	One resident with weight loss does not have documented evidence that interventions in the long term care plan are updated.	Ensure that the resident long term care plan is updated to reflect the resident needs.	90
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
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 Low	Three resident files sampled do not show documented evidence that the long term care plan has been reviewed six monthly	Ensure that all residents' long term care plans are reviewed at least six monthly and that this is documented.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management	PA Moderate	(i)Eight of 12 medication charts	(i)Ensure that the GP reviews	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		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.		reviewed do not have documented evidence that the GP had seen the resident three monthly and signed the medication chart (one resident is on respite care). (ii) There is no general practitioner prescription chart for the resident on respite care however staff are administering medications and signing for medications on a signing sheet.	every resident medication chart three monthly and signs the medication chart. (ii) Ensure that the respite resident has a current prescription chart prescribed by the GP.	
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Medical equipment including blood pressure machine, ear thermometer and pulse oximeter have not been calibrated.	Ensure that all medical equipment is calibrated by an external technician. Since the draft report, the manager provided evidence that calibration occurred 29/09/14	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:**

Wimbledon Villa has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about abuse and neglect and advocacy services that includes the Code, at orientation and as part of the in-service programme. Interview with three care assistants demonstrate an understanding of the Code. Elder abuse training is included in the two-yearly in-service programme. Relatives (five) confirm staff respect privacy, and support residents in making choice where able.

### 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:**

There is a welcome pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed through the facility. The resident/family meetings (minutes sighted) also provide the opportunity for residents/family to raise issues. Relatives interviewed (five) inform information has been provided around the Code. The management team informs an open door policy for concerns or complaints.

D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, CoR pamphlet, advocacy and Health & Disability Commission. The manager and registered nurses describe discussing the information pack with residents/relatives on admission.

D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**



**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Resident files are stored out of sight. Staff could describe aspects of abuse and neglect, which is included in the training programme. A resident satisfaction survey is completed annually (September 2014). Survey forms were still being returned at the time of audit. The returned forms (13 received) informed 82% were overall satisfied with the service. Interview with five family members informed satisfaction with the service being provided.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with three care assistants describe how choice is incorporated into resident cares. There is an abuse and neglect policy being implemented and staff attend education around abuse and neglect (April 2014).

D4.1a Six resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs.

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

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

E4.1a Five family members from the dementia unit state their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

#### **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:**

A3.2 Wimbledon Villa has a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is an ethnicity awareness policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. While there are two Maori residents at the time of audit, there were no relatives visiting to interview during the period of audit. D20.1i There are policies being implemented that guide staff in cultural safety. Special events and occasions are celebrated and this could be described by staff.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and family are invited to attend (link 1.3.8). Relatives interviewed (five) confirm that staff take into account their culture and values. D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whānau. D4.1c Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Staff meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with two registered nurses confirm an awareness of professional boundaries. Interview with three care assistants could discuss professional boundaries in respect of gifts.

### 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:**

Wimbledon Villa has a suite of appropriate policies and procedures that are updated as necessary. Wimbledon Villa participates in the Healthcare Help benchmarking programme that monitors against clinical indicators. There is an active culture of ongoing staff development with the ACE programme being implemented. There is evidence of education being supported outside of the prescribed training plan such as wound care.

A2.2 Services are provided at Wimbledon Villa that adhere to the health & disability services standards.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for care assistants and registered nurses including: medication and manual handling. RNs have access to external training.

Relatives interviewed (five) were positive about the care they receive. Interview with three care assistants inform they are supported by the RN's and management team.

### 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:**

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Eight of ten incident forms reviewed across July and August (2014) identify family were notified following a resident incident, the remaining two forms noted 'non-injury, family do not wish to be informed'. Interview with three care assistants and two registered nurses inform family are appropriately notified following a resident change in health status.

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

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

D16.4b relatives (five), interviewed stated that they are informed when their family member's health status changes or of any other issues arising.

D11.3 The information pack is available in large print and this can be read to residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for treatment.

Wimbledon Villa's philosophy includes an emphasis on working towards maintaining and fostering resident's unique interests, relationships and achievements. Interviews with staff and families supported that they have input and are given choices. Care plans and 24 hours multidisciplinary care plans demonstrate resident choice as appropriate.

D13.1 There were five admission agreements sighted (one resident was on respite care) and these had been signed on or near the day of admission.

D3.1.d Discussion with five family identified that the service actively involves them in decisions that affect their relative's lives.



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

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

**Attainment and Risk:** FA

**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:**

Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interview with the management team confirms practice.

D4.1d; Relatives interviewed (five) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of how to access advocacy services.

### **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:**

D3.1h: Relatives interviewed (five) confirm they can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility.

D3.1.e Discussion with three care assistants, the activities staff, and relatives (five) confirm residents are supported and encouraged to remain involved in the community and external groups.

### 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:**

There is a complaints policy to guide practice. The business facility manager leads the investigation and management of complaints (verbal and written) supported by the clinical nurse manager. The complaints (and compliments) register records activity. Complaints are discussed at the monthly management and staff meeting, as well as the fortnightly quality meetings. Complaints forms are visible at the entrance of the facility.

There are six recorded 2014 complaints one of which is from the Health and Disability Commissioner's Office (HDC). HDC informed the service 28 August (2014) no further action is being taken. Complaints have been investigated and a response provided to the complainant in a timely manner. Of the six complaints recorded, two have been received by staff.

Relatives interviewed (five) confirm they are aware of how to make a complaint.

D13.3h. a complaints procedure is provided to residents within the information pack at entry

E4.1biii. There is written information on the service philosophy and practices particular to the unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on: minimising restraint, behaviour management, complaint policy.

### **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:**

Wimbledon Villa provides care for up to 38 dementia residents across two wings. In Rose wing there were 11 (of 18) residents including one respite and in the main villa there are 14 (of 19) residents. There are two double rooms in the main villa, each of which had one resident at the time of audit.

Wimbledon Villa is privately owned. The owner lives in Christchurch, however is readily available to the management team. The business facility manager provides monthly reports to the owner (sighted). There is a business plan (2013/2014) that includes a vision and identifies a strategic objective as: To achieve an average 90% occupancy rate over the next two year period and at least this rate subsequently, and to further adopt the Eden principles of care.

The management team determine the quality objectives/goals and review them annually. Goals have actions that will demonstrate if the goal has been achieved eg: Goal: Wimbledon Villa will provide client focused services that recognise and respect the preferences and needs of individual residents as noted in their care plans. Attainment of this goal will be determined by: care plans will be accurate and give a clear 'picture' of the resident preferences and needs as verified by compliance to internal audit of care plans 3 monthly.

The service report a recent focus on improving the reporting and trending of clinical indicator data. As a result it was noted falls have been trending upwards and further analysis was undertaken including time and location – noting higher numbers of falls during the night duty. The clinical nurse manager reports involvement in the national falls strategy.

There is an established and implemented quality programme that includes participation in the Healthcare Help benchmarking programme. Discussion about clinical indicators (eg. incident trends, infection rates), is included at the fortnightly quality meeting and monthly management and staff meetings. Incident forms are collated and graphed by the quality coordinator monthly.

The clinical nurse manager and business facility manager report directly to the managing director/owner and work in partnership to run the service – this structure was put in place in July 2013. The business facility manager (non-clinical) has been in post for four years and prior to July 2013 was the service manager. In July 2013 the current clinical nurse manager was appointed (was previously an RN in the service since 2012). There is a quality coordinator (non-clinical) who works two half days/week.

ARC,D17.3di (rest home), the manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

During a temporary absence of the clinical nurse manager one of the two registered nurses covers clinical matters and administrative functions continue to be overseen by the business facility manager. In the absence of the business facility manager the clinical nurse manager will provide cover with support from the quality coordinator and registered nurses.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Wimbledon Villa is implementing a quality and risk management system and participates in the Healthcare Help benchmarking programme which includes collection of clinical indicator data. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.

Quality matters are taken to the fortnightly quality meetings that comprise the clinical nurse manager and quality coordinator, and then to the monthly staff meetings. The quality coordinator who works two half days/week supports the service in implementing the quality programme. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff via the monthly staff meetings.

Wimbledon Villa staff meetings also act as the infection control and health & safety committees. Infections (number and type) and health and safety matters – such as staff accidents - are discussed. Information is then taken to the quality meeting and feedback going to staff and management meetings (monthly). Resident/relative meetings are held monthly and minutes review indicates issues raised are followed up.

Wimbledon Villa is implementing an internal audit programme that includes aspects of clinical care – such as file review. Issues arising from internal audits are added to the corrective action plan summary sheet. This sheet is used to monitor corrective actions. On the summary sheet there are outstanding actions from January onwards and this is an area of improvement.

D19.3: There is a H&S and risk management programme in place including policies to guide practice. A care assistant has recently been appointed to the role and reports she will be involved in monitoring staff accidents and incidents. There is a current hazard register in place.

D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and interventions on an individual basis such as sensor mats and low beds.

#### 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:**

An internal audit programme is being implement and includes aspects of clinical care such as medication management and file review. Noncompliance identified from internal audits are added to the corrective action plan summary sheet. This sheet is used at the quality meeting to monitor and record close out of corrective actions.

**Finding:**

On the corrective action plan summary sheet there are outstanding actions across the majority of months January to August. While it is acknowledged there are corrective actions that are still in progress, there is no evidence that recording progress towards the corrective action is completed – such as a corrective action plan.

**Corrective Action:**

Corrective actions from internal audit are signed out as completed.

**Timeframe (days):** 180 (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:** PA Low

**Evidence:**

D19.3c: The service collects incident and accident data and discuss aggregated figures at the fortnightly quality meeting and with staff at the monthly staff meetings. Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event when on site, and/or the following day. The completed form is forwarded to the clinical nurse manager for final sign off, and the quality coordinator for data entry and trending. Family are notified. Ten incident forms reviewed across August and September and indicate appropriate intervention has been undertaken. Four files were reviewed and there was an incident of bruising that did not have an associated incident form, and one incident form that did not get reported through the monthly data process. This is an area of improvement.

A resident recently absconded from the facility and police were notified, however there was no notification to other relevant authorities. In addition there are resident incident forms that do not indicate timely notification to the registered nurse on call. Appropriate notification (internal and external) is also an area of improvement.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.

### 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:** PA Low

**Evidence:**

Interview with the management team could describe circumstances that require notification to various authorities.

**Finding:**

This finding relates to appropriate internal and external notification following events:

a) Early September a resident inappropriately left the service (incident form reviewed) and police were notified. There was no notification to other relevant authorities such as the DHB and/or MoH.

b) The internal incident reporting process is that non-injury resident incidents that occur after 2200 hours are reported to the registered nurse/clinical nurse manager at 0700 the following morning. Of the ten incident forms reviewed two did not record escalation to the registered nurse either at the time or the next day. Interview with the clinical nurse manager confirmed this is an area of improvement. There is no evidence resident care has been compromised and the risk is therefore considered to be low.

**Corrective Action:**

Appropriate notification – internal and external - is made following resident incidents. Following the draft report the provider identified that they have been addressing this prior to audit by coaching staff.

**Timeframe (days):** 180 (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:** PA Low

**Evidence:**

Incident forms are completed by staff following an event. The resident is reviewed by the registered nurse at the time of event and/or the following day. Family are seen to have been notified. Interview with the clinical nurse manager confirms an awareness of resident incidents and resulting outcomes.

**Finding:**

Four (of four) resident files were reviewed and there was one reported incident of bruising that did not have an associated incident form (since the draft report the manager forwarded a copy of this form). There was an incident form attached to a complaint (received April) that had not been reviewed and signed out by the clinical nurse manager, and potentially did not get included in the monthly clinical indicator reporting. The incident was a resident fall.

**Corrective Action:**

Changes in resident health status are reported through the incident reporting process.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files were reviewed (clinical nurse manager – who is also the restraint/infection control coordinator, one registered nurse; three care assistants, cook, activities coordinator) and all had relevant documentation relating to employment. Performance appraisals were current.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented induction checklists (sighted). Staff interviewed (three care assistants, two registered nurses) were able to describe the orientation process and believed new staff were adequately orientated to the service.

Wimbledon has a two yearly training plan, and has recently introduced the requirement to complete a questionnaire in lieu of attendance at training. Care staff are required to complete ACE and are enrolled after three months employment (and completion of orientation requirements). There is evidence that additional training opportunities are offered to staff such as attendance at wound care. Interview with three care assistants confirm participation in the ACE training programme. A competency programme is in place that includes annual medication competency for staff administering medications (sighted). The registered nurses, who administer insulin had not completed the required competency and there is not always a first aid trained member of staff on every shift. In addition chemical safety training has not been delivered since August 2012. These are areas for improvement.

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

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency

E4.5f There are 17 care assistants, nine have received certificates, two have completed requirements and are awaiting marking, three are working towards their dementia standards (and have been employed less than six months), and three have yet to commence (employed less than three months).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a two yearly education programme being implemented. Attendance is recorded on a database, and the service has recently implemented the requirement to complete a questionnaire either during the in-service or in lieu of attending. Follow up with staff who are not meeting training requirements is seen to take place. All the required training is part of the two yearly programme. In addition staff are required to complete the ACE programme, in particular the dementia standards.

**Finding:**

The following was noted:

- a) Approximately two shifts across the week's roster reviewed did not have a first aid trained member of staff on every shift. First aid training has been booked for staff who do not hold a current certificate.
- b) RN's do not have an insulin competency and there are three insulin dependent diabetics at the facility. These were completed during the audit. Care assistants do not administer insulin. (since the draft the provider has confirmed the RNs have completed the insulin competencies).
- c) Chemical safety training was last delivered August 2012, and while it was scheduled for August this year did not get delivered. It is noted the session has been rescheduled for October 2014.

**Corrective Action:**

Required training is completed.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows:

RN 0800-1630 seven days, on Wednesday this is the clinical nurse manager.

Rose wing (11 of 18 residents):

AM: 1x 0700-1000, 1x 0800-1615; PM: 1x 1600-1215; ND: 12mid-0815

Villa (14 of 19 residents):

AM: 1x 0700-1500, 1x 0700-1515; PM: 1x 1500-2315, 1x 1500-2300; ND: 1x 2300-0715, 1x 2300-0700

There is also a 'teatime' care assistant – 1630-2030, this person assists in Rose wing once tea duties are complete.

Interview with the management team inform once resident numbers in Rose wing increase to 14 an extra am shift and a PM short shift will be rostered.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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



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

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

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

**Attainment and Risk:** FA

**Evidence:**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. An initial care plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. D7.1 Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Policies contain service name.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are pre-entry and admission procedures in place. Residents are assessed on entry to the service and needs assessments are sighted on the six resident files sampled. The service liaises with assessment services and service coordinators as required. The service is pro-active in the community and meets with groups such as Alzheimer's Society/Age concern. The service has a well presented information booklet for residents/families/whanau at entry. It is comprehensive and designed so it can be read with ease (spaced and larger print).

E4.1.b There is written information on the service philosophy and practices particular to the service included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on: minimising restraint, behaviour management, complaint policy.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

E3.1 Six resident files were reviewed and all includes a needs assessment as requiring specialist dementia care.

### 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 reason for declining service entry to residents is recorded should this occur and communicated to the resident/family/whanau. Staff report that the referring coordinator would be advised when a resident is declined access to the service and it is then their responsibility to inform the resident/family/whanau of other options that may assist them to meet their needs.

#### 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; D16.5c; 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:** PA Low

**Evidence:**

Wimbledon Villa provides a caring homely environment for up to 38 residents in two wings. On the day of the audit there were 25 residents (14 in Wimbledon wing and 11 in Rose wing including one respite resident). Each wing has its own open plan kitchenette, dining and lounge area. The staff are committed to the Eden Care Principles, a philosophy encouraging and maintaining one's "spark of life". Establishing relationships with families is achieved with community visits and activities. There is a two monthly

residents meeting that families are invited to and an annual relatives meeting. Five relatives spoke highly of the staff, the care, activities programme, medical care and the environment.

D16.2, 3, 4: The six files reviewed identified that in all six files an assessment was completed within 24 hours and five of six files identify that the long term care plan was completed within three weeks (one resident is on respite care and has been at the service less than three weeks). There is documented evidence that the care plans are reviewed by a registered nurse (RN) and amended when current health changes (link 1.3.6.1 and 1.3.8.2). Referral for physiotherapy and dietitian is completed as required through a referral process when resident health needs change, however three residents with documented weight loss show no evidence that a referral for dietitian input has been initiated. This is an area requiring improvement.

D16.5e: Five of six resident files reviewed identified that the GP has seen the resident within two working days (one resident is on respite care). It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly as evidenced in two residents files.

The GP reports having confidence in the clinical staff to carry out his instructions and contact him in a timely fashion. The GP visits residents three monthly and as required for residents with a change in medical needs. The GP has been attending the service for over four years and has a number of residents under his care. The GP has no concerns with the service. The GP is on call and there is an after-hours service available.

The two RN's interviewed described verbal and written RN handovers. There is a communication book available. The care assistants then receive handover from the RN on duty. The RN's state the care assistants are very prompt in reporting any resident health changes or incidents. Progress notes are maintained each shift. The clinical nurse manager has completed InterRAI training and will start to introduce the InterRAI assessment tool into the service.

A range of assessment tools are completed on admission and reviewed at least six monthly (# link 1.3.4.2) as applicable and include (but not limited to); continence assessment, falls risk, Braden pressure area tool, wound, nutritional screening, activity initial assessment, pain assessment tools, and challenging behaviour. The activity co-ordinator also completes a comprehensive social assessment.

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:** PA Low

**Evidence:**

Referral for physiotherapy and dietitian is completed as required through a referral process when resident health needs change.

**Finding:**

Three residents with documented weight loss do not show evidence of referral to a dietitian for specialist input.

**Corrective Action:**

Ensure residents with weight loss are referred to a dietitian for specialist input.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The information gathered at admission is used to develop care plan goals and objectives for residents. There is an on-going assessment of resident's policy that includes assessments that should be in place and timeframes. RN's complete initial assessments within 24 hours of admission that includes mobility, continence, self-cares, nutrition, sensory, sleep, social and family support, memory loss/confusion and medication.

A range of assessment tools are completed on admission. Four of six files identify risk assessments are reviewed at least six monthly as applicable and include (but not limited to); continence assessment, coombes falls risk, Braden pressure area tool, wound, nutritional screening, activity initial assessment, pain assessment tools and challenging behaviour, as evidenced in one resident file sampled. This is an area requiring improvement. The activity co-ordinator also completes a comprehensive social and cultural assessment. Assessments are conducted at the facility in agreement with the resident/family member or EPOA. Residents have private rooms where they can be assessed. Challenging behaviour assessments are well documented (with one exception) with excellent follow up into care plans for the dementia care files sampled. Behaviour monitoring forms are used to record behavioural or disruptive actions and describe distraction techniques.

E4.2; Five of six resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a; Challenging behaviours assessments are completed appropriately for four of six resident files sampled.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The information gathered at admission is used to develop care plan goals and objectives for residents. There is an on-going assessment of resident's policy that includes assessments that should be in place and timeframes. RN's complete initial assessments within 24 hours of admission. A range of assessment tools are completed on admission. Risk assessment are reviewed at least six monthly as applicable and include (but not limited to); continence assessment, coombes falls risk, Braden pressure area tool, wound, nutritional screening, activity initial assessment, pain assessment tools and challenging behaviour.

**Finding:**

Two residents do not show documented evidence that risks assessment were reviewed six monthly.

**Corrective Action:**

Ensure that all residents have risks assessments reviewed at least six monthly.

**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:**

Care plans are developed and reviewed by the RN's. The long term care plan is developed within three weeks of admission. The care plan plans are holistic, comprehensive and meets residents needs and includes diagnosis/needs, aim and action. The first page of the long term care plan includes the resident details, medical problems, any special needs and name and signature of the resident/family member who has participated in the development of the long term care plan. The long term care plan describes needs as follows: safety/potential for injury/risk assessment/identification, mobility, continence/elimination, activities of daily living/hygiene and grooming, dietary needs-eating and drinking, medication, pain management, sleep/comfort/sexuality-intimacy, communication/sensory, memory loss/confusion, behaviour management, respiratory function, spiritual/cultural/social, skin/wound care, other and additional evaluations. A 24 hour care plan is completed by the activity co-ordinator and RN. The 24 hour care plan details the residents morning and afternoon habits, behaviours, activities or diversions that work, nocte pattern, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation. The activities person or family complete a resident activity profile/cultural assessment sheet. The activity care plan identifies the resident's individual values, beliefs, spirituality and culture. Short-term care plans are being utilised and reviewed on an on-going basis. The care plans are monitored for integration of notes through the regular care plan audit last completed in September 2014 (61% compliance). Service delivery plans demonstrate service integration (# link 1.3.3.4).

Resident files are integrated and include; a) admission details, b) permissions, consents, c) activities profile, d) property list, e) significant events, f) family contact, g) LTCP and 24 hour care plan , h) activities plan, i) STCP, j) progress notes, k) incident forms, l) all assessments, m) allied health input, n) GP and other medical notes, o) lab results, p) NASC, q) correspondence.

E4.3, Five of six resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, Short term care plans are in use for changes in health status.

D16.3f; Six resident files reviewed identified that family were involved. Five relatives interviewed confirmed they are involved in the care planning process.

### 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 Low

**Evidence:**

Residents' care plans are completed by the registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation (# link 1.3.3.4). Interventions are updated in the resident long term care plan when a residents need change as evidenced in five of six files sampled. The care plans are well written, in-depth and reflect the service philosophy of care and support (with exceptions # link 1.3.6.1 and 1.3.8.2). The service actively links with community groups such as Alzheimer's. The staff and facilities are appropriate for providing these services and are meeting the needs of residents. Five family members confirmed on interview they are notified of any changes to their relative's health including accident/incidents, infections, GP visits, appointments etc. Discussions with families are documented on the family contact form in the resident file.

Three care assistants and two RNs interviewed state there is adequate equipment to carry out the cares as instructed in the care plans including (but not limited to); sensor mats, pressure area mattresses and cushions, standing hoist (checked August 2014), transferring equipment, walking frames, wheelchairs and gloves, masks and aprons. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessments are comprehensive and include type, location and body map, graph, Braden score, classification, factors delaying healing and any additional information. There is one wound (skin tear) in Rose wing. Wound assessment and treatment schedule is current. Specialist wound management advice is available if required and this could be described by the RN's interviewed. Wound audit conducted in May 2014 resulted in 100%.

Continence products are available and resident files include an admission urinary and bowel continence assessment that is reviewed at least six monthly or earlier if there are any changes in resident continence (# link 1.3.4.2). Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained. Specialist continence advice is available as needed and this could be described by the RN's interviewed. Staff attended continence management in-services (November 2013). Continence audit conducted in May 2014 resulted in 100%.

Abbey pain assessments are completed on admission and reviewed at least six monthly for all residents prescribed pain relief (# link 1.3.4.2). The effectiveness of pain relief is written into the progress notes.

Monitoring forms in use included behaviour monitoring, blood sugar levels, neuro observations and vital signs. RN faxes to GPs regarding changes in resident health status, suspected infections, new admission, and medication requests sighted in the resident files sampled.

The dietitian visits following referral by the general practitioner and attends to any referrals received for example residents with weight loss, initiates special authority for supplements and liaises with the cook regarding any resident dietary changes/requirements (# link 1.3.3.4). Residents are weighed monthly or more frequently as per the weight loss management policy.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Residents' care plans are completed by the registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Interventions are updated in the resident long term care plan when a residents need change as evidenced in the five of six files sampled.

**Finding:**

One resident with weight loss does not have documented evidence that interventions in the long term care plan are updated.

**Corrective Action:**

Ensure that the resident long term care plan is updated to reflect the resident 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:**

Wimbledon Villa has two activities co-coordinators who are currently completing the diversional therapy training. One activity co-ordinator works five days per week (Monday-Friday 9am-4.30pm) and one activity coordinator works four afternoons per week (Monday-Thursday 2-4pm). They both attend monthly diversional therapy meetings to discuss and exchange activity ideas. One activity co-ordinator has recently attended the diversional therapy conference. The activity co-ordinators develop a monthly programme that covers both wings and there is close liaison with each other to ensure residents can attend entertainment or activities happening at the service. Care assistants assist with the activities programme in the evening and the weekends (care assistants are orientated to the activities programme). Resident preferences, including spiritual and cultural preferences and capabilities are considered in the delivery of the service activities programme. Activities are provided in the lounges, dining areas,

gardens (when weather permits) and one on one input in resident's rooms when required. Monthly interdenominational church services are held on-site. Over the two days of audit a variety of small group and individual activities are observed happening throughout the wings from the morning until late afternoon. The programme commences at 9.30am to 4.00pm. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete social history of past and present interests and life events. Information from this is added into the long term care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the diversional therapy/activity care plan.

There is a wide range of activities offered that reflect the resident needs including but not limited to; group walking, pet therapy, card games, cross words, ball sport news and views, music and entertainment. Community involvement includes van outings, picnics, café/lunches, visiting other facilities, visits from other facilities and visits from school children

Wimbledon Villa has its own van for transportation. Residents have weekly van outings and attendance at a variety of community events including Opportunity club and seniors club. Both activities co-ordinators have a current first aid certificate.

D16.5d Resident files reviewed identified that the 24 hour individual activity plan is reviewed when at care plan review.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Nursing care plans are reviewed regularly and care plans are evaluated at least six monthly and more frequently when clinically indicated as evidenced in one file sampled (one resident is on respite care and one resident has been at the service for less than six months). This is an area requiring improvement. A multidisciplinary six monthly review is also completed with input from the nursing and care staff, GP, resident/family/whanau as appropriate. Short-term care plans are reviewed as required and are in

use for infections, weight loss and management of a fracture as evidenced. There is at least a three monthly review by the medical practitioner of the resident and their medications (# link 1.3.12.1). On-going nursing evaluations occur daily/as indicated and are included within the progress notes.

D16.4a Care plans are evaluated six monthly and more frequently when clinically indicated for one file sampled.

D16.3c: Five of six initial care plans were evaluated by the RN within three weeks of admission (one resident is on respite care and has been at the service less than three weeks).

### **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 Low

**Evidence:**

Nursing care plans are reviewed regularly and care plans are evaluated at least six monthly and more frequently when clinically indicated as evidenced in one file sample (one resident is on respite care and one resident has been at the service for less than six months).

**Finding:**

Three resident files sampled do not show documented evidence that the long term care plan has been reviewed six monthly

**Corrective Action:**

Ensure that all residents' long term care plans are reviewed at least six monthly and that this is documented.

**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 facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Discharge and transfer planning policies are available to guide staff in this process. The service has access to a physiotherapist and a dietitian through a referral process. There is good communication with the mental health for the older person's team and the psychogeriatric services. Residents' and/or their family/whanau are involved as appropriate when referral to another service occurs. Referrals sighted in the resident files sampled include: DHB psychiatric service for elderly community team, wound nurse specialist, psychiatric district nurse, physiotherapist, consultant psychiatrist and NASC services.

D16.4c; the service provided an example of where a residents condition had changed and the resident was reassessed from dementia care to rest home level of care.

D 20.1 discussions with two registered nurses identified that the service has access to a physio, dietitian and nurse specialists from the DHB.

#### 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:**

There is a discharge planning and transfer policies to guide staff in this process. Discussions with the service confirm that resident exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of residents care through the completed transfer form, copy of relevant progress notes, copy of medication chart and doctor's notes. A staff member or family member accompany dementia care residents to the hospital. There is a verbal handover where required to new service providers to ensure continuity of residents care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The medication management system includes Medication Policy and Procedures that follows recognised standards and guidelines for safe medicine management practice including, but are not limited to: a) medication management, b) medication charting c) standing orders, d) medication storage, e) blister pack management, f) medication administration, g) medication errors, h) staff training, i) storage and administration of controlled drugs, and j) medication audit. The service uses medico blister packs which are delivered monthly. The RN checks these on arrival from the supplying pharmacy and completes the blister pack check form and also signs the bottom of the blister pack.

RN's and care assistants administer medications. Orientation to medications include a self-learning package and supervised medication rounds. Annual competency is completed for staff administering medications. Medication education was held July 2014. The medication folders contain standing orders, medication information folder on common medications and MOH medication guidelines. Medication audit in August 2014 resulted in 89%.

Each wing has a medication folder, medication trolley and a locked medication storage area. There are no residents on controlled drugs at the service. Controlled drugs are stored in a locked safe in a locked cupboard in the treatment room in Rose wing if required. The controlled drug safe, as sighted, was empty. A controlled drugs register is maintained and evidence of past weekly checks was sighted. There are adequate pharmaceutical and medical supplies sighted. Eye drops are dated when opened. Medication expiry dates are checked four weekly. There is a medication fridge in the treatment room that is monitored daily with temperatures in the acceptable range as sighted.

There is a policy at Wimbledon Villa that states residents will not be involved in self-medicating related to their lack of insight secondary to their diagnosis, however one resident has been reassessed as requiring rest home level care (waiting for placement) and self-administers insulin. The manager stated that while the resident administers insulin this is done under full supervision to ensure compliance. The supervising RN signs the medication chart.

One respite resident has been admitted with blister packed medication from the community. There is no general practitioner prescription chart however staff are administering medications and signing for medications on a signing sheet. This is an area requiring improvement.

D16.5.e.i.2; Three of 12 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed (one resident is on respite care). This is an area requiring improvement. GP prescribing meets the legislative requirements.

All medication charts had current photo identification and allergies noted. Special medication instructions and precautionary advice is recorded on the medication charts. There are no gaps in the administration signing sheets.

One registered nurse and two care assistants were observed administering medications safely and correctly.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The medication management system includes Medication Policy and Procedures that follows recognised standards and guidelines for safe medicine management practice including, but are not limited to: a) medication management, b) medication charting c) standing orders, d) medication storage, e) blister pack management, f) medication administration, g) medication errors, h) staff training, i) storage and administration of controlled drugs and j) medication audit. The service uses medico blister packs which are delivered monthly.

**Finding:**

(i) Eight of 12 medication charts reviewed do not have documented evidence that the GP had seen the resident three monthly and signed the medication chart (one resident is on respite care). (ii) There is no general practitioner prescription chart for the resident on respite care however staff are administering medications and signing for medications on a signing sheet.

**Corrective Action:**

(i) Ensure that the GP reviews every resident medication chart three monthly and signs the medication chart. (ii) Ensure that the respite resident has a current prescription chart prescribed by the GP.

**Timeframe (days):** 7 (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:**

There is a kitchen service manual located in the kitchen which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. The main kitchen provides food to both wings. Food is transported to Rose wing in a hot box. Food is served directly from the kitchen to residents in Wimbledon wing. Temperature checks are undertaken daily for the fridges, freezers, and hot foods at each meal time. There is a kitchen journal form that is completed daily by the cook that includes all temperatures taken, equipment monitoring cleaning, food deliveries and food prepared for the day. Food in the pantry is stored off the floor, dated and stock is rotated each week when the food order is delivered. Perishable food is covered and dated in the fridges. The cook has been employed for two months. Food safety and hygiene training has been completed (August 2014). The cook manages the kitchen during the day and there is an evening meal assistant. There is a four weekly winter and summer menu in place which has been reviewed by a dietitian (August 2104). The service has access to a dietitian through a referral process as required (# link 1.3.3.4). A resident dietary profile is undertaken on each resident on admission and a copy provided to the cook and updated as required by the RN's. Special diets, meal textures, likes and dislikes are known and catered for. Changes to residents' dietary needs are communicated to the kitchen. Monthly weights are completed and where there is an issue this is addressed through the care planning process and communicated to the cooks (# link 1.3.6.1). A resident's weight audit has been completed in June 2014 resulting in 79%. Resident's weight education has been provided in April 2014. The cook reports that residents that are underweight are provided with extra cream to food, ice cream, extra desserts, bigger portions if applicable and food supplements. Special equipment is available as required such as lipped plates. Care plans include clear instructions for nutrition needs across the 24 hours. Nutrition and hydration is identified as a component of the care plan and these were noted in the six resident files sampled.

Feedback on the food service is received through staff and resident meetings. The cook meets with management regularly. Chemicals are stored safely within the kitchen. Common kitchen hazards are identified.

Meals viewed in wings noted that food services and the staff serving made efforts to provide meals that resident would eat.

E3.3f. There is evidence that there is additional nutritious snacks available over 24 hours.

D19.2. Staff have been trained in safe food handling.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

### Standard 1.4.1: 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:**

The service has in place Management of Waste and Hazardous Materials policy (Health and Safety policies) and relevant procedures to support the safe disposal of waste and hazardous substances. These include, but are not limited to: a) sharps procedure and b) cleaning/chemicals procedures and c) exposure to blood or other body fluid contamination policy. There is an incident reporting system that includes investigation of these types of incidents. Chemicals are labelled correctly and stored safely throughout the facility. There is appropriate protective equipment and clothing for staff. Staff attended chemical safety training in August 2012 (# link 1.2.7.5). The chemical supplier provides the safety data sheets and conducts quality control checks on the effectiveness of chemicals. Waste management contractors deliver and collect the drums weekly. Infectious material is double bagged and disposed of into the general rubbish drum. Recycling occurs. Sharps containers are delivered and collected by an external supplier with the approved containers for the disposal of sharps. Staff interviewed were able to describe waste management and chemical safety procedures.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The building has a current warrant of fitness that expires 8 July 2015. The building, plant and equipment meet the required regulatory standards. The service has completed a building upgrade to Rose wing that is now fully operational. The service is divided into two home-like dementia care wings (Rose and Wimbledon). Each wing has its own kitchenette, dishwasher, microwave, fridge, open plan dining and lounge areas. The décor is calming with bright artwork and adornments. Fresh flowers on the tables added to the home-like setting. Furniture and fittings are selected with consideration to residents' abilities and functioning.

The maintenance person checks the maintenance books in each nurse station for day to day requests. Hot water and air temperature is checked monthly and is within acceptable range as sighted. There is a pool of contractors available for larger maintenance problems. Planned maintenance schedules are in place for internal and external building maintenance. There is a 2014 maintenance plan. There is an electrical register (including resident's rooms) and electrical equipment has been tested and tagged (July 2014). Medical equipment includes a blood pressure machine, ear thermometer and pulse oximeter that requires calibration. This is an area requiring improvement. Chair weighing scales are hired two-four weekly.

Residents were able to move freely inside and within the secure outside environments. The paths are flat and the exterior including the extensive gardens are well maintained. The residents can enter/visit the other wings from any of the external walk ways. There is shaded seating areas/gazebo and raised flower and vegetable gardens. The wings are spacious and wide corridors allow for the use of mobility equipment. Handrails are in place within the communal areas.

The service has a van for resident outings which has a current WOF that expires in February 2015 and van registration that expires in 29 September 2014.

E3.4d, The lounge areas are designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; The following equipment is available, shower trolley, shower chairs, walking frames, gutter frames, over bed tables, commodes, pressure relieving mattresses, shower chairs, roho pressure relieving cushions, hoist, resident transferring aids.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; There is a safe and secure outside area that is easy to access.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** PA Low

**Evidence:**

The maintenance person checks the maintenance books in each nurse station for day to day requests. Hot water and air temperature is checked monthly and is within acceptable range as sighted. There is a pool of contractors available for larger maintenance problems. Planned maintenance schedules are in place for internal and external building maintenance. There is a 2014 maintenance plan. There is an electrical register (including resident's rooms) and electrical equipment has been tested and tagged (July 2014). Medical equipment includes blood pressure machine, ear thermometer and pulse oximeter that requires calibration. Chair weighing scales are hired two to four weekly.

**Finding:**

Medical equipment including blood pressure machine, ear thermometer and pulse oximeter have not been calibrated.

**Corrective Action:**

Ensure that all medical equipment is calibrated by an external technician. Since the draft report, the manager provided evidence that calibration occurred 29/09/14

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

Some of the rooms in both wings have ensuites and there are large communal toilets in both wings including shower/shower trolley rooms. The facilities are close enough and large enough to meet the needs of the residents. Fixtures, fittings and floor and wall surfaces are made of accepted materials for meeting hygiene and infection control practices. Communal toilets and showers are well signed and identifiable. There are engaged/vacancy signs on the doors and privacy curtains. There are appropriately placed handrails in the bathrooms and toilets in the ensuites and communal areas.

**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:**

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids and hoists. The bedrooms are personalised. The bedrooms have photos identifiable to the resident on their bedrooms doors. There are beds with mattress sensors in Rose wing that can be programmed to alert staff when the resident gets out of bed. The sensor system also initiates the resident's bathroom light to come on when they get out of bed and triggers the nurse call alarm. Sensor mats are utilised in resident's room in Wimbledon wing that triggers the nurse call alarm.

### **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 maneuver 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:**

Each wing has its own kitchenette and open plan dining and lounge areas. Furniture is arranged to allow residents to freely mobilise between the different areas of each home and to the outside. In all wings, the lounges are accessible and accommodate the equipment required for the residents. The service has no dead-end corridors and residents are free to mix and join in different activities. Activities take place in the dining rooms or lounge areas of each wing dependent on the type of activity. There are cameras in areas away from the main lounges connected to surveillance monitors for resident safety. Residents have easy access to secure out door areas with raised flower and vegetable gardens, water features and art work of interest.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

### 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:**

The service has in place policies and procedures for effective management of cleaning and linen practices. The laundry is completed daily by an external contractor. A small amount of personal laundry is carried out by care assistants if required. There is a small locked laundry with one washing machine, one dryer and a sluice. The laundry duties completed by the cleaner include the cleaning of lint from the dryer and maintaining a clean and tidy laundry area. The chemical system is maintained in the locked



laundry. Other chemicals are kept in the locked cleaner's cupboard. The cleaners have a dedicated trolley for their equipment and chemicals when carrying out the cleaning duties. There are two sluice rooms within the facility, one for each wing. Protective equipment available in the laundry and sluice rooms are aprons, gloves and face shields. Families interviewed are very satisfied with the cleanliness of their relative's rooms and the care taken with personal clothing. A cleaning and laundry services audit carried out in March 2014 resulted in 81% satisfaction. Chemical training was last held August 2012 (# link 1.2.7.5).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Appropriate training, information, and equipment for responding to emergencies is provided (link 1.2.7). There is an approved evacuation plan (letter dated 18/10/13). Fire evacuations are held six monthly and the last drill was completed 06/07/14, noting this was an actual drill. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, two generators, two water tanks, and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery back up. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas - indicator panels are in the newly built Rose wing. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

### 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:**

General living areas and resident rooms are appropriately heated and ventilated. Lounges and corridors are heated by heat pumps and resident's rooms have individual wall panel heaters. Corridor heating is thermostat controlled. Air conditioning is available. Family members interviewed state the home is lovely and warm. Residents have access to natural light in their rooms and there is adequate external light in communal areas.

#### 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:**

Wimbledon Villa has comprehensive policies and procedures on restraint minimisation and safe practice. The clinical nurse manager is the restraint coordinator and confirms that the service promotes a restraint-free environment.

Policy states that enablers are voluntary. There are no residents using enablers and no residents assessed as requiring restraint. The service has been restraint free for over 12 months. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers.

Documentation includes restraint register, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms. Restraint education (including challenging behaviour) provided for staff in April 2014 with associated questionnaire and competency. Restraint audit has been completed in March 2014 resulting in 100%

Restraint is discussed monthly as part of the team meeting (general staff meeting). The restraint approval group meets six monthly (20 August 2014) and the last meeting included updating the policy on emergency restraint (as sighted in the minutes).

All staff have either completed ACE dementia training or are currently completing the modules.

E4.4a The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

---

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator who is the clinical nurse manager. There is an implemented infection control programme that is linked into the quality management system. The infection control programme is reviewed annually. The facility has access to GPs, local Laboratory, the infection control and public health departments at the local DHB for advice. Infection control matters are taken to the monthly staff and management meetings and also discussed at the fortnightly quality meetings.

#### 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 team is essentially the staff with the clinical nurse manager taking the lead. The facility also has access to infection control nurse specialist, district health board specialists, public health and GP's.

**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:**

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures. Policy review involves the infection control coordinator and the management team.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has completed appropriate IC training including completion of a post graduate health policy and practice paper through Victoria University. The orientation package includes specific training around hand washing. The IC coordinator provides training both at orientation and ongoing. Training on infection control is included in as part of the training schedule and last provided August 2014. Monthly surveillance audits also include opportunistic education with staff. Resident education is expected to occur as part of providing daily cares.

#### 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:**

There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection report forms are completed for all infections. Infections are included on a monthly summary sheet completed by the infection control coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality meetings, management and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. The service reports having had norovirus outbreak in April 2014. Appropriate notifications were made (sighted), and the virus affected 10 residents and four staff. The service was 'shut down' for ten days.

### **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.)*