# Ohope Beach Care Limited

## Current Status: 1 October 2014

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

## General overview

Ohope Beach Rest Home provides residential care for up to 36 residents assessed as requiring dementia level care and rest home level care. The governing body is Ohope Beach Care Limited and there are two directors.

Thirty three areas were identified as requiring improvement during this audit. The improvements relate to: management of advance directives and consent; the complaints register; reporting to the governing body; maintenance of quality and risk management systems including adverse event reporting; maintenance of human resource management systems; distribution of staffing; management of resident documentation; content of the admission agreement; resident care planning documentation including completion of risk assessments, short term care plans, individualised care plans, interventions to meet resident’s needs, completion of evaluations and timeframes; medicine management including completion of competency assessments, transcribing, and regular stock taking; management of food services including completion of dietary assessments and monitoring of food temperatures; environmental management including the absence of a documented preventative maintenance programme, the safety of the external areas in the dementia wing; and the call bell system.

## Audit Summary as at 1 October 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 1 October 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Organisational Management as at 1 October 2014

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

### Continuum of Service Delivery as at 1 October 2014

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

### Safe and Appropriate Environment as at 1 October 2014

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

### Restraint Minimisation and Safe Practice as at 1 October 2014

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

### Infection Prevention and Control as at 1 October 2014

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

## Audit Results as at 1 October 2014

### Consumer Rights

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the complaints processes and the Nationwide Health and Disability Advocacy Service, is accessible and is brought to the attention of residents’ and their families on admission to the facility. Residents and family members interviewed confirmed that their rights are met, staff are respectful of their needs, communication is appropriate, and they have an understanding of their rights and the facility’s processes if these are not met.

During interview residents and family confirm consent forms are provided to them. Improvements are required with the management of consent documentation including advance directives and resuscitation orders, and permission for transportation of the residents by the provider.

The facility manager is responsible for the management of complaints. A complaints register is not maintained that includes all dates and actions taken; improvements are required to aspect of service delivery.

### Organisational Management

Ohope Beach Care Limited is the governing body and is responsible for the service provided at Ohope Beach Rest Home. A business plan is reviewed and includes a strategic direction, vision, mission statement, scope of services, objectives and an action plan. Improvements are required as there is no documented evidence of regular reporting by the facility manager to the governing body.

Ohope Beach Rest Home is managed by a non-clinical facility manager who was appointed to this position in July 2006. There are two recently appointed registered nurses who job share the clinical manager position and who are responsible for oversight of the clinical care provided. The two clinical managers / registered nurses work four days a week each and provide cover seven days a week. Both registered nurses (RN's) have current annual practising certificates.

Improvements are required to the quality and risk management systems as resident / family meetings are not held on a regular basis, there is no formal document control process in place and several of the policies and procedures reviewed are not up-to-date, quality improvement data is not being analysed to identify trends, and corrective action plans are not being developed and implemented to address shortfalls identified. There is an internal audit programme in place and the majority of the audits scored 100%. Adverse events are documented on accident/incident forms, however improvements are required as not all sections are being filled in, they are not consistently being reviewed by the registered nurse, neurological observations are not being completed for residents who have unwitnessed falls or injuries that could result in a head injury, the forms do not indicate whether or not the family and the GP have been notified of the adverse event. The accident/incident forms are filed together in a separate folder rather than in the residents notes and improvements are required.

There are policies and procedures on human resources management, however improvements are required to this aspect of service delivery. The improvements required relate to maintenance of a practising certificate register, completion of reference checking for all employees, provision and completion of an orientation by all new employees, and provision of key education sessions and completion of competency assessments by staff.

There is a documented rationale for determining staffing levels however improvements are required as all staff are based in the dementia unit.

Resident information is entered into a register in an accurate and timely manner. Improvements are required with the management of resident documentation as staff are not recording their designation in resident’s notes and not all resident notes have the resident’s name, or other unique identifier, on them.

### Continuum of Service Delivery

The systems are implemented that evidence each stage of service provision has been developed with the resident and/or the family input and is coordinated to promote continuity of service delivery. All residents admitted to the facility are assessed as requiring rest home or dementia level of care. There is an area requiring improvement around the admission agreement to include all the contractual requirements.

The documentation and observations made of the provision of services demonstrate that consultation and liaison is occurring with other services. The residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs, their participation in care planning and care plan evaluations and access to a typical range of life experiences and choices. There are areas requiring improvement around service delivery timeframes; completion of initial care plans; completion and evaluation of risk assessments; care plan interventions; care plan evaluations and the use of short term care plans.

The residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. There are areas requiring improvement around the 24 hour activities plans, activities staff and the activities programme.

The medication area in the facility evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. There is one controlled drugs storage in the facility and this is secure. The residents' medicine charts list all medications a resident is taking, three monthly medication reviews, allergies and residents’ photo identification. There are areas requiring improvement around the medication system to comply with legislation, protocols and guidelines and for all staff who administer medicines to have current medication competencies.

The facility has a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety training. The menu has been reviewed by a dietitian. There are areas requiring improvement around the residents’ dietary needs to be communicated to the kitchen staff and kitchen staff to wear hats when preparing meals, decanted foods to be dated and food temperatures to be monitored.

### Safe and Appropriate Environment

There are two double bedrooms, however all bedrooms provide single accommodation. Some of the bedrooms have wash hand basins and toilets and there is one bedroom with full ensuite facilities.

There are adequate toilet and shower facilities throughout the facility. Residents' rooms are of varying sizes and are large enough to allow for the safe use of mobility aids as well as a carer. One of the bedrooms in the dementia unit does not have a wardrobe and improvements are required. There are three external areas in the dementia unit and the fencing in these areas are potential climbing hazards and improvements are required. Other areas identified as requiring improvement include the time it takes for the door between the dementia unit and the rest home to close, the management of hot water temperatures at a safe level, and maintenance is required to the splash guard behind the sink in the main laundry. A call bell system is in place although improvements are required as if the call bells are activated by residents in the rest home, there is no audible sound as it rings in the dementia unit and staff come from the dementia unit to answer the call bell.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. All laundry is washed on site and the cleaning and laundry systems include monitoring systems to evaluate the effectiveness of these services. Staff have received training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided.

### Restraint Minimisation and Safe Practice

The service demonstrates compliance with the Standard. Documentation of policies and procedures and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive. The facility was not using restraints or enablers on audit days.

### Infection Prevention and Control

The Infection Prevention and Control (IC) Programme includes policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice. New employees are provided with training in infection control practices and there is on-going education available for all staff. Staff interviews confirm staff are familiar with infection control measures at the facility. Surveillance infection data are collated at the end of each month and reported to staff through meetings.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Ohope Beach Care Limited |
| **Certificate name:** | Ohope Beach Care Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | HealthShare Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Ohope Beach Care |
| **Services audited:** | Rest home care (excluding dementia care); Dementia care |
| **Dates of audit:** | **Start date:** | 1 October 2014 | **End date:** | 2 October 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 29 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 12 | **Hours off site** | 12 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 10 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXXX  |  |  | **Hours** | 4 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 26 | Total audit hours | 50 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 7 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 8 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 19 | Total number of staff (headcount) | 29 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Thursday, 6 November 2014

## **Executive Summary of Audit**

**General Overview**

Ohope Beach Rest Home provides residential care for up to 36 residents assessed as requiring dementia level care and rest home level care. Occupancy was 29 during this audit. The governing body is Ohope Beach Care Limited and there are two directors.

Thirty three areas were identified as requiring improvement during this audit. The improvements relate to: management of advance directives and consent; the complaints register; reporting to the governing body; maintenance of quality and risk management systems including adverse event reporting; maintenance of human resource management systems; distribution of staffing; management of resident documentation; content of the admission agreement; resident care planning documentation including completion of risk assessments, short term care plans, individualised care plans, interventions to meet resident’s needs, completion of evaluations and timeframes; medicine management including completion of competency assessments, transcribing, and regular stock taking; management of food services including completion of dietary assessments and monitoring of food temperatures; environmental management including the absence of a documented preventative maintenance programme, the safety of the external areas in the dementia wing; and the call bell system.

**Outcome 1.1: Consumer Rights**

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the complaints processes and the Nationwide Health and Disability Advocacy Service, is accessible and is brought to the attention of residents’ and their families on admission to the facility. Residents and family members interviewed confirmed that their rights are met, staff are respectful of their needs, communication is appropriate, and they have an understanding of their rights and the facility’s processes if these are not met.

During interview residents and family confirm consent forms are provided to them. Improvements are required with the management of consent documentation including advance directives and resuscitation orders, and permission for transportation of the residents by the provider.

The facility manager is responsible for the management of complaints. A complaints register is not maintained that includes all dates and actions taken; improvements are required to aspect of service delivery.

**Outcome 1.2: Organisational Management**

Ohope Beach Care Limited is the governing body and is responsible for the service provided at Ohope Beach Rest Home. A business plan is reviewed and includes a strategic direction, vision, mission statement, scope of services, objectives and an action plan. Improvements are required as there is no documented evidence of regular reporting by the facility manager to the governing body.

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There is a documented rationale for determining staffing levels however improvements are required as all staff are based in the dementia unit.

Resident information is entered into a register in an accurate and timely manner. Improvements are required with the management of resident documentation as staff are not recording their designation in resident’s notes and not all resident notes have the resident’s name, or other unique identifier, on them.

**Outcome 1.3: Continuum of Service Delivery**

The systems are implemented that evidence each stage of service provision has been developed with the resident and/or the family input and is coordinated to promote continuity of service delivery. All residents admitted to the facility are assessed as requiring rest home or dementia level of care. There is an area requiring improvement around the admission agreement to include all the contractual requirements.

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**Outcome 1.4: Safe and Appropriate Environment**

There are two double bedrooms that are used to provide single, otherwise all bedrooms provide single accommodation. Some of the bedrooms have wash hand basins and toilets and there is one bedroom with full ensuite facilities.

There are adequate toilet and shower facilities throughout the facility. Residents' rooms are of varying sizes and are large enough to allow for the safe use of mobility aids as well as a carer. One of the bedrooms in the dementia unit does not have a wardrobe and improvements are required. There are three external areas in the dementia unit and the fencing in these areas are potential climbing hazards and improvements are required. Other areas identified as requiring improvement include the time it takes for the door between the dementia unit and the rest home to close, the management of hot water temperatures at a safe level, and maintenance is required to the splash guard behind the sink in the main laundry. A call bell system is in place although improvements are required as if the call bells are activated by residents in the rest home, there is no audible sound as it rings in the dementia unit and staff come from the dementia unit to answer the call bell.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. All laundry is washed on site and the cleaning and laundry systems include monitoring systems to evaluate the effectiveness of these services. Staff have received training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided.

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

The service demonstrates compliance with the Standard. Documentation of policies and procedures and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive. The facility was not using restraints or enablers on audit days.

**Outcome 3: Infection Prevention and Control**

The Infection Prevention and Control (IC) Programme includes policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice. New employees are provided with training in infection control practices and there is on-going education available for all staff. Staff interviews confirm staff are familiar with infection control measures at the facility. Surveillance for residents who develop infection are collated at the end of each month and reported to staff through meetings.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 26 | 0 | 5 | 14 | 0 | 0 |
| **Criteria** | 0 | 60 | 0 | 15 | 18 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.4 | The service is able to demonstrate that written consent is obtained where required. | PA Low | There is no evidence of a consent form for residents’ outings. | Provide evidence of consent for outing. | 180 |
| HDS(C)S.2008 | Criterion 1.1.10.7 | Advance directives that are made available to service providers are acted on where valid. | PA Moderate | The ‘not for resuscitation’ orders completed by the GP do not always evidence the resident signature. | Provide evidence the ‘not for resuscitation’ orders are valid. | 30 |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management  | The right of the consumer to make a complaint is understood, respected, and upheld.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | A complaints register that includes all complaints, dates and actions taken is not being kept. | Provide evidence that a complaints register that includes all complaints, dates and actions taken is being maintained. | 90 |
| HDS(C)S.2008 | Standard 1.2.1: Governance | The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.1.1 | The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Moderate | There is no formal process in place for reporting by the facility manager to the governing body.  | Provide evidence a formal process of regular reporting by the facility manager to the governing body has been implemented.  | 90 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.1 | The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | Resident and family meetings are not held on a regular basis  | Provide evidence that resident meetings for rest home residents and family and resident meetings for residents in the dementia unit are held on a regular basis. | 180 |
| HDS(C)S.2008 | Criterion 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. | PA Low | (i)The majority of the clinical policies and procedures reviewed during this audit have not been reviewed since 2011. (ii) Documentation reviewed does not consistently provide evidence that policies and procedures are based on evidence-based rationales. | Provide evidence that (i) a process has been implemented to ensure that all policies and procedures are reviewed on a regular basis by appropriate personnel; and (ii) policies and procedures are based on evidence-based rationales. | 180 |
| HDS(C)S.2008 | Criterion 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. | PA Low | There is no formal document control process in place to manage the policies and procedures with a view to ensuring that documents are up to date. | Provide evidence that a document control process has been implemented to ensure that documents are up to date. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | There is no documented evidence available indicating that quality improvement data is being collated, evaluated and analysed and the results of this reported to staff. | Provide documented evidence indicating that quality improvement data is being collated, evaluated and analysed and the results of this reported to staff. | 90 |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Corrective action plans are not being developed to address all areas identified as requiring improvement, timeframes and person/s responsible for the corrective actions are not being consistently documented; and evidence of implementation and monitoring of the corrective action plan is not always evident. | Provide evidence that (i) corrective action plans are being developed to address all areas identified as requiring improvement; (ii) timeframes and person/s responsible for the corrective actions are being consistently documented; and (iii) evidence of implementation and monitoring of the corrective action plan is being documented. | 180 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting  | 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.  | PA Moderate |  |  |  |
| 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 Moderate | (i)Accident and incident forms do not provide consistent evidence that they are being reviewed and signed off by the registered nurse; (ii) The accident and incident forms do not provide evidence that the family and / or the residents GP has been advised (or not) of the adverse event; (iii) Several of the accident and incident forms reviewed for July have not been fully completed; (iv) Neurological observations are not being taken and recorded following unwitnessed falls and following any potential head injury.  | Provide evidence that: (i) all accident and incident forms are being reviewed by the registered nurse and are signed off as completed; (ii) any contact, or not, with the family and the GP is clearly recorded on the accident and incident form; (iii) all accident and incident forms are fully completed; and (iv) that neurological observations are being taken for all residents following unwitnessed falls and following any adverse event that could potentially involve a head injury.  | 60 |
| 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.2 | Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low | Current copies of practising certificates are not held on site for the pharmacists, podiatrist and GP. Current copies of these were obtained by the facility manager during this audit. | Provide confirmation that a process for ensuring professional qualifications are validated, including evidence of registration and scope of practice for service providers is maintained. | 180 |
| HDS(C)S.2008 | Criterion 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Evidence of reference checking is not evident on seven of the seven staff files reviewed. | Provide evidence that reference checking is completed for all new employees. | 180 |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Moderate | (i)Three of the seven staff files reviewed, including one of the clinical managers / registered nurses, does not have evidence that an orientation has been completed. (ii) The two clinical managers / registered nurses advise during interview that they have not received an orientation that is specific to their role. | Provide evidence that (i) an orientation is completed for all new members of staff; and (ii) that the two clinical managers receive an orientation that is specific to their role. | 90 |
| 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 Moderate | (i)Some of the key education sessions have not been provided and / or attended by all relevant staff including but not limited to medicine management, cultural safety, and management of challenging behaviours. (ii) The two clinical manager’s / registered nurses do not have current medication management competencies. | Provide evidence that (i) all staff receive challenging behaviour and cultural safety education and that all relevant staff receive medication management education; and (ii) the two clinical managers / registered nurses have completed medication management competency assessments. | 90 |
| HDS(C)S.2008 | Standard 1.2.8: Service Provider Availability  | Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | There is no member of staff located in the rest home 24 hours a day as they are based in the dementia unit. | Provide confirmation that a staff member is located in the rest home at all times. | 30 |
| HDS(C)S.2008 | Standard 1.2.9: Consumer Information Management Systems  | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.9.9 | All records are legible and the name and designation of the service provider is identifiable. | PA Moderate | Staff are not consistently recording their designation on resident’s progress notes; and (ii) the date, their signature and designation on all resident forms. | Provide evidence that staff are consistently recording (i) their designation when making an entry on resident’s progress notes; and (ii) the date, their signature and designation on all resident forms. | 90 |
| HDS(C)S.2008 | Criterion 1.2.9.10 | All records pertaining to individual consumer service delivery are integrated. | PA Low | (i)Resident’s accident and incident forms are not retained in resident’s files; (ii) A unique identifier for each resident, for example the stickers with resident’s NHI number, name and date of birth, is not being recorded on all pages of resident’s documentation in their clinical file. | Provide confirmation that (i) resident’s incident and accident forms are integrated in to the resident‘s records; and (ii) that a unique identifier for each resident, for example the stickers with resident’s NHI number, name and date of birth, is being recorded on all pages of resident’s documentation in their clinical file.. | 90 |
| HDS(C)S.2008 | Standard 1.3.1: Entry To Services  | Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The admission agreement does not contain all the requirements of the DHB contract (ARC contract D13). | Provide evidence of the admission agreement complying with the DHB contract requirements. | 180 |
| 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | The service delivery is not consistently provided within specified timeframes. | Provide evidence each stage of service provision is provided within specified timeframes. | 90 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment  | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | The assessments and care planning process on admission does not always include completion of the initial care plan and the required risk assessments such as: pain; cultural, activities (ARC contract E4.2a & b) and challenging behaviour assessments (ARC contract E3.4a) and these are not always reviewed six monthly. | Provide evidence the initial care plans and all required risk assessments are completed on admission and reviewed regularly. | 90 |
| HDS(C)S.2008 | Standard 1.3.5: Planning  | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The required support and interventions are not consistently recorded on residents’ care plans.  | Provide evidence of the support required around identified needs and interventions and for the interventions to be detailed to guide staff in service delivery to residents. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The care plan interventions do not consistently meet the residents’ assessed needs. | Provide evidence the care plan interventions are consistent with meeting residents’ needs. | 90 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.7.1 | Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | i) The 24 hour activity plans do not always record the required areas of challenging behaviour and appropriate activities specific to a 24 hour timeframe.ii) The annual residents’ meeting does not evidence discussion in respect of activities at the home.iii) The activities programme does not cover sun downing period and there is no evidence of care staff providing the planned activities in the weekend. iv) The activities staff have not completed diversional training and the activities programme has not been reviewed by a diversional therapist. | i) Provide evidence the 24 hour activities plans detail appropriate, individualised activities to implement for residents’ challenging behaviours.ii) Provide evidence frequent residents’ meetings are conducted with evidence of input from residents in respect of the activities programme.iii) Provide evidence of an activities programme for sun downing period and records to support this is provided when activities staff are not present at the facility.IV) Provide evidence of trained diversional therapist for dementia residents, as per DHB contract. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation  | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.2 | Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | i) The activities care plan evaluations are not consistently conducted six monthly. When activities care plans are evaluated, the evaluations are not transferred / recorded on to the activities care plan.ii) The care plan evaluations do not consistently record the degree of achievement to the interventions and support provided. | Provide evidence the activities evaluations are recorded on the activities care plans and evaluations record the degree of achievement towards meeting the resident’s goals. | 90 |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | There is evidence short term care plans are not consistently recorded for short term problems. | Provide evidence of short term care plan use for short term problems. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | i) There is no evidence of six monthly stocktakes of controlled drugs.Ii) Evidenced transcribing on medicationii) Single use normal saline is taped after use and reused. | Provide evidence the medication system complies with legislation, protocols and guidelines. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Not all staff who administer medication have current medication competencies. | Provide evidence of the staff who administer medicines have current medication competencies. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.2 | Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Moderate | The residents’ dietary assessments are not always provided to kitchen staff.  | Provide evidence all residents’ dietary needs are communicated to the kitchen and kitchen staff are aware of the residents’ allergies, likes and dislikes. | 30 |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | i) There is inconsistent dating of decanted foods.ii) Food temperatures are not conducted regularly.iii) Staff in the kitchen do not wear hats. | Provide evidence kitchen staff wear hats when preparing meals, decanted foods are dated and food temperatures are monitored.  | 90 |
| 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 | (i)Hot water temperatures exceed 45 degrees Celsius at five hot water outlets used by residents. The plumber was contacted during this audit and adjusted the tempering valves; (ii) there is no documented planned preventative maintenance programme in place; (iii) the splash board behind the tubs in the main laundry is water damaged and presents a potential infection control risk; (iv) room 8A in the dementia unit does not have a wardrobe for the resident’s clothes. | Provide confirmation that (i) hot water temperatures do not exceed 45 degrees Celsius at five hot water outlets used by residents; (ii) A documented planned preventative maintenance programme is developed and implemented; (iii) the splash board behind the tubs in the main laundry has been repaired; (iv) a wardrobe has been installed in room 8A in the dementia unit. | 90 |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | The door between the dementia unit and the rest home is slow to close. | Provide confirmation that the door between the dementia unit and the rest home has been adjusted so that it closes more quickly so that residents are not able to leave the dementia unit | 30 |
| HDS(C)S.2008 | Criterion 1.4.2.6 | Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | The fences in the three external areas in the dementia unit are potentially able to be climbed over by residents. It is acknowledged the facility manager is aware of this issue and is attempting to address it. | Provide confirmation that the external areas in the dementia unit are safe and residents are not able to climb over the fences. | 90 |
| HDS(C)S.2008 | Standard 1.4.7: Essential, Emergency, And Security Systems  | Consumers receive an appropriate and timely response during emergency and security situations. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.7.5 | An appropriate 'call system' is available to summon assistance when required. | PA Low | There is no indicator panel or audible indicator to alert staff who are working in the rest home area that a resident has used their call bell.  | Provide confirmation that staff working within the rest home are alerted, and respond in a timely manner, when a resident within the rest home activates their call bell. | 90 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Staff receive training in the Code of Health and Disability Services Consumers’ Rights’ (the Code) and this was last provided in January 2014 by the advocate from the Health and Disability Service. Care staff are observed interacting respectfully and communicating appropriately with residents. Staff encourage residents to make choices demonstrating their knowledge of residents’ rights.

Residents (six rest home) and family members (five dementia) are able to verify that services are provided with dignity and respect, privacy is maintained, and individual needs and rights are upheld.

Interviews with staff (facility manager, the two clinical mangers / registered nurses, three care givers and one activities co-ordinator) demonstrate an understanding of resident rights.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

The Code of Rights (the Code) and information on the advocacy service are displayed and are available at the facility and in the information pack provided on admission to the facility. Residents interviewed confirm they have access to an independent advocate if needed.

Residents and family members interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service in the facility’s admission package prior to the resident’s admission. This information is reviewed and includes an information booklet. Residents and family interviewed confirm explanations regarding their rights occur on admission and at any time that they may have a query.

The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. An improvement is required to the admission agreement as it does not comply with the District Health Board requirements (see link criterion 1.3.1.4).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of residents (six rest home) and family members (five dementia).

Documentation reviewed provides confirmation that staff last received training on the Code, including abuse and neglect, advocacy and complaints, in January 2014 and that this education was provided by the Health and Disability advocate.

Staff are observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Activities in the community are encouraged and several residents attend community events independently. Church services are held on site as part of the activities programme. Eight residents files are reviewed (four rest home and four dementia level residents) and needs and values are documented to varying degrees (see link criterion 1.3.4.2)

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisation has guidelines for the provision of culturally safe services for Māori residents that includes information on cultural awareness, cultural safety, and the importance of whanau. There are currently two residents in the facility that identify as Māori and the facility manager describes the processes they follow when a resident who identifies as Māori is admitted. The files of the two residents who identify as Māori indicates that whanau are as involved in the care of these residents as the individual resident desires. These care plans indicate that cultural assessments are not completed for these residents and improvements are required (see criterion 1.3.4.2). Access to Māori support and advocacy services is available via family members of residents and from Kuia and Kaumatua from the local iwi as well as from the District Health Board.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that residents who identify as Māori have access to appropriate services. The facility manager advises that cultural safety education has not been provided for some time (see criterion 1.2.7.5).

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation reviewed during this audit provides evidence that appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. The facility manager and care manager / registered nurse describe processes on how to access appropriate expertise from for example cultural specialists and interpreters.

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. Church services are held on site on a regular basis as part of the activities programme.

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

There are policies and procedures in place that outline the safeguards to protect residents from abuse and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and house rules which include information on conflicts of interest including the accepting of gifts and personal transactions with residents and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which are reviewed on staff files (seven).

A review of the accident/incident reporting system, complaints register and interviews of the facility manager indicates there has been one allegation made by the District Health Board against staff alleging unacceptable behaviour. This complaint is currently being investigated by the District Health Board.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. During interviews the care managers / registered nurses and the facility manager describe the process for ensuring service provision is based on best practice, including access to clinical nurse specialists and District Health Board specialists. Staff interviewed confirm understanding of professional boundaries and practice. Documentation reviewed does not consistently provide evidence that policies and procedures are based on evidence-based rationales and the improvements required are detailed in criterion 1.2.3.3.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An open disclosure policy and procedures are in place to ensure staff maintain open communication with residents and their families. Residents' files reviewed (four rest home and four dementia) provide evidence that communication with family members is being documented in residents' records. Improvements are required with completion of accident and incident forms as there is no evidence of communication with the GP and family following adverse events (see criterion 1.2.4.3). The facility manager advises this contact is recorded in family communication sheets and in progress notes in the individual resident's files.

Residents (six rest home) and family members (five dementia level residents) interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care.

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

The residents and family are informed of the scope of services and any items they have to pay for that is not covered by the agreement (see link criterion 1.3.1.4).

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The eight of eight resident files (four rest home and four dementia) reviewed evidence general consent, however this consent does not include consent for outings and the advance directive stating ‘not for resuscitation’ orders are not always signed by the residents.

The residents and family participate in assessment, care planning and care evaluations, confirmed at six rest home residents and five dementia family interviews.

There are requirements for improvement relating to advanced directives stating that the resident ‘is not for resuscitation’ to only be signed by the resident who is competent to make the decision and for general consents to include outings.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

All eight residents’ files sampled (four rest home and four dementia) evidence completed informed consent forms. The informed consent form records:” consent for collecting and storage of resident information; routine procedures (such as lab tests, X-rays , ECG, influenza vaccinations, wound care); consent to allow visiting personnel involvement and implementation of resident care under supervision of staff if it is beneficial to their leaning and work experience; use of photos for identification and display of relevant information and photos; and consent for environmental restraint for dementia residents.”

**Finding:**

There is no evidence of a consent form for residents’ outings.

**Corrective Action:**

Provide evidence of consent for outing.

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

**Evidence:**

The policy records advance directives can be made by the resident or their appointed agent. The policy on informed consent requires review (refer to 1.2.3.3). Resuscitation/advance directive form has a flow chart for resuscitation treatment plan completed by the GP.

All eight files reviewed (four rest home and four dementia) have the resuscitation treatment plan with a not for resuscitation order in place signed by the GP. The second page of this resuscitation treatment plan is to be completed to indicate the resident’s decision in respect of the resuscitation request. The GP is to complete if the resident is competent to make this decision, signature of both the GP and the resident are required on this form. The resuscitation treatment plan is not consistently fully completed to indicate a discussion has been held with the resident. The residents who are deemed competent by the GP have ‘ not for resuscitation’ form completed without their signature or evidence of discussion with the competent resident, sighted in three of four rest home residents’ files.

**Finding:**

The ‘not for resuscitation’ orders completed by the GP do not always evidence the resident signature.

**Corrective Action:**

Provide evidence the ‘not for resuscitation’ orders are valid.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

The District Health Board contract requirements are met.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Improvements are required with this aspect of service delivery as a complaints register is not maintained that includes all complaints, dates and actions taken (see criterion 1.1.13.3)

The manager advises there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, Police, Accident Compensation Corporation (ACC), or the Coroner since the previous audit at this facility. They advise there has been one complaint from the District Health Board (DHB) that is currently being investigated,

Complaints policies and procedures are reviewed and are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents / their families as part of the admission process. Residents and family interviewed demonstrate an understanding and awareness of these processes.

A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of quality / clinical meeting minutes provide evidence of reporting of complaints.

Not all of the District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A complaints folder is reviewed and has completed complaints forms and a “Concerns Resolution Audit’. The ‘Concerns Resolution Audit’ is a month by month summary of the numbers of complaints for each month, and includes a section to record the number of complaints that have been responded to within five days, as well as other timeframes. The facility manager developed a complaints register template during this audit.

 The ‘Concerns Resolution Audit’ indicates two complaints have been received in 2014, one from the District Health Board (DHB) in September 2014 regarding the care of a resident in the dementia unit who was exhibiting challenging behaviour. The letter from the DHB and a response from the provider to the DHB as well as the providers meeting minutes with the DHB are reviewed during this audit.

**Finding:**

A complaints register that includes all complaints, dates and actions taken is not being kept.

**Corrective Action:**

Provide evidence that a complaints register that includes all complaints, dates and actions taken is being maintained.

**Timeframe (days):** 90 *(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:** PA Moderate

**Evidence:**

There is no formal reporting process in place where the facility manager reports on a regular basis to the governing body and improvements are required (see criterion 1.2.1.1.)

Ohope Beach Care Limited is the governing body and is responsible for the service provided at Ohope Beach Rest Home. A business plan is reviewed and includes a strategic direction, vision, mission statement, scope of services, objectives and an action plan. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

Ohope Beach Rest Home is managed by a non-clinical facility manager who was appointed to this position in July 2006. There are two recently appointed registered nurses who job share the clinical manager position and who are responsible for oversight of the clinical care provided. The two clinical managers / registered nurses work four days a week each and provide cover seven days a week. Both registered nurses (RN's) have current annual practising certificates.

Ohope Beach Rest Home is certified to provide rest home level care and rest home dementia care and has contracts with the District Health Board (DHB) to provide aged related residential care - rest home, dementia, and respite services.

Not all of the District Health Board contract requirements are met.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

A 2014 business plan is reviewed and includes goals, objectives, action plan as well as core values and the management structure. A ‘Strategic Direction’ (August 2014) is reviewed and includes a vision, mission statement, scope of services and strategic direction.

The facility manager advises the director (one of two) visits monthly but these meetings are not minuted. The facility manager also advises they are in contact with one of the directors at least weekly by phone.

One report to the director dated 30 May 2012 was reviewed during this audit and the facility manager advises they will reinstate these reports.

**Finding:**

There is no formal process in place for reporting by the facility manager to the governing body.

**Corrective Action:**

Provide evidence a formal process of regular reporting by the facility manager to the governing body has been implemented.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are systems in place to ensure the day-to-day operation of the service continues should either of the care managers / registered nurses be absent and they relieve for each other. The facility manager advises their daughter, who is not an employee, relieves for them if they are absent.

Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the care managers / registered nurse and the facility manager confirms their responsibility and authority for their roles. The principal care giver is also interviewed during this audit and describes their responsibilities.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Several areas requiring improvement have been identified during this audit relating to maintenance of quality and risk management systems. These improvements are required because resident / family meetings are not held on a regular basis, there is no formal document control process in place, several of the policies and procedures reviewed are not up-to-date and do not provide evidence they are based on evidence based rationales and best practise, quality improvement data is not being analysed to identify trends, and corrective action plans are not being developed and implemented to address shortfalls identified (see criteria 1.2.3.1, 1.2.3.3., 1.2.3.4. 1.2.3.6, 1.2.3.8).

There is an internal audit programme in place and completed internal audits for 2014 are reviewed and the majority of the audits scored 100%. A written ‘Quality Plan February 2014 – February 2015’ is reviewed.

Collated resident satisfaction surveys completed in August 2014 are reviewed and indicate acceptable levels of satisfaction. The family satisfaction survey was completed in September 2014 and has not been collated at the time of this audit. The annual family meeting was held on 30 September 2014 and was attended by 20 people. The collated results of the resident survey is reviewed and the majority of the responses are recorded as an eight to ten on a scale of one to ten with ten being the highest.

Completed surveys also include positive feedback on the care provided. This finding confirmed during interviews of six residents and five family members.

Two monthly staff meetings and two monthly clinical / quality meetings are held along with two monthly health and safety meetings. Meeting minutes reviewed and are available for review by staff.

There is a hazard reporting system available and a hazard register. Chemical safety data sheets available identifying potential risks for each area of service. Calibration programmes are in place and reviewed and biomedical equipment has appropriate performance verified stickers in place.

Not all the District Health Board contract requirements are met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The facility manager advises that family and resident meetings are held once a year following satisfaction surveys to provide feedback to residents and their family. The facility manager advises they have an open door policy and residents and or their family can discuss anything they want with them at any time. Resident/ family meeting minutes September 2014 reviewed and indicate a general discussion was held.

**Finding:**

Resident and family meetings are not held on a regular basis

**Corrective Action:**

Provide evidence that resident meetings for rest home residents and family and resident meetings for residents in the dementia unit are held on a regular basis.

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

##### **Criterion 1.2.3.3 (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:** PA Low

**Evidence:**

The facility manager advises they are responsible for ensuring policies and procedures are current and that they read through the policy and procedure to see if they need updating. The facility manager advises they do the updating of policies and procedures as required. The facility manager advises they seek input from the registered nurse as and if required.

The facility manager advises that new and reviewed policies and procedures are put in the staff room for staff to read, or staff are notified by a memo. This is confirmed during staff interviews.

**Finding:**

(i)The majority of the clinical policies and procedures reviewed during this audit have not been reviewed since 2011. (ii) Documentation reviewed does not consistently provide evidence that policies and procedures are based on evidence-based rationales.

**Corrective Action:**

Provide evidence that (i) a process has been implemented to ensure that all policies and procedures are reviewed on a regular basis by appropriate personnel; and

(ii) policies and procedures are based on evidence-based rationales.

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

##### **Criterion 1.2.3.4 (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:** PA Low

**Evidence:**

The facility manager advises they are responsible for document control processes.

**Finding:**

There is no formal document control process in place to manage the policies and procedures with a view to ensuring that documents are up to date.

**Corrective Action:**

Provide evidence that a document control process has been implemented to ensure that documents are up to date.

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

##### **Criterion 1.2.3.5 (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:** PA Low

**Evidence:**

A pie graph for accidents and incidents for August 2014 is reviewed attached to clinical meeting minutes for September 2014. The facility manager advises this is the first time this chart has been developed by one of the new clinical managers / registered nurses.

**Finding:**

There is no documented evidence available indicating that quality improvement data is being collated, evaluated and analysed and the results of this reported to staff.

**Corrective Action:**

Provide documented evidence indicating that quality improvement data is being collated, evaluated and analysed and the results of this reported to staff.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

An action sheet template with corrective actions, by when, by whom, evaluation and sign off is sighted attached to some of the internal audits. Also sighted at the end of each audit template is s section for ‘opportunities to improve’, ‘corrective action plan’ and ‘evaluation that plan has been successful’

The majority of the internal audits reviewed had a score of 100%, however, some with reviewed with areas requiring improvement identified but no corrective action plan has been developed to address the required improvements.

Hot water temperatures are recorded monthly and the records reviewed indicate they exceed 45 degrees Celsius but no corrective action plan to address the issue (see link criterion 1.4.2.1.).

**Finding:**

Corrective action plans are not being developed to address all areas identified as requiring improvement, timeframes and person/s responsible for the corrective actions are not being consistently documented; and evidence of implementation and monitoring of the corrective action plan is not always evident.

**Corrective Action:**

Provide evidence that (i) corrective action plans are being developed to address all areas identified as requiring improvement; (ii) timeframes and person/s responsible for the corrective actions are being consistently documented; and (iii) evidence of implementation and monitoring of the corrective action plan is being documented.

**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 Moderate

**Evidence:**

Improvements are required with completion of accident and incident forms as these are not being reviewed by the registered nurse, not all sections are being completed, neurological observations are not being documented following unwitnessed falls and any adverse event with the potential for head injury, and there is no evidence of communication with the GP and family following adverse events (see criterion 1.2.4.3). The facility manager advises this contact is recorded in family communication sheets and in progress notes in the individual resident's files. Accident and incident forms are not being filed in resident’s notes and improvements are required (see criterion 1.2.9.10)

Family members (five dementia level residents) interviewed during this audit advise they are contacted if their family member has an accident/incident, and/or if there is any change in their condition.

Staff confirm during interview that they are made aware of their essential notification responsibilities through job descriptions and policies and procedures.

Not all the District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Staff advise they record the contact with resident’s family and / or the GP in the residents progress notes. Staff also confirm they are completing accident / incident forms for adverse events.

**Finding:**

(i)Accident and incident forms do not provide consistent evidence that they are being reviewed and signed off by the registered nurse; (ii) The accident and incident forms do not provide evidence that the family and / or the residents GP has been advised (or not) of the adverse event; (iii) Several of the accident and incident forms reviewed for July have not been fully completed; (iv) Neurological observations are not being taken and recorded following unwitnessed falls and following any potential head injury.

**Corrective Action:**

Provide evidence that: (i) all accident and incident forms are being reviewed by the registered nurse and are signed off as completed; (ii) any contact, or not, with the family and the GP is clearly recorded on the accident and incident form; (iii) all accident and incident forms are fully completed; and (iv) that neurological observations are being taken for all residents following unwitnessed falls and following any adverse event that could potentially involve a head injury.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Several areas requiring improvement relating to human resource management have been identified (see criteria 1.2.7.2, 1.2.7.3, 1.2.7.4, 1.2.7.5).

There are policies and procedures in relation to human resources management and these are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which were reviewed on staff files (seven). The facility manager advises they have been completing criminal record vetting since May 2013 and evidence of this is reviewed on three staff files for staff that have started since May 2013. There is no evidence of reference checking on any of the seven staff files reviewed and improvements are required (see criterion 1.2.7.3). There is no evidence that orientations have been completed on three of the seven staff files and improvements are required (see criterion 1.2.7.4). A generic orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The facility manager advises that staff are orientated for two to three shifts at the beginning of their orientation.

Improvements are required with the completion of medication competency assessments (see criterion 1.2.7.5) as one of the care managers / registered nurses has not completed a medication competency. There is no register of practising certificates and improvements are required (see criterion 1.2.7.2)

The facility manager is responsible for management of the in-service education programme and there is evidence available indicating in-service education is provided for staff once a month. The education planner for 2014 is reviewed and provides evidence that ongoing education is provided although not all essential education topics are provided. Improvements are required with the ongoing education programme as none of the staff have received medication management education, not all staff have received education on the management of challenging behaviours, and education relating to cultural safety has not been provided for some time (see criterion 1.2.7.5).

The facility manager advises they are an on-site assessor for the Careerforce unit standards and that 16 staff have completed the dementia specific unit standards. They also advise that five are currently completing the dementia specific unit standards and one member of staff has enrolled and is about to start completing these modules. Evidence of completion of the unit standards is viewed on the wall outside the care staff in the dementia unit.

Individual records of education are maintained for each staff member and copies are reviewed. An appraisal schedule is in place and current staff appraisals are sighted on all staff files reviewed.

Care staff also confirm their attendance at on-going in-service education and the currency of their performance appraisals.

Not all the District Health Board contract requirements are met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Practising certificates are reviewed on two of two registered nurses files. A practising certificate is reviewed for the GP that expired 31 May 2014. The facility manager obtained a copy of the GPs current practising certificate during this audit.

**Finding:**

Current copies of practising certificates are not held on site for the pharmacists, podiatrist and GP. Current copies of these were obtained by the facility manager during this audit.

**Corrective Action:**

Provide confirmation that a process for ensuring professional qualifications are validated, including evidence of registration and scope of practice for service providers is maintained.

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

**Evidence:**

Seven staff files are reviewed and evidence of criminal vetting is evident on three of the seven staff files. The facility manager advises it has been company policy to undertake criminal vetting since May 2013. The three staff with evidence of criminal vetting have started since May 2013 and the four without criminal vetting started working at Ohope Beach Rest Home prior to May 2013. Employment agreements are reviewed on all staff files.

**Finding:**

Evidence of reference checking is not evident on seven of the seven staff files reviewed.

**Corrective Action:**

Provide evidence that reference checking is completed for all new employees.

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

**Evidence:**

Orientation checklist reviewed and is meant to be completed within two weeks of commencing employment.

One of the two clinical managers / registered nurses has a completed orientation checklist on their file and one does not have evidence of this. Both clinical managers/ registered nurses report they have not received a role specific orientation.

**Finding:**

(i)Three of the seven staff files reviewed, including one of the clinical managers / registered nurses, does not have evidence that an orientation has been completed. (ii) The two clinical managers / registered nurses advise during interview that they have not received an orientation that is specific to their role.

**Corrective Action:**

Provide evidence that (i) an orientation is completed for all new members of staff; and (ii) that the two clinical managers receive an orientation that is specific to their role.

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

**Evidence:**

A 2014 training schedule is reviewed along with individual staff education records and records for each education session provided.

Medication competencies reviewed for all staff with the exception of the two clinical managers / registered nurses. A competency is reviewed for one of the two clinical managers that was completed at another organisation but the other organisation uses a different type of medication management system

Understanding dementia education was attended by seven members of staff in September 2014.

**Finding:**

(i)Some of the key education sessions have not been provided and / or attended by all relevant staff including but not limited to medicine management, cultural safety, and management of challenging behaviours. (ii) The two clinical manager’s / registered nurses do not have current medication management competencies.

**Corrective Action:**

Provide evidence that (i) all staff receive challenging behaviour and cultural safety education and that all relevant staff receive medication management education; and (ii) the two clinical managers / registered nurses have completed medication management competency assessments.

**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:** PA Moderate

**Evidence:**

The service has a documented rationale for determining service provider levels (Policy on Staff Numbers and Skill Mix) which is reviewed and contains rostered numbers, and other factors to be considered when determining staffing levels.

All staff working in the rest home and dementia areas are based in the care station in the dementia unit and improvements are required (see criterion 1.2.8.1) The minimum staff on duty at any one time is during the night shift and consists of two care givers who are based in the care station in the dementia unit. One of the care managers / registered nurses is also on-call after hours. The facility manager advises they are also available after hours if required.

Care staff interviewed report there is adequate staff available and that they are able to get through their work.

Not all the District Health Board contract requirements are met.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The facility manager advises that all staff are based in the care station in the dementia unit and that when residents in the rest home unit activate their call bells staff from the dementia unit who have been allocated primary responsibility for the rest home residents go to the rest home to answer the call bell.

Roster reviewed and indicates that the minimum staff on duty is two care givers during the night shift and both are based in the dementia unit. The facility manager advises that the staff member allocated primary responsibility for the rest home does two hourly rounds at night.

Residents interviewed advise there is enough staff on duty to provide them with adequate care.

**Finding:**

There is no member of staff located in the rest home 24 hours a day as they are based in the dementia unit.

**Corrective Action:**

Provide confirmation that a staff member is located in the rest home at all times.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Improvements are required to resident’s documentation (see criteria 1.2.9.9. and 1.2.9.10)

Resident information is entered in an accurate and timely manner into a register that is appropriate to the service and is in line with the requirements of NZHIS. Interview of the facility manager confirms they are responsible for entering the resident's data into an electronic spreadsheet on the day of admission to the facility. With the exception of accident and incident forms, resident files are integrated and recent test/investigation/assessment information is located in residents' files (see criterion 1.2.9.10). Approved abbreviations are listed.

A visual inspection of the facility evidences that residents' information is stored in staff areas and is held securely and is not on public display. The resident's NHI number, name, and date of birth are used as the unique identifier although improvements are required as not all resident documentation has unique identifiers on it (see criterion 1.2.9.10). Resident documentation reviewed indicates staff record their name and time of entry although they are not recording their designation and improvements are required (see criterion 1.2.9.9.)

Clinical staff interviewed (three caregivers, two clinical managers / registered nurses and one facility manager) confirm they know how to maintain confidentiality of resident information. Historical records are held on site and accessible.

Not all the District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Resident files (eight) are reviewed and the recording of name and designation of the person making the entry is not consistently recorded.

**Finding:**

Staff are not consistently recording their designation on resident’s progress notes; and (ii) the date, their signature and designation on all resident forms.

**Corrective Action:**

Provide evidence that staff are consistently recording (i) their designation when making an entry on resident’s progress notes; and (ii) the date, their signature and designation on all resident forms.

**Timeframe (days):** 90 *(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:** PA Low

**Evidence:**

Resident files are removed and with the exception of incident and accident forms, their records are integrated.

**Finding:**

(i)Resident’s accident and incident forms are not retained in resident’s files; (ii) A unique identifier for each resident, for example the stickers with resident’s NHI number, name and date of birth, is not being recorded on all pages of resident’s documentation in their clinical file.

**Corrective Action:**

Provide confirmation that (i) resident’s incident and accident forms are integrated in to the resident‘s records; and (ii) that a unique identifier for each resident, for example the stickers with resident’s NHI number, name and date of birth, is being recorded on all pages of resident’s documentation in their clinical file..

**Timeframe (days):** 90 *(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:** PA Low

**Evidence:**

The service’s philosophy and mission statement is communicated to residents, family, relevant agencies and staff. The service provides information to potential referral sources. This facility operates 24/7.

All residents' admission agreements sampled evidence resident or family and facility representative sign off. There is a facility information pack available for resident and their family. The resident information pack was sighted and contains all relevant information.

The residents' files sampled demonstrate all needs assessments are completed for either rest home or dementia levels of care.

Interview with six of six rest home residents and five of five dementia family members confirm the admission process was conducted by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.

There is an area requiring improvement around the admission agreement to include all the contractual requirements.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

All residents' admission agreements sampled evidence resident or family and facility representative sign off.

**Finding:**

The admission agreement does not contain all the requirements of the DHB contract (ARC contract D13).

**Corrective Action:**

Provide evidence of the admission agreement complying with the DHB contract requirements.

**Timeframe (days):** 180 *(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 systems to decline resident entry to the service are documented. The scope of the service is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required. The resident will be declined entry if not within the scope of the service or if a bed is not available at the time.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

In the resident files sampled, there is evidence that each stage of service provision has been developed with resident and/or family input. Eight of eight residents' files (four rest home and four dementia) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member. Six of six rest home resident and five of five dementia family interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews. The family communication sheets are maintained, sighted in all eight residents' files reviewed.

Five of five clinical staff (three care givers and two clinical nurse managers /RNs) interviews confirm residents and/or family members are involved in all stages of service provision.

Staff education and competencies are not consistently conducted (refer to 1.2.7.5 and 1.3.12.3). There is evidence in the residents’ files reviewed that staff entries into residents progress notes are recorded on each shift and when any untoward events occur, confirmed at staff interviews (refer to 1.2.9.9).

GP interview is conducted and confirms the GP is providing medical visits to the facility once a week and when required. (refer to 1.3.3.3).

There is an area requiring improvement around service delivery timeframes.

The District Health Board contract requirements are not fully met.

Tracer methodology-rest home

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

Tracer Methodology –dementia

*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:** PA Moderate

**Evidence:**

The GP visits to the facility occur weekly, confirmed at GP and clinical nurse managers’ interviews. In the residents’ files sampled there is evidence that at times the residents are assessed by the GP weekly, however there are also up to three months when the resident is not seen by the GP. There is no evidence of GP exception in all the eight of eight resident files reviewed (as per ARC contract D16.5ei1). The risk assessments and the initial care plans are not consistently conducted on admission (refer to 1.3.4.2).

Policy on care planning and timeframes requires review to adhere to the DHB contract requirements (refer to 1.2.3.3).

**Finding:**

The service delivery is not consistently provided within specified timeframes.

**Corrective Action:**

Provide evidence each stage of service provision is provided within specified timeframes.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. Policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.

The residents' files sampled evidence residents' discharge/transfer information from DHB (where required) or other health provider (NASC) assessments are available. The facility has appropriate resources and equipment.

There are areas identified requiring improvement around completion of initial care plan and risk assessments.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Six of six rest home residents and five of five dementia family interviews confirm their involvement in their assessments, care planning, review, treatment and evaluations of care. Eight of eight residents’ files sampled (four rest home and four dementia). The initial care plan could not be located in the clinical files or the archived files for six of eight residents. Challenging behaviour risk assessments for all dementia residents have not been conducted. Pressure area and pain risk assessments are not conducted for one of eight files reviewed. Four of eight files evidence risk assessments such as falls, continence, dietary and pressure area have not been reviewed six monthly when care plan is reviewed.

**Finding:**

The assessments and care planning process on admission does not always include completion of the initial care plan and the required risk assessments such as: pain; cultural, activities (ARC contract E4.2a & b) and challenging behaviour assessments (ARC contract E3.4a) and these are not always reviewed six monthly.

**Corrective Action:**

Provide evidence the initial care plans and all required risk assessments are completed on admission and reviewed regularly.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The residents' files sampled evidence residents' care plans are individualised. The residents have input into their care planning and review, confirmed at all six of six rest home resident and five of five dementia family interviews. Three of three care givers interviewed confirm that care plans guide the care delivery to the residents. The facility ensures access to regular GP care, confirmed at GP interview.

There is an area requiring improvement around the care plan interventions to be detailed to guide staff in service delivery to residents.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Eight residents’ files sampled (four rest home and four dementia). In four of eight residents' files sampled there is evidence the risk assessment findings are not recorded on the care plans. In four of eight residents’ files sampled the required encouragement, direction, or supervision of a resident completing an intervention themselves is not recorded in the care plans sampled (ARC contract E4.3bi & ii).

**Finding:**

The required support and interventions are not consistently recorded on residents’ care plans.

**Corrective Action:**

Provide evidence of the support required around identified needs and interventions and for the interventions to be detailed to guide staff in service delivery to residents.

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. The general practitioner’s documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the service agreement.

Six of six rest home residents and five of five dementia family interviewed confirm their and their relatives’ current care and treatments they are receiving meet their needs. Family communication sheets record family communications, sighted in all eight residents' files sampled.

There is an area requiring improvement around the details of residents’ care plan interventions.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Interview with residents and family confirm the intervention notes in their care plans meet their needs. Resident and family interviews confirm participation in care planning. Eight of eight residents’ files sampled (four rest home and four dementia). The three of eight residents' files sampled evidence the care plans do not consistently record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents.

**Finding:**

The care plan interventions do not consistently meet the residents’ assessed needs.

**Corrective Action:**

Provide evidence the care plan interventions are consistent with meeting residents’ needs.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are two activities staff employed at the facility. One of the two activities staff interviewed confirms they have been employed as the activities co-ordinator for approximately six months and work for 22.5 hours a week on Wednesdays, Thursdays and Fridays from 9 am to 4.30 pm. The second activities coordinator (AC) is employed on Mondays and Tuesdays each week, from 9 am to 4.30 pm.

There is one activities programme for both the rest home and the dementia residents. The activities programme sighted records activities are provided for the dementia residents on Monday morning 10.30 am to 12pm; Tuesday morning from 11.30 am to 12pm and Thursday morning from 10.30 till 12 pm. The Saturday and Sunday activities include music/TV and videos and one on one activities by care staff, stated by the AC interviewed. The AC states the dementia residents also participate in activities provided for the rest home residents.

The AC confirms the activities programme meets the needs of the service group and the service has appropriate equipment. Activities attendance records are maintained and are sighted. In the eight of eight residents’ files sampled there is no evidence of activities assessments being competed (refer to 1.3.4.2). The activities care plan evaluations are conducted, however the findings of the evaluations are not transferred / recorded on to the activities care plan ( refer to 1.3.8.2).

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

The clinical nurse managers’ files do not evidence orientation specific to dementia services (refer to 1.2.7.4).

There are areas requiring improvement around the 24 hour activities plans, activities staff, residents’ meetings and the activities programme during sun downing period.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Residents and family interviewed confirm satisfaction with the activities programme. The resident meetings are held once a year. The residents’ meeting minutes are sighted for a meeting held on 30 September 2014. The meeting minutes evidence presentation of happenings at the facility such as information about the new building, renovations and employment of staff. There is no evidence of discussion regarding activities.

There is one activities programme provided for the rest home and dementia service. The programme is provided from Monday to Friday 9 to 4.30 pm. There are no planned activities during sun downing and no recorded evidence the care staff conduct activities in the dementia unit when the AC are not present (ARC contract E4.4b).

There is a form titled 24 hour care plan, however this does not record resident’s individualised challenging behaviours, triggers and specific strategies to minimise the challenging behaviour or any reference to timeframes over the 24 hour period (ARC contract E4.3biii & iv).

The activities programme does not have recorded evidence of review by a diversional therapist (ARC contract E4.5cii).

**Finding:**

i) The 24 hour activity plans do not always record the required areas of challenging behaviour and appropriate activities specific to a 24 hour timeframe.

ii) The annual residents’ meeting does not evidence discussion in respect of activities at the home.

iii) The activities programme does not cover sun downing period and there is no evidence of care staff providing the planned activities in the weekend.

iv) The activities staff have not completed diversional training and the activities programme has not been reviewed by a diversional therapist.

**Corrective Action:**

i) Provide evidence the 24 hour activities plans detail appropriate, individualised activities to implement for residents’ challenging behaviours.

ii) Provide evidence frequent residents’ meetings are conducted with evidence of input from residents in respect of the activities programme.

iii) Provide evidence of an activities programme for sun downing period and records to support this is provided when activities staff are not present at the facility.

IV) Provide evidence of trained diversional therapist for dementia residents, as per DHB contract.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The residents’ care plan evaluations are conducted by the clinical nurse managers /RNs with input from the resident, family, staff and GP. The family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews. The rest home residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed.

Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines (refer to 1.2.3.3). There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. The residents' files evidence referral letters to specialists and other health professional, where this has been requested.

There are areas requiring improvement around care plan evaluations and the use of short term care plans.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The residents’ care plan evaluations are conducted by the clinical nurse managers /RNs with input from the resident, family, staff and GP. The family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews. The rest home residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed.

Eight of eight residents’ files sampled (four rest home and four dementia). In the files reviewed there is evidence activities care plans are not always reviewed six monthly, sighted in two of eight files. Care plan evaluations do not always record the degree of achievement towards meeting residents’ goals, sighted in three of eight files sampled.

**Finding:**

i) The activities care plan evaluations are not consistently conducted six monthly. When activities care plans are evaluated, the evaluations are not transferred / recorded on to the activities care plan.

ii) The care plan evaluations do not consistently record the degree of achievement to the interventions and support provided.

**Corrective Action:**

Provide evidence the activities evaluations are recorded on the activities care plans and evaluations record the degree of achievement towards meeting the resident’s goals.

**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:** PA Moderate

**Evidence:**

Short term care plans are not consistently recorded for short term problems, sighted in two of eight files sampled.

**Finding:**

There is evidence short term care plans are not consistently recorded for short term problems.

**Corrective Action:**

Provide evidence of short term care plan use for short term problems.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

The residents’ files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. The family communication sheets document family involvement and facility communication with them, as appropriate. The family interviews confirm staff communicate well with them.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The medication area in the facility evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. There is one controlled drugs storage in the facility and this is secure. The controlled drug register is maintained and evidences weekly checks. The medication fridge temperatures are conducted and recorded. The residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given).

Medication round was observed in the dementia unit and evidences staff are knowledgeable about the medicine administered and sign off, as the dose is administered.

There are care givers and clinical nurse managers (registered nurses) who administer medicines. The two registered nurses do not hold current medication competencies. The staff education in medicine management has not been provided (refer to 1.2.7.5).

Nineteen medicine charts are sampled (nine rest home and 10 dementia). All 19 charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs.

There is one rest home resident at the facility that self-administers medicines. An interview with the resident who self-administers medicines is conducted and evidences the resident is competent and aware of the responsibilities with self-administration of medicines. The medication policy around self -administration of medicines requires review (refer to 1.2.3.3).

There are areas requiring improvement around the medication system to comply with legislation, protocols and guidelines and for all staff who administer medicines to have current medication competencies.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Nineteen medicine charts are sampled (nine rest home and 10 dementia). All 19 charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. The controlled drug register does not evidence six monthly stock takes. There is evidence of one medication being transcribed. Normal saline /single use only are evidenced to be sealed with tape and used for multiple uses.

**Finding:**

i) There is no evidence of six monthly stocktakes of controlled drugs.

Ii) Evidenced transcribing on medication

ii) Single use normal saline is taped after use and reused.

**Corrective Action:**

Provide evidence the medication system complies with legislation, protocols and guidelines.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are care staff and two clinical nurse managers (RNs) who administer medicines. There is no evidence of one of the CNM having conducted medication competency. The second CNM has conducted medication competency away from the facility.

**Finding:**

Not all staff who administer medication have current medication competencies.

**Corrective Action:**

Provide evidence of the staff who administer medicines have current medication competencies.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

An interview with the head cook confirms there is a new seasonal four weekly menu that is introduced every six months. The manager states the menu was last reviewed by a dietitian in June 2013, sighted. Food safety training for kitchen staff has been conducted.

An interview with the head cook is conducted and confirms they are aware of the residents’ dietary profiles. They state they have been providing the meal service at the facility for many years and know the residents at the facility, however not all dietary profiles of residents are located in the kitchen. The residents' dietary requirements are recorded, as sighted in the eight of eight residents’ files sampled. The resident's nutritional needs and interventions are documented on care plans sighted. Additional snacks are available for residents when the kitchen is closed. The residents' files sampled demonstrate monthly monitoring of individual resident's weight.

The residents interviewed are satisfied with the food service provided.

Fridge, chiller and freezer temperatures are recorded, sighted. Visual inspection and interview with the head cook evidences not all decanted food is dated, food temperatures are not being recorded and hats are not being worn in the kitchen.

There are areas requiring improvement around the residents’ dietary needs to be communicated to the kitchen staff and kitchen staff to wear hats when preparing meals, decanted foods to be dated and food temperatures to be monitored.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The residents' dietary requirements are recorded, as sighted in the eight of eight residents’ files sampled. The resident's nutritional needs and interventions are documented on care plans sighted. The review of the dietary assessment file in the kitchen evidences there are 18 residents dietary assessments located on the file. Two of 18 dietary profiles are dated 2010 and one of 18 dated 2011. There is no recorded evidence that all the residents’ likes and dislikes and food allergies are communicated to the kitchen to guide kitchen staff.

**Finding:**

The residents’ dietary assessments are not always provided to kitchen staff.

**Corrective Action:**

Provide evidence all residents’ dietary needs are communicated to the kitchen and kitchen staff are aware of the residents’ allergies, likes and dislikes.

**Timeframe (days):** 30 *(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:** PA Low

**Evidence:**

The manager and the head cook interviews confirm food safety training for kitchen staff has been conducted.

**Finding:**

i) There is inconsistent dating of decanted foods.

ii) Food temperatures are not conducted regularly.

iii) Staff in the kitchen do not wear hats.

**Corrective Action:**

Provide evidence kitchen staff wear hats when preparing meals, decanted foods are dated and food temperatures are monitored.

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are documented processes for the management of waste and hazardous substances in place. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available and are accessible for staff. A hazard register is available. Staff receive training and education on safe and appropriate handling of waste and hazardous substances, including chemical safety and education. Monthly visits are made by the chemical supplier representative who reviews cleaning and laundry processes.

Sluice facilities are available for the disposal of waste and hazardous substances. A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled is provided. Goggles, gloves, aprons and masks are viewed in the two laundries and the cleaners’ room.

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Improvements are required with the management of environment (see criteria 1.4.2.1, 1.4.2.4., 1.4.2.6).

A visual Inspection provides evidence of safe storage of medical equipment. Corridors are of varying widths and allow residents to pass each other. Safety rails are secure and are appropriately located, equipment does not clutter passageway, floor surfaces/coverings are appropriate to the resident group and setting and floor surfaces and coatings are maintained in good order.

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

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

Not all of the District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** PA Low

**Evidence:**

A current Building Warrant of Fitness is displayed that expires on 11 October 2014. The facility manager advises that they are currently in the process of obtaining a new building warrant of fitness.

A maintenance person is contracted for four to ten hours a week. The facility manager advises during interview that they are responsible for maintenance and they call in contractors as required. A book for staff to record items requiring maintenance is kept in the dementia unit and is reviewed. The facility manager and the contracted maintenance person tick the items as they are attended to.

Hot water temperatures are recorded monthly and exceed 45 degrees Celsius at five areas used by residents. There is no corrective action plan to address this issue, but the facility manager contacts a plumber during this audit that visits and adjusts the tempering valves.

Calibration reports and evidence of electrical testing and tagging is reviewed.

**Finding:**

(i)Hot water temperatures exceed 45 degrees Celsius at five hot water outlets used by residents. The plumber was contacted during this audit and adjusted the tempering valves; (ii) there is no documented planned preventative maintenance programme in place; (iii) the splash board behind the tubs in the main laundry is water damaged and presents a potential infection control risk; (iv) room 8A in the dementia unit does not have a wardrobe for the resident’s clothes.

**Corrective Action:**

Provide confirmation that (i) hot water temperatures do not exceed 45 degrees Celsius at five hot water outlets used by residents; (ii) A documented planned preventative maintenance programme is developed and implemented; (iii) the splash board behind the tubs in the main laundry has been repaired; (iv) a wardrobe has been installed in room 8A in the dementia unit.

**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:** PA Moderate

**Evidence:**

There is a door that separates the dementia unit and the rest home that is very slow to close and residents can leave the dementia unit in the time it takes the door to close. The facility manager advises that residents have followed visitors out this door as it is closing.

**Finding:**

The door between the dementia unit and the rest home is slow to close.

**Corrective Action:**

Provide confirmation that the door between the dementia unit and the rest home has been adjusted so that it closes more quickly so that residents are not able to leave the dementia unit

**Timeframe (days):** 30 *(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:** PA Low

**Evidence:**

There are three external areas in the dementia unit for residents to use. All three areas have fencing that is currently being adjusted to minimise the risk of residents climbing over the fence and absconding. The facility manager advises they have at least one resident who is a ‘climber’ and who has climbed over the fencing. Visual inspection indicates that the majority of the fencing is trellising and the fences are having their height extended by adding soft wire mess type fence above the trellising. The facility manager advises that residents are supervised whenever they are in any of the outside areas

**Finding:**

The fences in the three external areas in the dementia unit are potentially able to be climbed over by residents. It is acknowledged the facility manager is aware of this issue and is attempting to address it.

**Corrective Action:**

Provide confirmation that the external areas in the dementia unit are safe and residents are not able to climb over the fences.

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

There are an adequate number of toilet and shower facilities available throughout the facility. Visual inspection provides evidence that toilet and shower facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals (see link criterion1.4.2.1.)

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

With two exceptions all bedrooms provide single accommodation. The facility manager advises the two double bedrooms are used as single bedrooms. Visual inspection provides evidence that the bedrooms provide adequate personal space to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. Resident’s bedrooms are personalised to varying degrees.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

Visual inspection provides evidence that adequate access is provided to the lounge and the dining areas in the rest home and dementia areas. Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

Laundry staff are responsible for management of the laundry and all linen is washed on site in the main laundry in the dementia unit. There is a second smaller laundry in the dementia unit that is used if the machines in the main laundry are full. There is one door in and out of the laundry and the dirty/clean flow is adequate. One of the two laundry workers is interviewed in the main laundry and they describe the management of laundry including transportation, sorting, storage, laundering, and return to residents.

Cleaning staff are employed and are responsible for management of the cleaning. A cleaner is interviewed and describes the management of cleaning processes including the use of personal protective equipment.

Visual Inspection provides evidence that cleaning and laundry processes are implemented. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning are reviewed.

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

Residents and family interviewed state they are satisfied with the cleaning and laundry service and this finding is confirmed during review of the satisfaction surveys completed in August and September 2014.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is no indicator panel or audible indicator to alert staff who are working in the rest home area that a resident has used their call bell and improvements are required (see criterion 1.4.7.5).

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

A New Zealand Fire Service (NZFS) letter dated 12 June 2014 is sighted advising the fire evacuation scheme was approved 05 June 2005. The last trial evacuation was held on 11 April 2014 and the facility manager advises the next one will be held in October 2014.

All senior staff are required to complete first aid training and evidence of this is sighted on staff files reviewed. Staff interviews and review of staff files provides evidence of current training in relevant areas. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff confirm recent education on fire, emergency and security situations. Staff records sampled provides evidence of current training regarding fire, emergency and security education.

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

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

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

Not all of the District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The facility manager advises that all staff are based in the care station in the dementia unit and that when residents in the rest home unit activate their call bells staff from the dementia unit who have been allocated primary responsibility for the rest home residents go to the rest home to answer the call bell.

Visual inspection confirms that there is a light outside each resident’s bedroom door and that there is no indicator panel in the rest home area.

The new dementia wing has a separate call bell system to the one for the rest home and ‘old’ dementia wing. The indicator panel is located above the indicator panel for the ‘old’ dementia wing and rest home.

Four of the rest home residents interviewed report that staff usually respond to the call bells in a timely manner.

**Finding:**

There is no indicator panel or audible indicator to alert staff who are working in the rest home area that a resident has used their call bell.

**Corrective Action:**

Provide confirmation that staff working within the rest home are alerted, and respond in a timely manner, when a resident within the rest home activates their call bell.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Documented systems are in place to ensure the use of restraint is actively minimised and the use of least restrictive practices are encouraged where required. The Restraint Minimisation and Safe Practice (RMSP) policy definitions of enablers and restraint align with the NZS 8134.2 Standard. The service has an overarching risk and quality management system that demonstrates compliance with the Standard. The process of assessment and evaluation of enabler use is documented in policies and procedures to guide staff. There are no residents using restraint or enablers on audit day

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control (IC) policy meets the needs of the service and provides information and resources to inform the staff on infection prevention and control, confirmed at staff interviews. The delegation of infection control matters is documented along with an IC co-ordinator (ICC) job description, sighted. There is documented evidence regular reports on infection related issues are completed. The IC programme is last reviewed in 2014 and the IC programme is sighted for 2014 to 2015.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme meets the needs of the service and provides information and resources to inform and guide staff. The IC co-ordinator is the clinical nurse manager/ RN, who has been in this position since their employment, approximately six weeks prior to this audit. The IC co-ordinator has access to relevant and current information which is appropriate to the size and complexity of the organization, including but not limited to; IC manuals, internet, access to experts (DHB and Lab), and on-going in-service education.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The service provider's documentation evidences that infection control education is provided to all staff, as part of their initial orientation and is on-going.

The ICC attended external education on IC in September 2014, confirmed at interview and sighted in the staff’s file reviewed. The staff education was provided in September 2014 by the ICC/ RN. All education sessions have evidence of staff attendance and content of the presentations.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The IC programme / policy details surveillance processes, relevant to the service setting and its complexity. The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes.

Infection control monthly data is completed for each resident. Infection log is maintained.

Numbers of infections are collated at the end of each month and reported to management and to staff at meetings. Care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, and daily handovers.

##### **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.)*