CHT Healthcare Trust - St Margaret's Hospital and Rest Home

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

St Margaret's is a purpose built rest home and hospital facility. The service provides care for up to 88 rest home, dementia and hospital residents. The current occupancy is six rest home residents, 59 hospital residents and 19 residents in the dementia unit. St Margaret's is part of the CHT organisation. The CHT group has strong board and effective governance practices. The manager is a registered nurse who has been in the role for 3 ½ months and has a background in health management. She is supported by a clinical coordinator who has been at the service for three weeks and is completing orientation. She also has a background in clinical leadership and health management. Resident and family feedback during the audit was very positive.

This audit has identified areas for improvement around facility meetings, meetings, incident follow up, reference checks, training for dementia staff, staff first aid training, environmental restraint, restraint assessments, consents, monitoring and evaluations, timeliness of assessments and care plans, care plans, family and resident involvement in care planning, aspects of medication documentation, care planning, resuscitation orders and care interventions.

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

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

Consumer Rights as at 1 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 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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

St Margaret's provides resident centred care. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ('the Code') is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan and a Tikanga best practice policy to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. There is an improvement required around resuscitation orders.

Organisational Management

St Margaret's has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. There is an improvement required around facility meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at six weekly resident meetings, at resident's focus groups and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly. There is improvement required around implementing recommendations following incidents. St Margaret's has job descriptions positions that include the role and responsibilities of the position. There is an improvement required around reference checks and training for dementia staff. There is an annual in-service training programme that has been implemented for the year and staff is supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing and healthcare assistants, residents and family members report staffing levels are sufficient to meet resident needs.

Continuum of Service Delivery

The service has a comprehensive information pack. Assessments (including InterRAI), care plans and evaluations are completed by the registered nurses. Care plans are individualised and risk assessment tools and monitoring forms are available. Care plans are evaluated six monthly. The resident and family/whanau interviewed are complimentary about the staff and standard of care

provided. There are improvements required around completion of care plans within required timeframes, documented evidence of resident/family/whanau involvement in care planning, inclusion of cultural needs in the care plan, documentation of interventions to reflect the resident's current needs and aspects of wound management.

The team of four activity co-ordinators provide a seven day activities programme for the rest home/hospital and dementia care residents that is varied, interesting and involves community visitors and outings. The programme meets the recreational, spiritual and cultural preferences of the consumer groups.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration complete annual competencies and education. The general practitioner (GP) reviews the medication chart three monthly. There is an improvement required around GP prescribing and indications for as required medication.

An external contractor prepares meals on site and the menu has been approved by a dietitian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

Safe and Appropriate Environment

St Margaret's rest home and hospital facility holds a current warrant of fitness. There is a reactive and planned maintenance programme in place. The facility is spacious with sufficient space in bedrooms and communal areas to allow the movement of residents around the facility using the mobility aids or lazy boy chairs. All bedrooms have ensuites. Electrical equipment is tested and clinical equipment checked and calibrated. Hot water temperatures are monitored. The outdoor areas are safe and easily accessible with seating and shade. Chemicals are stored safely throughout the facility. There are appropriate procedures for managing emergencies and staff have been trained around emergency, fire and disaster management. There is stored water and supplies for three days if required. There is an improvement required around having a staff member on duty with a first aid certificate at all times.

Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently 10 residents requiring restraints and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management. Improvements are required around environmental restraint, restraint assessments, consents, monitoring and evaluations.

Infection Prevention and Control

The infection control coordinator is a registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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:	CHT Healthcare Trust
Certificate name:	CHT Healthcare Trust - St Margaret's Hospital and Rest Home

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Certification Audit
Premises audited:	St Margaret's Hospital and Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; 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:	84

Audit Team

Lead Auditor	XXXXXXXX	**Hours on site**	16	**Hours off site**	7
Other Auditors	XXXXXXXX	**Total hours on site**	32	**Total hours off site**	7
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXXXX			**Hours**	3

Sample Totals

Total audit hours on site	48	Total audit hours off site	17	Total audit hours	65

Number of residents interviewed	12	Number of staff interviewed	15	Number of managers interviewed	3
Number of residents' records reviewed	10	Number of staff records reviewed	9	Total number of managers (headcount)	3
Number of medication records reviewed	20	Total number of staff (headcount)	68	Number of relatives interviewed	11
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 3 November 2014

Executive Summary of Audit

General Overview

St Margaret's is a purpose built rest home and hospital facility. The service provides care for up to 88 rest home, dementia and hospital residents. The current occupancy is six rest home residents, 59 hospital residents and 19 residents in the dementia unit. St Margaret's is part of the CHT organisation. The CHT group has strong board and effective governance practices. The manager is a registered nurse who has been in the role for 3 ½ months and has a background in health management. She is supported by a clinical coordinator who has been at the service for three weeks and is completing orientation. She also has a background in clinical leadership and health management. Resident and family feedback during the audit was very positive.
This audit has identified areas for improvement around facility meetings, meetings, incident follow up, reference checks, training for dementia staff, staff first aid training, environmental restraint, restraint assessments, consents, monitoring and evaluations, timeliness of assessments and care plans, care plans, family and resident involvement in care planning, aspects of medication documentation, care planning, resuscitation orders and care interventions.

Outcome 1.1: Consumer Rights

St Margaret's provides resident centred care. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ('the Code') is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan and a Tikanga best practice policy to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. There is an improvement required around resuscitation orders.

Outcome 1.2: Organisational Management

St Margaret's has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. There is an improvement required around facility meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at six weekly resident meetings, at resident's focus groups and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly. There is improvement required around implementing recommendations following incidents. St Margaret's has job descriptions positions that include the role and responsibilities of the position. There is an improvement required around reference checks and training for dementia staff. There is an annual in-service training programme that has been implemented for the year and staff is supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing and healthcare assistants, residents and family members report staffing levels are sufficient to meet resident needs.

Outcome 1.3: Continuum of Service Delivery

The service has a comprehensive information pack. Assessments (including InterRAI), care plans and evaluations are completed by the registered nurses. Care plans are individualised and risk assessment tools and monitoring forms are available. Care plans are evaluated six monthly. The resident and family/whanau interviewed are complimentary about the staff and standard of care provided. There are improvements required around completion of care plans within required timeframes, documented evidence of resident/family/whanau involvement in care planning, inclusion of cultural needs in the care plan, documentation of interventions to reflect the resident's current needs and aspects of wound management.

The team of four activity co-ordinators provide a seven day activities programme for the rest home/hospital and dementia care residents that is varied, interesting and involves community visitors and outings. The programme meets the recreational, spiritual and cultural preferences of the consumer groups.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration complete annual competencies and education. The general practitioner (GP) reviews the medication chart three monthly. There is an improvement required around GP prescribing and indications for as required medication.

An external contractor prepares meals on site and the menu has been approved by a dietitian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

Outcome 1.4: Safe and Appropriate Environment

St Margaret's rest home and hospital facility holds a current warrant of fitness. There is a reactive and planned maintenance programme in place. The facility is spacious with sufficient space in bedrooms and communal areas to allow the movement of residents around the facility using the mobility aids or lazy boy chairs. All bedrooms have ensuites. Electrical equipment is tested and clinical equipment checked and calibrated. Hot water temperatures are monitored. The outdoor areas are safe and easily accessible with seating and shade. Chemicals are stored safely throughout the facility. There are appropriate procedures for managing emergencies and staff have been trained around emergency, fire and disaster management. There is stored water and supplies for three days if required. There is an improvement required around having a staff member on duty with a first aid certificate at all times.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently 10 residents requiring restraints and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management. Improvements are required around environmental restraint, restraint assessments, consents, monitoring and evaluations.

Outcome 3: Infection Prevention and Control

The infection control coordinator is a registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually. Infection control education is provided annually for staff and

infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	38	0	6	6	0	0
Criteria	0	87	0	9	5	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Low	1) In seven of ten resident files sampled the CPR form had not been signed appropriately for two rest home residents, (i) there is no evidence of GP discussion with family regarding the not for resuscitation status and (ii) a resident recently admitted and deemed competent by the GP has not signed the CPR form (this was corrected on the day of audit). 2) One hospital file had	Ensure all CPR forms are signed appropriately.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				the CPR form signed by a relative and four out of four dementia care CPR forms had been signed by a relative. The GP had not stated on the one hospital and four dementia care CPR forms if the resident is competent or not competent.		
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	(i) There are only health and safety/quality meeting minutes available for May and June in 2014. (ii) May meeting minutes do not reflect discussion of incidents or infections and June minutes do not reflect discussion around incident trends. (iii) Registered nurse meeting minutes for February, June and September 2014 (all that are available) do not reflect discussion of incident or infection trends; (iiv) Three complaints in 2014 document on the complaint investigation that there is to be discussion at registered staff meetings. Registered nurse meeting minutes do not reflect this occurring and this is an area requiring improvement	Ensure that health and safety/quality meetings occur regularly and that quality data trends analysis outcomes are discussed in these and registered nurse meetings. Ensure that complaints investigations required outcomes including discussion in meetings occurs.	90
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	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		consumers and where appropriate their family/whānau of choice in an open manner.				
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	Two of twelve incidents sampled indicate that follow up actions have not been implemented. For one resident the incident form states the lap belt must be fastened behind the resident. The care plan has not been updated to reflect this. For the other the incident form states the resident should be changed to a low, low bed. The resident remains on a high low bed.	Ensure that actions required from incident investigation are implemented.	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Seven of nine staff files sampled do not have a documented reference check. Note that five of these files are for staff that commenced prior to 2009 and the organisation did not have formal reference checking procedures prior to this. Therefore two of the files that should have reference checks do not. This is an area requiring improvement.	Ensure reference checks are documented for all new staff.	180
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Three of 11 health care assistants employed in the dementia unit have not completed the required NZQA dementia standards. All three have been employed longer than	Ensure all staff in the dementia unit have the required dementia training.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				12 months.		
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	(i) Two residents with cultural needs have not been documented in the care plan. (ii) There is no long term care plan in place for one hospital resident admitted in May 2014.	(i) Ensure resident cultural needs are documented in the care plan. (ii) Ensure long term care plans are developed within 21 days of admission (link 1.3.3).	60
HDS(C)S.2008	Criterion 1.3.5.3	Service delivery plans demonstrate service integration.	PA Low	Two of two rest home files, three of four hospital files and three of four dementia care files do not have documented evidence of resident/family/whanau involvement in the care planning process.	Ensure there is documented evidence of resident/family/whanau involvement in the care planning process.	180
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 Low	1) Twelve of 16 wound assessments are incomplete (no date, no signature/designation, and no wound size). Seven wounds have not been evaluated as per the wound management plan. 2) There are no pain assessments for two hospital residents who identify new episodes of pain as per the progress notes and GP visits. 3) One hospital resident with swallowing difficulties does not have interventions documented in the care plan. 4) The high falls risk for one dementia care	1) Ensure wound assessments are completed. Ensure wounds are evaluated at the required frequency. 2), 3) and 4) Ensure care plans reflect the resident's current health status.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				resident has not been updated in the care plan.		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	1) There is no evidence of medication reconciliation on delivery of medicines into the facility. 2) GP prescribing on 18 of 20 medications charts do not meet the legislative requirements for prescribing medications. Brackets are used with one signature for several medications and dittos are used for dates. 3) There are no indications for use of PRN medication on seven of 20 medications charts (XXXXX, , and XXXXXX).	1) Ensure documented evidence of medication reconciliation. 2) Ensure GP prescribing of medications meet legislative requirements. 3) Ensure all PRN medications have an indication for use prescribed on the medication chart.	30
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 1.4.7.1	Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	There is not always a staff member on duty with a first aid certificate.	Ensure there is a staff member on duty with a first aid certificate at all times.	90
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 2.1.1.4	The use of enablers shall be	PA Low	During the audit a hospital	When environmental restraint is	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.		resident was sighted to be in the dementia unit. This is environmental restraint. The dementia unit health care assistant spoken to reports this occurs occasionally to prevent the resident wandering. The restraint policies do not include environmental restraint and the resident has not been assessed for environmental restraint. The use of the environmental restraint and ways to manage the risks of this are not included in the resident's care plan.	used ensure this is documented in policy and that the resident has an appropriate assessment and that the care plan includes the use of environmental restraint and ways to manage the risk of this.	
HDS(RMSP)S.2008	Standard 2.2.2: Assessment	Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	PA Moderate			
HDS(RMSP)S.2008	Criterion 2.2.2.1	In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;	PA Moderate	Two of six resident files sampled for residents using restraint (both in the dementia unit) do not have an assessment and consent form completed. One further file for a resident for who restraint was commenced in August 2013 did not have an assessment and consent form completed until January 2014.	Ensure all residents have an assessment and consent form completed prior to the use of restraint.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		(f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.				
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Moderate			
HDS(RMSP)S.2008	Criterion 2.2.3.2	Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made: (a) Only as a last resort to maintain the safety of consumers, service providers or others; (b) Following appropriate planning and preparation; (c) By the most appropriate health professional; (d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation.	PA Moderate	(i) Two of the six restraint files sampled do not have restraint use identified in the care plan. One further file does not have interventions to guide staff in restraint use and managing the risks of restraint. (ii) Four of six restraint files sampled do not document the frequency of monitoring required. (iii) One of six restraint files does not have a record of monitoring for the use of a lap belt. (iv) Four of six restraint monitoring forms sighted have not had monitoring completed two to three hourly, or hourly for one resident with a documented monitoring frequency of hourly.	(i) Ensure restraint use and the management of the risks of restraint is documented in the care plan. (ii), (iii) and (iv) Ensure monitoring frequency is documented and that monitoring occurs in the stated timeframes.	90
HDS(RMSP)S.2008	Standard 2.2.4: Evaluation	Services evaluate all episodes of restraint.	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.4.1	Each episode of restraint is evaluated in collaboration with	PA Low	One of six restraint files sampled did not have an evaluation	Ensure restraint evaluation occurs at least six monthly as	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers.		completed between August 2013 and April 2014.	documented in the restraint policy.	

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:

There is a policy that describes the code of rights. On interview all staff (ten health care assistants (six who work in the hospital/rest home and four who work throughout the facility), three registered nurses (RN), one enrolled nurse, one clinical coordinator and one manager), were aware of consumers rights and were able to describe how they incorporated consumer rights within their service delivery. Code of rights is discussed at resident meetings. Twelve of 12 residents (six rest home and six hospital) interviewed spoke highly of the staff's respect of all aspects of the Code of rights.
Code of rights training was last carried out in May 2012 and is booked for 12 November 2014 (email confirmation sighted).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

There are posters of the code of rights on display throughout the facility and leaflets in the foyer of the facility. On entry to the service residents receive an information pack that includes a code of rights information and a service agreement. Large format and Maori information is also available. On interview all staff (ten health care assistants (six who work in the hospital/rest home and four who work throughout the facility), three registered nurses (RN), one enrolled nurse, one clinical coordinator and one manager), stated that they take time to explain the rights to residents and their family members. Twelve of 12 residents (six rest home and six hospital) and 11 family members (one rest home, four dementia and six hospital), confirmed that they had received information about their rights on entry to the service.
The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service an RN, clinical coordinator or the manager discusses the information pack with the resident and the family/whānau. This includes the Code of rights, complaints and advocacy. On interview residents and family members were able to state their understanding of the code of rights.
Health and disability advocacy service leaflets are on display on the notice board in the foyer. A brochure advertising the service is also included in the information pack provided to new residents. The service can access local Maori advisory services should this be requested. Education on advocacy services is provided.

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission information.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All 12 residents and 11 family members interviewed stated staff were highly respectful and maintained resident's privacy especially when discussing personal issues and that personal belongings are not used as communal property. Privacy training as part of code of rights training occurred in May 2012 and is booked for 12 November 2014 (email confirmation sighted).
The resident's initial assessments and care plans detail their cultural needs (link 1.3.5.2), values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. All 12 residents interviewed stated their needs were met. All 10 resident files reviewed have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this.
There is a policy that describes spiritual care. There are various churches locally and residents are encouraged to attend these. Church services are conducted in the facility every Sunday. Communion is provided to residents who wish at their bedside. All residents and family members interviewed indicated that resident's spiritual needs are being met when required. On interview 12 of 12 residents (six rest home and six hospital) stated staff respect their rights. The service includes emotional wellbeing in the care planning process.
Resident preferences are identified during the admission and care planning processes and family involvement is documented. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered. On interview all 12 residents stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview all ten health care assistants (six who work in the hospital/rest home and four who work throughout the facility) could described how they encouraged residents to engage in activities in the facility and to link with community activities including school and church groups and the RSA.
There is a policy that describes abuse and neglect and the topic is covered at orientation and has been addressed at staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Abuse and neglect training last occurred in June 2013. Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. Twelve residents and 11 family members were complementary of the care provided and

stated staff were very approachable and friendly
D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.
D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.
D4.1a: Resident files reviewed identified that cultural, spiritual values and individual preferences are identified.

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 service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan, a Tikanga best practice policy and a cultural appropriateness policy. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policies/procedures.

Staff training includes cultural safety at orientation. There are present there is one resident who identify as Maori. St Margaret's identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health plan and policies.
Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review (link 1.3.5.2). This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by an RN, with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual's service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with ten health care assistants (six who work in the hospital/rest home and four who work throughout the facility), three registered nurses, one enrolled nurse, one clinical coordinator and one manager, confirm that they are aware of the need to respond to cultural differences. On interview all staff were able to identify how to obtain support so that they could respond appropriately.

A3.2: There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e).
D20.1i: The service has developed a link with a local kaumatua to obtain Maori advisory services and advocacy should this be required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has established cultural policies aimed at helping meet the cultural needs of its residents. There is a Maori health plan. All residents and family members interviewed reported that they were satisfied that their cultural and individual values were being met.
Family are involved in assessment and the care planning process. Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on (link 1.3.5.2). Agreement is reached by all parties involved in the consultation process and the care plan is implementation within the service delivery.

D3.1g: The service provides a culturally appropriate service by ensuring initial assessments fully capture residents information regarding culture and beliefs
D4.1c: Care plans reviewed included the resident's social, spiritual, cultural and recreational needs (link 1.3.5.2).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes covers harassment and exploitation. All residents interviewed reported that the staff respected them. Elderly abuse prevention training occurs at orientation and as part of the in-service training schedule and includes professionalism and standards of conduct. The RN's supervise staff to ensure professional practice is maintained in the service.
Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

The service has policies to guide practice that align with the health and disability services standards. There is a quality framework that is being implemented that supports an internal audit programme. The healthcare assistants are encouraged to complete ACE NZQA level training and an internal in-service training programme is implemented. The manager attends external training sessions appropriate for her position.

A2.2: Services are provided at St Margaret's that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring (link 1.2.3.6).
D1.3: All approved service standards are adhered to.
D17.7c: There are implemented competencies for the registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twelve incidents/accidents forms were viewed for September 2014. The forms includes a section to record family notification. All 12 forms indicated family were informed or if family did not wish to be informed. On interview 12 of 12 residents (six rest home and six hospital), 11 family members (one rest home, four dementia and six hospital) and ten health care assistants (six who work in the hospital/rest home and four who work throughout the facility), three registered nurses (RN), one enrolled nurse, the clinical coordinator and one manager), all stated that family are informed following changes in the residents' health status.
The registered nurses interviewed stated that they record contact with family/whanau. Contact records were documented in all files reviewed.
Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.
A residents meeting occurs six weekly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan.
There is a policy that describes the availability of interpreter services when required.
D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry
D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b: Eleven family members stated that they are always informed when their family members health status changes.
D11.3: The information pack is available in large print and advised that this can be read to residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process. Written consent is obtained for release of health information, photograph, blood tests and x-rays etc., student involvement in cares, transport and outings and annual influenza vaccination. Ten healthcare assistants (six rest home/hospital and four who work across all services) interviewed are familiar with the code of rights and informed consent when delivering resident cares.
Cardio-pulmonary resuscitation (CPR) forms are in place and appropriately signed for three resident's files of ten resident files sampled (four hospital, four dementia care and two rest home). There is an improvement required around the appropriate signing of CPR forms. There are copies of enduring power of attorney in resident files where appropriate.

D3.1.d: Discussion with 11 family members (six hospital, one rest home and four dementia care) identifies that the service actively involves them in decisions that affect their relative's lives.
D13.1: Ten admission agreements sighted have been signed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Cardio-pulmonary resuscitation (CPR) forms are in place and appropriately signed for three hospital residents of ten resident files sampled (four hospital, four dementia care and two rest home). There are copies of enduring power of attorney in resident files where appropriate.

Finding:

1) In seven of ten resident files sampled the CPR form had not been signed appropriately for two rest home residents, (i) there is no evidence of GP discussion with family regarding the not for resuscitation status and (ii) a resident recently admitted and deemed competent by the GP has not signed the CPR form (this was corrected on the day of audit). 2) One hospital file had the CPR form signed by a relative and four out of four dementia care CPR forms had been signed by a relative. The GP had not stated on the one hospital and four dementia care CPR forms if the resident is competent or not competent.

Corrective Action:

Ensure all CPR forms are signed appropriately.

Timeframe (days): 90 *(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 is a policy that describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with 10 healthcare assistants, 12 residents and 11 family members informed they are aware of advocacy and how to access an advocate.
D4.1d; Discussion with 11 family members (one rest home, four dementia and six hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions.
ARC D4.1e: The resident file includes information on resident's family/whānau and chosen social networks.

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:

Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview all staff (ten health care assistants (six who work in the hospital/rest home and four who work throughout the facility), three registered nurses (RN), one enrolled nurse, one clinical coordinator and one manager), stated that residents are encouraged to build and maintain relationships. On interview all residents and family members confirmed this.
D3.1h; Discussion with 11 family members (one rest home, four dementia and six hospital) stated that they are encouraged to be involved with the service and care.
D3.1.e: Discussion with all staff and 11 family members confirm that they are supported and encouraged to remain involved in the community and external groups such as church and RSA visits.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with 12 of 12 residents (six rest home and six hospital) inform an understanding of the complaints process. All staff interviewed are able to describe the process around reporting complaints.
There is a complaints register. Complaints for 2014 to date were reviewed. Verbal and written complaints are documented. There was one complaint to the Health and Disability Commission in November 2013. The complaint was advised as closed by the Health and Disability Commission on 11 April 2014 following the service providing a six week Hospice led training for all registered nurses that included two sessions around communication. There have been 11 further complaints in 2014 to date.
All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants. However three complaints in 2014 document on the complaint investigation that there is to be discussion at registered staff meetings. Registered nurse meeting minutes do not reflect this occurring (link 1.2.3.6).

Discussions with 12 residents and 11 family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns.

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

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

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)
The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)
An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

St Margaret's is a purpose built rest home and hospital facility. The service provides care for up to 88 rest home, dementia and hospital residents. The current occupancy is six rest home residents, 19 dementia residents and 59 hospital residents. St Margaret's is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care. There are four residents on disability contracts.

St Margaret's is part of the CHT organisation. St Margaret's has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year and aligns with the CHT operational strategic goals and business plan for 2014. The quality process being implemented includes regularly review of policies, an internal spot audits and a health and safety programme that includes hazard management. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Combined health and safety / quality meetings and registered nurse meetings overall discuss key components of the quality system and any issues are reported (link 1.2.3.6). There is an internal spot audit schedule that is completed six monthly by the area manager and corrective action plans used to manage shortfalls.
The manager is a registered nurse who has been in the role for 3 ½ months and has a background in health management. She is supported by a clinical coordinator who has been at the service for three weeks and is completing orientation. She also has a background in clinical leadership and health management. The manager and clinical coordinator cover all on-call. The job description for the manager outlines her authority, accountability and responsibility. The manager has completed on-going training appropriate to their positions. There is RN cover in the facility 24/7.
ARC E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)
The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)
The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

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

Attainment and Risk: FA

Evidence:

In the absence of the manager the clinical coordinator oversees the management of St Margaret's with support from the regional manager (who is a registered nurse) and senior registered nurses.
D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies and quality improvement programme includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)
During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

St Margaret's has a quality framework that is being implemented. The manager is directly involved in operations at the facility and the clinical coordinator supports her in this role. There is a current business plan that includes goals and a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (ten health care assistants (six who work in the hospital/rest home and four who work throughout the facility), three registered nurses (RN), one enrolled nurse, one clinical coordinator and one manager); inform an understanding of the quality activities undertaken at St Margaret's.
Resident meetings occur six monthly (minutes viewed). Twelve of 12 residents interviewed are aware meetings are held. Annual surveys are conducted of residents and relatives by Press Gayney. The survey conducted in November 2013 compared St Margaret's with 177 similar facilities in Australia and New Zealand. The satisfaction level at the service has dropped slightly since the previous survey. Following the results the area manager met with all residents and families around the survey results and then a focus group was held with a smaller group of residents focussing on the three areas of poorest outcome across the organisation. All residents and relatives interviewed stated they are asked for feedback regarding the service. The results have been discussed in a staff meeting and the survey data is currently being studied by the organisation so corrective action plans can be developed from the results.

D5.4 The service has appropriate policies/ procedures to support service delivery; Policies and procedures align with the client care plans.
D10.1: Care of the deceased resident procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.
D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.
D19.2g: Falls prevention strategies such as physiotherapy reviews and instruction around prevention in care plans.

Policies and procedures are in place with evidence of review. The manager manages quality systems. There is a quality team which includes all staff. The quality programme is reviewed annually and is being implemented. Meetings standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. There is an improvement required around meeting minutes.
Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility.
Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented.

The area manager completes a six monthly internal spot audit covering all areas of the service. All issues found in the 2014 audits have identified corrective action plans and resolutions. Results of audits are discussed in quality and staff meetings.
Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits is not always reported through to health and safety/quality meetings (link 1.2.3.6). Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and

implementation. Quality improvements have been regularly completed and documented in the health and safety/quality meeting minutes. All staff interviewed could describe the corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme.

Three complaints in 2014 document on the complaint investigation that there is to be discussion at registered staff meetings. Registered nurse meeting minutes do not reflect this occurring and this is an area requiring improvement.
St Margaret's has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be utilised. Ten healthcare assistants interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Monitoring data that is collected by way of monthly: incident report, infection collation. Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. Quality improvements have been regularly completed and documented in the health and safety/quality meeting minutes. All staff interviewed could describe the corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme.

Finding:

(i) There are only health and safety/quality meeting minutes available for May and June in 2014. (ii) May meeting minutes do not reflect discussion of incidents or infections and June minutes do not reflect discussion around incident trends. (iii) Registered nurse meeting minutes for February, June and September 2014 (all that are available) do not reflect discussion of incident or infection trends; (iv) Three complaints in 2014 document on the complaint investigation that there is to be discussion at registered staff meetings. Registered nurse meeting minutes do not reflect this occurring and this is an area requiring improvement

Corrective Action:

Ensure that health and safety/quality meetings occur regularly and that quality data trends analysis outcomes are discussed in these and registered nurse meetings. Ensure that complaints investigations required outcomes including discussion in meetings occurs.

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: FA

Evidence:

Finding:

Corrective Action:

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There is a policy that describes accident/incident management. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the manager who monitors issues. Two of twelve incidents sampled indicate that follow up actions have not been implemented. For one resident the incident form states the lap belt must be fastened behind the resident. The care plan has not been updated to reflect this. For the other the incident form states the resident should be changed to a low, low bed. The resident remains on a high low bed. This is an area requiring improvement. If risks are identified these are also processed as hazards. Incidents are trended monthly and raw data is reported to the health and safety/quality meetings (link 1.2.3.6).
Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification.
Twelve incidents/accidents for September 2014 were viewed. Incidents are collated monthly onto a reporting sheet to monitor issues and trends. Preventative and corrective actions are documented as required.

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

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:

There is a policy that describes accident/incident management. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the manager who monitors issues.

Finding:

Two of twelve incidents sampled indicate that follow up actions have not been implemented. For one resident the incident form states the lap belt must be fastened behind the resident. The care plan has not been updated to reflect this. For the other the incident form states the resident should be changed to a low, low bed. The resident remains on a high low bed.

Corrective Action:

Ensure that actions required from incident investigation are implemented.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There are job descriptions available for positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of registered nurses (RN)'s are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist and physiotherapist. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, and training. Seven of nine staff files sampled do not have a documented reference check. Note that five of these files are for staff that commenced prior to 2009 and the organisation did not have formal reference checking procedures prior to this. Therefore two of the files that should have reference checks do not. This is an area requiring improvement.

There is an annual appraisal process in place and appraisals are current in all nine staff files reviewed.
There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with ten healthcare assistants described the orientation programme that includes a period of supervision. The healthcare assistants reported that supervision can be extended if needed. This was verified by the manager. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Interview with ten healthcare assistants inform there is access to sufficient training. Medication competencies are completed for all RN's and the enrolled nurse who administer medication.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication.

E4.5d: The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.
E4.5e: Agency staff receives an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.
E4.5f: Eight of eleven healthcare assistants who work in the dementia unit have completed the required dementia training through the ACE (aged care education) programme. All healthcare assistants who work in the dementia unit have been at the service longer than one year. An improvement is required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)
The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: PA Low

Evidence:

There are job descriptions available for positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of RN's are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist and physiotherapist. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, and training.

Finding:

Seven of nine staff files sampled do not have a documented reference check. Note that five of these files are for staff that commenced prior to 2009 and the organisation did not have formal reference checking procedures prior to this. Therefore two of the files that should have reference checks do not. This is an area requiring improvement.

Corrective Action:

Ensure reference checks are documented for all new staff.

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

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)
New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)
A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: PA Low

Evidence:

There is an annual appraisal process in place and appraisals are current in all nine staff files reviewed.
There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed.

Interviews with ten healthcare assistants described the orientation programme that includes a period of supervision. The healthcare assistants reported that supervision can be extended if needed. This was verified by the manager. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Interview with ten healthcare assistants inform there is access to sufficient training. Medication competencies are completed for all RN's and the enrolled nurse who administer medication.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication.

E4.5d: The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.
E4.5e: Agency staff receives an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.
E4.5f: Eight of eleven healthcare assistants who work in the dementia unit have completed the required dementia training through the ACE (aged care education) programme. All healthcare assistants who work in the dementia unit have been at the service longer than one year.

Finding:

Three of 11 health care assistants employed in the dementia unit have not completed the required NZQA dementia standards. All three have been employed longer than 12 months.

Corrective Action:

Ensure all staff in the dementia unit have the required dementia training.

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All residents and family members interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the manager or clinical coordinator will be on-call at all times, and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. Turnover is 3 to 4 %.
A contractor physio attends the facility for eight hours a week.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate).
All resident files are in V-care and hard copy files are available. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident's files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home and hospital setting. The service keeps a resident register.
St Margaret's has a control of documents and records process that outlines expectations for record keeping and retention times for specific documents and records.
Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards.
Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. V-care is password protected.
Hard copy resident files are stored securely and protected from unauthorised access by being held at the nurses' station in a secured cabinet. Old files are individually archived and locked in a secure area for 10 years.
Resident records are up to date and reflect residents' current overall health and care status. Records can be accessed only by relevant personnel.
Care plans and progress notes are legible, signed and dated by staff. Medical notes and allied health input are signed and dated appropriately.
D7.1: Entries are legible, dated and signed by staff including designation.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)
All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)
Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

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

Attainment and Risk: FA

Evidence:

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:
1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.
D13.3 the admission agreement reviewed aligns with a) -k) of the ARC contract.
D14.1 Exclusions from the service are included in the admission agreement.
D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.
E3.1 Four files reviewed all include a needs assessment as requiring specialist dementia care.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The admission policy describes the declined entry to services process. St Margaret's records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whanau back to the referral agency.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D16.2, 3, 4 A registered nurse undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. InterRAI assessments are completed with a V care short term care plan in place for the first three weeks of admission. InterRAI initial admission assessment, initial care plans and long term care plans are completed by a registered nurse. V-care computer generated long term care plans are in place within three weeks of admission in the nine of 10 resident files sampled (four hospital, two rest home and four dementia care) (link 1.3.5.2). Residents and family/whanau interviewed feel involved in the care planning process. A lifestyle questionnaire is completed by the resident/relative prior to admission. Activity assessments are incorporated into the V-care long term care plan which is reviewed six monthly.

Care plans are used by nursing staff and healthcare assistants (HCAs) to ensure care delivery meets the residents assessed needs. There is a verbal and written handover for healthcare assistants and registered nurses at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. Progress notes are completed by the RNs and HCAs each shift. All 10 files identified integration of allied health including general practitioner, physiotherapist, dietitian, community mental health nurse, nurse specialist services such as wound nurse. Stamps are used in the progress notes to identify GP visits, nursing and family contact.

Medical assessments are completed within 48 hours of admission by the general practitioner (GP) in 10 of 10 resident files sampled. St Margaret's contracts a local GP for twice weekly visits and as required at other times for resident concerns and admissions. The GP (interviewed) is available by mobile up until 10pm at night with the exception for his palliative care patients. Palliative care patients retain their own GPs for continuity of care. The GP is available to meet with families during his twice weekly visits. After hours calls for visits to residents are appropriate and clinical assessments have improved with observations completed and resident files readily available. Locum cover is provided by other GPs in the local practice. The geriatricians, mental health services for the older person and nurse specialists are accessible and provide good support. The GP states there is good support provided by the secondary services.

A physiotherapist is contracted for eight hours a week to provide (but not limited to) physio assessments, equipment assessments, reviews and re-assessment of residents post falls and exercise plans. The dietitian monitors all residents with weight loss and follows up their progress on the REAP nutritional programme.

Tracer Methodology: Rest home resident .

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

Tracer Methodology: Hospital resident .

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

Tracer Methodology: Dementia care resident .

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment and the first resident care plan within the required timeframes (link 1.3.5.2). Eleven relatives (four dementia care, one rest home and six hospital) and residents (six hospital and six rest home) advised on interview that assessments were completed in the privacy of their single room.

InterRAI assessments trigger the risk tools for assessment. Risk assessment tools completed on admission (if applicable) including (but not limited to); a) dietary assessment and mini nutritional assessment, b) falls risk (FRAT), d) Waterlow pressure area risk assessment, e) continence and bowel, f) wound assessment, g) restraint assessment, h) behaviour monitoring/depression scale (as applicable), and i) Pain assessment and Abbey pain scale.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

An initial assessment forms the basis of an initial care plan (short term V care) within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission in nine of ten files sampled. An improvement is required. The RN develops the long term care plan from information gathered over the first three weeks of admission. There is an improvement required around the documentation of cultural needs in the care plan. V care plans are evaluated six monthly.

Other allied health care professionals providing care such as physiotherapist or dietitian document notes in the integrated resident file.
The integrated resident file also contains admission documents, informed consent forms, care documents, risk assessment tools and reviews, medical documentation, test results (laboratory and radiology), allied health notes, referrals and other relevant health information, associated assessments such as activities, behavioural, recordings (weight, blood pressure), incidents and accidents and any correspondence. Short term care plans are available for use for short term needs.

Eleven family/whanau advised on interview that they were involved in the care plan and are kept well informed of changes to care or health status and support by staff is consistent with their expectations. There is an improvement required to evidence resident/family/whanau involvement in the care planning process. Family/whanau (six hospital, four dementia care and one rest home) interviewed are positive and complimentary about the staff, clinical and medical care provided. All are complimentary about activities provided over the seven day week.

D16.3f: There is an improvement required around evidencing family involvement.
D16.3k: Short term care plans are in use for changes in health status.

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:

An initial assessment forms the basis of an initial care plan (short term V care) within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term care plan from information gathered over the first three weeks of admission.

Finding:

(i) Two residents with cultural needs have not been documented in the care plan. (ii) There is no long term care plan in place for one hospital resident admitted in May 2014.

Corrective Action:

(i) Ensure resident cultural needs are documented in the care plan. (ii) Ensure long term care plans are developed within 21 days of admission (link 1.3.3).

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: PA Low

Evidence:

Eleven family/whanau advised on interview that they were involved in the care plan and are kept well informed of changes to care or health status and support by staff is consistent with their expectations.

Finding:

Two of two rest home files, three of four hospital files and three of four dementia care files do not have documented evidence of resident/family/whanau involvement in the care planning process.

Corrective Action:

Ensure there is documented evidence of resident/family/whanau involvement in the care planning process.

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The service provides services for residents requiring rest home, hospital and dementia level of care. Individual computer generated (V-Care) care plans are completed by registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP consultation. Each resident file has a family/whanau communication form in the resident file that records family notifications for any changes in health status, incidents/accidents and infections. Eleven relatives interviewed confirm they are kept informed of any changes in their relative's health.

The 10 HCAs, three RNs, one enrolled nurse and clinical co-ordinator interviewed state they have all the equipment referred to in care plans necessary to provide care, including hoists, electric beds, ultra-low beds , lazy boy hospital chairs, pressure relieving mattresses and cushions, shower chairs, transfer belts, wheelchairs, mobility aids, chair scale (two) calibrated August 2014, gloves, aprons and masks. Continence products are available and resident continence management plans are completes for residents as applicable.

D18.3 and 4; Dressing supplies are available and there are adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. Wound assessments and treatment plans are in place for 16 wounds. There are three residents in the hospital with pressure areas. There is an improvement required around the completion of wound assessments and evaluations. Pressure area interventions are documented in the care plan and chronic wounds are linked to the care plans. There is evidence of wound nurse specialist involvement in non-healing/chronic wounds.

Resident weight is recorded on admission and monitored monthly. Mini nutritional assessments are completed to assess the resident's level of risk of malnutrition. Weight loss reports are completed for any resident with weight loss. Residents with weight loss are commenced on the REAP (replenish energy and protein – food fortification) intervention therapy (link 1.3.13.2). A dietitian is readily accessible and dietitian and nutritional records are sighted in the files of residents with weight loss. Speech language therapists are accessed for residents with swallowing difficulties.

The service uses risk assessment tools and monitoring forms to monitor a resident's health status and level of risk such as falls risk, pressure area risk, pain assessments and monitoring tool. There is an improvement regarding documentation of interventions to reflect resident's current health status.

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

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

Attainment and Risk: PA Low

Evidence:

Wound assessments and treatment plans are in place for 16 wounds; Rest home – one surgical wound, one lesion, one skin tear and one leg wound; Hospital – one surgical wound, two skin tears, one laceration, two minor wound and one chronic wound; Dementia care – one skin tear, one minor wound and ne deep leg wound. There are three residents in the hospital with pressure area (one with sacral pressure area and two with pressure areas both heels). Pressure area interventions are documented in the care plan and chronic wounds are linked to the care plans. There is evidence of wound nurse specialist involvement in non-healing/chronic wounds.

Individual computer generated (V-Care) care plans are completed by registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP consultation. Each resident file has a family/whanau communication form in the resident file that records family notifications for any changes in health status, incidents/accidents and infections. The service uses risk assessment tools and monitoring forms to monitor a resident's health status and level of risk such as falls risk, pressure area risk, pain assessments and monitoring tool.

Finding:

1) Twelve of 16 wound assessments are incomplete (no date, no signature/designation, and no wound size). Seven wounds have not been evaluated as per the wound management plan. 2) There are no pain assessments for two hospital residents who identify new episodes of pain as per the progress notes and GP visits. 3) One hospital resident with swallowing difficulties does not have interventions documented in the care plan. 4) The high falls risk for one dementia care resident has not been updated in the care plan.

Corrective Action:

1) Ensure wound assessments are completed. Ensure wounds are evaluated at the required frequency. 2), 3) and 4) Ensure care plans reflect the resident's current health status.

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

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

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

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

Attainment and Risk: FA

Evidence:

The service employs a full-time diversional therapist (newly qualified) and a team of part-time activity co-ordinators to implement a seven day week activity programme across the three levels of care. There is an integrated rest home/hospital activity programme with activities that are rotated to occur in the lounges of each suite. An activity co-ordinator spends activity and one on one time in the Sunflower unit (dementia care) and this is identified on the monthly planner. On two mornings a week where there are two co-ordinators on duty there is a choice of many activities for the residents to attend. Residents in the Sunflower unit attend combined activities in the rest home/hospital such as entertainment, bowls, dog therapy, and exercises as appropriate and supervised. Other activities include (but not limited); ladies group, knitting, news, craft, crosswords and other board games, art, manicures and foot spas, flower arranging, trivia and snooker. Attendance at activities are voluntary. The activity co-ordinators make daily contact with residents who are unable to participate in activities or choose to stay in their rooms. One on one time with residents includes discussions, reminiscing, hand massages an individual activities. Discussion groups are held with guest speakers from the community and the residents are offered a library service with regular visits from the community librarian. The community ladies choir and older persons group visit monthly. There are outings at least weekly for residents in all levels of care. The service has access to wheelchair van shared between other local CHT facilities. There is a designated driver (with first aid) and an assistant on outings. Activity staff attend if the residents are getting out of the van to attend concerts or other community events.

There are interdenominational church services on Sundays and Catholic communion weekly on Fridays. Resident meetings and surveys provide residents with an opportunity to feedback on the activity programme. Festive and religious occasions are celebrated such as Easter, Christmas, resident birthdays, St Patrick's Day. Residents and the family confirm on interview they are involved in the development of the care plan which includes activities. The activity co-ordinators maintain an individual activity attendance sheet. Residents and relatives interviewed are satisfied with the content and variety of the activity programme.
D16.5d: The review of the activity plan and care plan occurs at the same time.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All initial assessments and initial care plans are developed by a RN within 48 hours of admission. The long term care plan is evaluated at least six monthly in six of 10 resident files sampled. Two hospital residents and two dementia care residents have not been at the service six months. InterRAI assessments are completed six monthly or earlier as required. Six monthly evaluations identify if the resident goals have been met or unmet. Care plans are updated with changes as identified in the evaluations. There is a three monthly review by the GP. Care plan reviews are signed as completed by an RN.

D16.4a; Care plans are evaluated six monthly more frequently when clinically indicated.

ARC: D16.3c; Initial care plans are evaluated by the RN within three weeks of admission for nine of 10 files sampled (link 1.3.5.2).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The registered nurses (interviewed) described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to dietitian, speech language therapist, physiotherapist, wound nurse specialist, bone density clinic, radiology, diabetic screening, ophthalmology, mental health nurse, psychiatric registrar and orthopaedic clinic.
D16.4c: The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.
D 20.1; Discussions with the registered nurses and clinical co-ordinator identified that the service has access to wound care nurse specialists, incontinence specialists, dietitian and physiotherapist.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. The service-use the district health board yellow envelope checklist. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.
Family contact records document regular communication with family/EPOA regarding the transfer and updates on residents' condition.

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:

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy is contracted to provide the medications and other pharmaceuticals. Returns are kept in a locked cupboard. Regular medications are dispensed in blister packs and prn medication are in bottles. The registered nurse (RN) checks the regular medications on delivery; however there is no formal checking process in place. PRN medications are dispensed in bottles and replaced every three months on expiry. There is a main medication room for the rest home and hospital. A medication trolley and medication supplies for the dementia unit is kept in the locked nurse's station. Medications for hospital residents are kept in a locked bedside cabinet drawer in the resident's rooms. The RN only has access to the medications and holds the master key. RNs and enrolled nurses complete annual medication competency to administer medications. `Medication competent staff attend annual education. The HCAs on nights complete a competency to check controlled drugs. RNs have completed syringe driver competency. Controlled drugs are checked weekly (register sighted). All eye drops in medication trolleys are dated on opening. The medication fridge temperature is recorded daily. The service has a specimen fridge only. There are no self-medicating residents. Standing orders are not used. Three telephone order forms sighted had been signed by two RNs and the GP had signed the order within 48 hours. The hospital holds hospital controlled drug stock and impress stock of antibiotics for GP use. Oxygen and suction is available.

All signing sheets sampled are completed correctly. PRN medications are dated and timed on administration on the signing sheet. There are special instructions for medication administration as required with the medication charts.

Twenty medication charts sampled (eight hospital, four rest home and eight dementia care) all had photo identification and allergies/adverse reactions noted. All 20 medication charts evidenced three monthly GP reviews. There is an improvement required around the prescribing of medications and the indication for use for of PRN medications.

D16.5.e.i.2; Twenty out of 20 medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.

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

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

Attainment and Risk: PA Moderate

Evidence:

The supplying pharmacy is contracted to provide the medications and other pharmaceuticals. Returns are kept in a locked cupboard. Regular medications are dispensed in blister packs and prn medication are in bottles. The registered nurse (RN) checks the regular medications on delivery.

Twenty medication charts sampled (eight hospital, four rest home and eight dementia care) all had photo identification and allergies/adverse reactions noted. All 20 medication charts evidenced three monthly GP reviews.

Finding:

1) There is no evidence of medication reconciliation on delivery of medicines into the facility. 2) GP prescribing on 18 of 20 medications charts do not meet the legislative requirements for prescribing medications. Brackets are used with one signature for several medications and dittos are used for dates. 3) There are no indications for use of PRN medication on seven of 20 medications charts.

Corrective Action:

1) Ensure documented evidence of medication reconciliation. 2) Ensure GP prescribing of medications meet legislative requirements. 3) Ensure all PRN medications have an indication for use prescribed on the medication chart.

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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An external contractor is contracted to provide meals. All meals are prepared and cooked on-site. There is a qualified chef, two kitchen hands (morning duty) and an afternoon kitchen hand on daily. There is a four week menu cycle in place that can be adapted to feedback received from resident feedback and preferences. The menu has been reviewed by a dietitian April 2014. Dietary information forms are completed on resident admission and reviewed six monthly with copies held in the kitchen. The chef is informed of any dietary changes. Dislikes are accommodated with alternative choices offered. Special diets provided are lactose intolerance, no pork, beef or lamb, food allergies and diabetic desserts. Soft and pureed meals are provided for the residents as assessed. The chef is responsible for ensuring fortified foods are prepared for residents on the REAP programme as per the REAP level.

Meals are transported by bain marie to the rest home/hospital dining room and served by the chef. Meals are plated and transported to the dementia care unit. All special diets are labelled. Lip plates and specialised utensils are provided for residents to promote independence at meal times. The midday meal in the dementia unit is observed with HCAs assisting residents as required. The meals are well presented and residents have adequate food and snacks available. End cooked and serving temperatures are recorded on every meal daily. Fridge and freezer temperatures are taken and recorded daily. All foods sighted in fridges and freezers are dated. Inward goods temperature are recorded on chilled and frozen goods. Dry goods in the pantry are sealed, dated, labelled and off the floor. The dishwasher temperature is taken daily and is serviced and checked by the chemical supplier regularly. Contractors are available 24/7 to for kitchen appliances. A cleaning schedule is maintained. Chemicals are stored safely. Staff are observed wearing correct protective wear, hats, aprons and gloves.

Snacks are readily available for residents as required outside of kitchen hours. A recent quality initiative in progress is for the provision of finger foods. Trolleys are used to deliver meals plated with heat lids to the hospital dining area and rooms and to the rest home dining room in scan boxes.

D19.2; Staff have been trained in safe food handling and hygiene. There is annual education last attended in May 2014. Chemical safety has been attended August 2014.

E 3.3f; There is a selection of nutritious foods and snacks delivered to the dementia unit daily including (but not limited to) sandwiches, soups, biscuits and fruit.

The service commenced using a Replenish Energy and Protein (REAP) programme in July 2012. REAP puts a focus on nutrition and 'nutrition alerts' and is an agenda item at nursing and health care assistants (HCA) meetings. The documented programme has been developed by the Medirest dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. There are three levels. The emphasis is on food first rather than commercial supplements for managing unintended weight loss. At St Margaret's there are residents on REAP level one, two and three (as listed). These residents are clearly documented on the whiteboard in the kitchen. When a resident is identified as having unintended weight loss a weight loss report is completed (sighted). This includes checking the mouth and teeth, reviewing diet type, monitoring food intake, consulting with the cook, consulting the dietitian, referring to the GP, referring to family and reviewing medication. Two files (one dementia care and one rest home) are sampled for residents who are the REAP programme. Both have been assessed by a dietitian prior to commencement on REAP and their weight. The residents are on food and fluid monitoring charts. Their weight is now stable. Ten HCAs, three registered nurses, one enrolled nurse and the clinical coordinator interviewed are all familiar with REAP and report the benefits to residents. The chef interviewed is knowledgeable in the REAP programme. Fortified foods are sighted in the kitchen fridge ready for delivery to the kitchenettes for the residents. The chef interviewed reports that ways in which he implements REAP including fortified food wherever possible for those on the programme. Examples include cream and brown sugar on cereals, extra margarine on vegetables, fortifying mashed potato, sauces and purees, cream on desserts in the evening (for level three), fortifying soup, providing fortified milk and fortified drinks, fortified custard for supper for those on REAP level three and sandwiches for supper on REAP level two (of which there are currently no residents). The service continues to evaluate and improve the REAP programme and initial results show a marked decrease in weight loss for those using the programme

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals are labelled with manufacturer labels. There is appropriate protective equipment and clothing for staff. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are evidenced stored securely in locked cleaning cupboards. Staff attended chemical safety in August 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The St Margaret's facility holds a current warrant of fitness which expires on 16 September 2015. St Margaret's is a large, spacious single story building divided into seven suites (A-G) of eight to 10 beds each for rest home/hospital residents. Sunflower dementia care unit is a 20 bed unit.

There is easy and safe access for residents from bedrooms to internal communal areas. Outdoor areas are safe to access and there is seating and shade provided. Hallways are sufficiently wide enough to allow residents to mobilise with the aid of walking frames safely and other mobility aids.

Reactive and preventative maintenance occurs. A maintenance manager oversees the maintenance team that covers the CHT sites in the region. A communication book is used to record maintenance and repair requests. The maintenance manager is available on call and there are 24/7 contractors for essential services. There is an internal monthly planner in place. A facility assets list is maintained and resident electrical items are listed. Electrical equipment has been checked and tagged November 2013. Electrical testing is two yearly. All clinical equipment has been checked/calibrated annually. Resident hot water temperature checks are carried out monthly with stable temperatures at 43-45 degrees Celsius.

The grounds and gardens are maintained by contracted service.

ARC D15.3; there is adequate equipment available for the rest home, hospital and dementia unit. Interviews with 10 HCAs, three registered nurses and one enrolled nurse confirmed there was adequate equipment including hoists, electric beds, ultra-low beds, lazy boy hospital chairs, pressure relieving mattresses and cushions, shower chairs, transfer belts, wheelchairs, mobility aids, chair scale (two) calibrated August 2014
E3.4d, There is an open plan lounge/dining area designed so that space and seating arrangements provide for individual and group activities. There are three other smaller lounges areas within he dementia care unit.
E3.3e; There are quiet, low stimulus areas that provide privacy when required.
E3.4.c; There is a safe and secure outside courtyard with walking path that is easy to access for dementia residents. There are raised gardens including vegetable gardens.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

All bedrooms have an ensuite. There are adequate numbers of communal toilets located near the lounge areas. There is safe flooring, seating and hand rails appropriately placed in the ensuite rooms and communal toilets. Toilet/shower facilities are constructed for ease of cleaning. Residents interviewed (six rest home and six hospital) confirmed that staff provide them with privacy when attending to personal hygiene cares.

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:

All bedrooms are spacious enough to manoeuvre transferring equipment to safely deliver care. Residents are observed manoeuvring walking frames in their rooms safely. Bedrooms have wide doors to allow easy access for hoists and ambulance trolley if required. All rest home/hospital beds are electric. There is a mix of normal beds and electric beds in the dementia unit. Residents and family/whanau are encouraged to personalise their bedrooms as viewed.

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:

There is a main rest home/hospital dining room and lounge area. Each suite has a kitchenette and small lounge. Able residents can move freely about the facility with the use of mobility aids and furniture is well arranged to facilitate this. There is adequate space in the lounge and dining areas to accommodate the specialised hospital level lounge chairs. Activities take place in the lounge areas.
E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. The dementia unit has three smaller lounges and a combined lounge/dining area.
D15.3d; Seating and space is arranged to allow both individual and group activities to occur.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a cleaning policy and a cleaning quality management plan. Cleaning audits occur. The cleaning room is a designated areas and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. All laundry is laundered off site. There is a separate dirty linen cupboard where laundry bags are collected from daily and taken out the back door to be transported off-site. Clean laundry is delivered through the front entrance. There is a documented laundry audit which is completed monthly for the service. The external contractor audits laundry and cleaning processes monthly and standards of laundry. Issues are followed up with staff by the supervisor or regional manager. Resident satisfaction with cleaning and laundry services is monitored through the annual satisfaction survey with a high level of satisfaction being reported.
The cleaner's rooms are designated areas and clearly labelled. There are rooms available for storage of chemicals. All chemicals are labelled with manufacturer's labels. MSDS are available in the laundry.
All bulk chemicals and chemicals used by the cleaner are kept in locked cupboards that cannot be accessed by residents.

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:

Civil defence is covered in the risk management procedure. This details aspects of civil defence including emergency supplies.
There is a fire safety and evacuation procedure.
Fire training and security situations are part of orientation of new staff - orientation checklist sighted. Staff training in emergency management including fire safety and evacuation, also emergency response for healthcare facilities, this occurred in April 2014. Fire evacuation also occurred on 3 April 2-14 and is booked for 3 October 2014 (email sighted).
Sighted policy and procedure on emergency and security situations including how services will be provided in health, civil defence or other emergencies according to the needs of the residents in the service, how the service will manage in a worst case scenario pandemic event. These policies have been reviewed within the last two years.
Interviews with ten health care assistants (six who work in the hospital/rest home and four who work throughout the facility), three registered nurses (RN), one enrolled nurse, one clinical coordinator and one manager, showed they are aware of emergency and security procedures. Fire equipment includes fire hose reels, fire extinguishers, smoke detectors and sprinklers - sighted. A fire services company conduct monthly checks. There is an improvement required around having staff on duty with a first aid certificate at all times.
An approved evacuation scheme was signed off by the New Zealand Fire Service on 25 November 2008.
Extra blankets are available. There is emergency lighting at the facility and torches and batteries are stored (sighted). The facility has emergency lighting and a gas BBQ is available for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. A store of emergency water is kept. The facility has Civil Defence kits. Staff are aware of how to find this equipment as confirmed at interviews with six health care assistants, one registered nurse and the manager.
Call bells are evident in resident's rooms, lounge, dining, and toilets/bathrooms.
There is a call bell system in place. Call bells are tested by the maintenance man and repaired in a timely fashion. Call bells were randomly tested during the audit and were all in working order. Twelve of 12 residents (six rest home and six hospital) interviewed commented that staff respond promptly to the call bell.
The service has a health and safety management system.
Visitors and contractors are required to sign in and out.

Exits are physically locked by afternoon staff at approximately 6pm each night. This is double checked by night staff when they come on duty at 11pm.
There is security lighting for after dark. All staff interviewed are familiar with security measures.
D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

Attainment and Risk: PA Low

Evidence:

Fire training and security situations are part of orientation of new staff - orientation checklist sighted. Staff training in emergency management including fire safety and evacuation, also emergency response for healthcare facilities, this occurred in April 2014. Fire evacuation also occurred on 3 April 2-14 and is booked for 3 October 2014 (email sighted).

Finding:

There is not always a staff member on duty with a first aid certificate.

Corrective Action:

Ensure there is a staff member on duty with a first aid certificate at all times.

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)
The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

All bedrooms and communal areas have large windows allowing adequate natural light. All the rest home/hospital rooms have doors that open out to the outdoors allowing for adequate ventilation and view. The facility has under floor heating.

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: PA Low

Evidence:

There is a restraint policy There is a restraint manual applicable to the type and size of the service. The restraint manual includes a section on training that covers policies, procedures, challenging behaviours management, de-escalation techniques, emergency / acute restraint and appropriate use of safety enablers. Restraint training occurs yearly. Challenging behaviour training has been provided. Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers.
The restraint manual determines that enablers are voluntary and the least restrictive option. There are no enablers in use in the facility and 10 residents with 11 restraints (eight lap belts and three bedrails). Four of the lap belts are in the dementia unit and the other restraints are for hospital level residents.

During the audit a hospital resident was sighted to be in the dementia unit. This is environmental restraint. The dementia unit health care assistant spoken to reports this occurs occasionally to prevent the resident wandering. The restraint policies do not include environmental restraint and the resident has not been assessed for environmental restraint. The use of the environmental restraint and ways to manage the risks of this are not included in the resident's care plan. This is an area requiring improvement.

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: PA Low

Evidence:

The restraint manual includes a section on training that covers policies, procedures, challenging behaviours management, de-escalation techniques, emergency / acute restraint and appropriate use of safety enablers. Restraint training occurs yearly. Challenging behaviour training has been provided. Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers.

The restraint manual determines that enablers are voluntary and the least restrictive option. There are no enablers in use in the facility and 10 residents with 11 restraints (eight lap belts and three bedrails). Four of the lap belts are in the dementia unit and the other restraints are for hospital level residents.

Finding:

During the audit a hospital resident was sighted to be in the dementia unit. This is environmental restraint. The dementia unit health care assistant spoken to reports this occurs occasionally to prevent the resident wandering. The restraint policies do not include environmental restraint and the resident has not been assessed for environmental restraint. The use of the environmental restraint and ways to manage the risks of this are not included in the resident's care plan.

Corrective Action:

When environmental restraint is used ensure this is documented in policy and that the resident has an appropriate assessment and that the care plan includes the use of environmental restraint and ways to manage the risk of this.

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator is the clinical coordinator who is experienced in aged care. She has been in the role for three weeks. Assessment and approval process for a restraint intervention includes the registered nurse, resident/or representative and medical practitioner.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The service has a comprehensive assessment form for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. A registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In four of six restraint files reviewed, assessments and consents were fully completed. This is an area requiring improvement. Consent for the use of restraint is completed with family involvement and a specific Consent for enabler / restraint form is used to document approval. These were sighted in the four of six restraint files reviewed where an assessment had been completed.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:
(a) Any risks related to the use of restraint;
(b) Any underlying causes for the relevant behaviour or condition if known;
(c) Existing advance directives the consumer may have made;
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
(f) Maintaining culturally safe practice;
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
(h) Possible alternative intervention/strategies.

Attainment and Risk: PA Moderate

Evidence:

The service has a comprehensive assessment form for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. A registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In four of six restraint files reviewed, assessments and consents were fully completed. Consent for the use of restraint is completed with family involvement and a specific Consent for enabler / restraint form is used to document approval. These were sighted in the four of six restraint files reviewed where an assessment had been completed.

Finding:

Two of six resident files sampled for residents using restraint (both in the dementia unit) do not have an assessment and consent form completed. One further file for a resident for who restraint was commenced in August 2013 did not have an assessment and consent form completed until January 2014.

Corrective Action:

Ensure all residents have an assessment and consent form completed prior to the use of restraint.

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

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

Services use restraint safely

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

Attainment and Risk: PA Moderate

Evidence:

The restraint manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints (link 2.2.2.1). Four of six files reviewed had a completed assessment form and three of six have a care plan that reflects risk. This is an area requiring improvement. Monitoring forms that included regular two to three hourly monitoring (or one hourly for one file) were present in two of six files reviewed. Two of six monitoring forms sampled indicate that monitoring has occurred regularly. Improvement is required around restraint monitoring. Four of six files reviewed have a consent form detailing the reason for restraint and the restraint to be used (link 2.2.2.1). The service has a restraint and enablers register for the facility that is up dated each month.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:
(a) Only as a last resort to maintain the safety of consumers, service providers or others;
(b) Following appropriate planning and preparation;
(c) By the most appropriate health professional;
(d) When the environment is appropriate and safe for successful initiation;
(e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: PA Moderate

Evidence:

The restraint manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints (link 2.2.2.1). Four of six files reviewed had a completed assessment form and three of six have a care plan that reflects risk. Monitoring forms that included regular two to three hourly monitoring (or one hourly for one file) were present in two of six files reviewed. Two of six monitoring forms sampled indicate that monitoring has occurred regularly. Four of six files reviewed have a consent form detailing the reason for restraint and the restraint to be used (link 2.2.2.1).

Finding:

(i) Two of the six restraint files sampled do not have restraint use identified in the care plan. One further file does not have interventions to guide staff in restraint use and managing the risks of restraint. (ii) Four of six restraint files sampled do not document the frequency of monitoring required. (iii) One of six restraint files does not have a record of monitoring for the use of a lap belt. (iv) Four of six restraint monitoring forms sighted have not had monitoring completed two to three hourly, or hourly for one resident with a documented monitoring frequency of hourly.

Corrective Action:

(i) Ensure restraint use and the management of the risks of restraint is documented in the care plan. (ii), (iii) and (iv) Ensure monitoring frequency is documented and that monitoring occurs in the stated timeframes.

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:
(a) Details of the reasons for initiating the restraint, including the desired outcome;
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
(c) Details of any advocacy/support offered, provided or facilitated;
(d) The outcome of the restraint;
(e) Any injury to any person as a result of the use of restraint;
(f) Observations and monitoring of the consumer during the restraint;
(g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: PA Low

Evidence:

The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). In the six restraint files reviewed, evaluations had been completed for two residents with the resident, family, restraint co-ordinator and medical practitioner. Four residents had not yet had restraint for three months. One of six restraint files sampled did not have an evaluation completed between August 2013 and April 2014. This is an area requiring improvement.

Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator and through health and safety/quality meetings. A restraint evaluation is completed for each individual month. Evaluation timeframes are determined by risk levels.

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

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

Attainment and Risk: PA Low

Evidence:

The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). In the six restraint files reviewed, evaluations had been completed for two residents with the resident, family, restraint co-ordinator and medical practitioner. Four residents had not yet had restraint for three months.

Finding:

One of six restraint files sampled did not have an evaluation completed between August 2013 and April 2014.

Corrective Action:

Ensure restraint evaluation occurs at least six monthly as documented in the restraint policy.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Individuals approved restraint is reviewed at least three monthly through the health and safety/quality meeting (link 1.2.3.6) and as part of six monthly facility approval team review with whanau involvement.

Restraint usage throughout the facility is analysed and information fed back to staff via all facility meetings (link 1.2.3.6).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control (IC) coordinator is an RN and has been in the post for over one year. The infection control coordinator can access external specialist advice from GP's, laboratories and DHB infection control specialists when required. The infection control programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the coordinator and external expertise when required. Infection control is a standing agenda item at the health and safety/quality

meetings (link 1.2.3.6) and RN meetings (link 1.2.3.6). Staff are informed about infection control practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the infection control coordinator and entered into the infection register.
There are job description for the infection control coordinator including the role and responsibilities of the infection control coordinator. IC is part of the audit schedule and is undertaken as part of the six monthly internal spot audit. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine.
The service has not had an outbreak since the previous audit.

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:

Infection control (IC) matters are taken to health and safety/quality meetings (link 1.2.3.6). The infection control coordinator can access external DHB, infection control nurse specialist, laboratories, and GP's specialist advice when required. They are responsible for reviewing the infection control programme annually at the organisational IC meeting. The coordinator complies with the objectives of the infection control policy and work with all staff to facilitate the programme. The coordinator has completed Bug Control training in 2013. Staff complete annual infection control education. Access to specialists from the DHB, laboratories and GP's is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.

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:

St Margaret's has infection control policies and an infection control manual which reflect current practise. The infection control programme defines roles and responsibilities of the infection control coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the infection control coordinator. The infection control programme is reviewed annually by the infection control coordinator and she can access external specialist advice to do this.
D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control coordinator has completed external IC training. All new staff receive infection control education at orientation including hand washing and preventative measures. Annual infection control education last occurred in March 2014. The training folder records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at St Margaret's are appropriate to the acuity, risk and needs of the residents.
The infection control coordinator enters infections on to the infection register and carry out a monthly analysis of the data. The analysis is intended to be reported to the health and safety/quality meeting and the RN meeting (link 1.2.3.6). The infection control coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting.

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.)*