**NNNM Enterprises Limited - Lester Heights Hospital**

**Current Status:** **24-Jun-13**

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

**General overview**

This audit was undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and to assess conformity prior to a facility being purchased. The proposed new owner has previously owned aged care facilities since 2008 and has recently purchased another aged care facility.

Since the onsite audit, further information provided by the prospective owner 15 July 13 included an updated transition plan. The plan identifies that the facility will be managed by the current clinical manager from 1 August until 9 September. An experienced clinical manager is appointed and commences on the 9th of September. She will be supported to transition into the role and receive monthly clinical supervision. Job descriptions for each position including authorities and responsibilities have been developed.

The existing policies and procedures will stay in place but will eventually be replaced by a complete Quality Assurance Programme. Staff will be trained on these new policies and procedures in the first six months.

Current employees have re-applied for their position and have been interviewed and will be provided with individual Employment Agreements and job descriptions including responsibilities and authorities. Each position/shift is accompanied by a task schedule. The current roster will be maintained.

The updated transition plan includes a schedule of events/responsibilities from 5 July until end of 2013. A preventative maintenance schedule has been developed and will be maintained by a delegated person.

There are required improvements around aspects of maintenance and medication management.

Lester Heights Hospital

NNNM Enterprises Ltd

Provisional audit - Audit Report

Audit Date: 24-Jun-13

**Audit Report**

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | NNNM Enterprises Ltd |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Lester Heights Hospital | 93 Fourth Avenue | Avenues | Whangarei |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| **Type of Audit** | Provisional audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 24-Jun-13 **End Date:** 24-Jun-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

**Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXX | RCompN, PGDipHSM, Auditor certificate | 8.00 | 6.00 | 24-Jun-13 |
| Auditor 1 | XXXXXXX | RN, auditor certificate | 8.00 | 6.00 | 24-Jun-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 3.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 15.00 | **Total Audit Hours** | 31.00 |
| **Staff Records Reviewed** | 5 of 22 | **Client Records Reviewed** *(numeric)* | 5 of 17 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 5 |
| **Staff Interviewed** | 7 of 22 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 5 of 17 | **Number of Medication Records Reviewed** | 10 of 17 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

**Declaration**

I, (full name of agent or employee of the company) XXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 19 day of July 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

**Services and Capacity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Lester Heights Hospital | 32 | 17 |       | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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**Executive Summary of Audit**

*General Overview*

Lester Heights is part of the Radius Residential Care Group. Lester Heights cares for up to 32 residents requiring hospital level care. On the day of the audit there were 17 residents. This audit was undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and to assess conformity prior to a facility being purchased. The proposed new owner has previously owned aged care facilities since 2008 and has recently purchased another aged care facility.

Since the onsite audit, further information provided by the prospective owner 15 July 13 included an updated transition plan. The plan identifies that the facility will be managed by the current clinical manager from 1 August until 9 September. An experienced clinical manager is appointed and commences on the 9th of September. She will be supported to transition into the role and receive monthly clinical supervision. Job descriptions for each position including authorities and responsibilities have been developed.

The existing policies and procedures will stay in place but will eventually be replaced by a complete Quality Assurance Programme. Staff will be trained on these new policies and procedures in the first six months. Current employees have re-applied for their position and have been interviewed and will be provided with individual Employment Agreements and job descriptions including responsibilities and authorities. Each position/shift is accompanied by a task schedule. The current roster will be maintained. The updated transition plan includes a schedule of events/responsibilities from 5 July until end of 2013. A preventative maintenance schedule has been developed and will be maintained by delegated person.

There are required improvements around aspects of maintenance and medication management.

*1.1 Consumer Rights*

Lester Heights practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights "the Code" and copies of the code are displayed through the facility. There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and continuing through the care planning process. There are implemented policies at Lester Heights to protect residents from discrimination or harassment. Clinical policies are reviewed by the clinical management committee at organisational level and there is a process in place to inform staff of policy change. There is an open disclosure and interpreters policy that staff understand. Family/friends are able to visit at any time and interviews verified on-going involvement with community activity is supported. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process.

*1.2 Organisational Management*

Lester Heights is part of the Radius group and as such, there are organisational wide processes to monitor performance. The facility is being purchased by a new owner. The new owner has hired a quality consultant to provide policies and procedures and a quality and risk management system for the service after the change of ownership. The quality consultant has provided a quality system for a large number of aged care providers in New Zealand. The new owner reports that the quality consultant will initially visit the site weekly. The new owner has owned three aged care facilities previously and has worked in the industry since 2008. In May 2013 they purchased another facility in Tauranga.

Weekly 'Heartbeat' meetings are used to monitor quality activities such as audit, complaints, health and safety, infection control and restraint. There is an adverse event reporting system implemented at Lester Heights and monthly data collection monitors predetermined indicators. There is a human resource manual to guide practice. There is an annual education programme and records of attendance are maintained. Five staff files were reviewed and all have a current appraisal and show human resource practices are followed. There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty match needs of different shifts. Resident information is kept confidential and old records are archived.

*1.3 Continuum of Service Delivery*

The service has a well-developed assessment process and resident’s needs are assessed prior to entry for hospital level of care. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement was discussed with them. Registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and guide all staff in cares. Care plans are reviewed at least six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals.

Medicines are managed and policies reflect legislative requirements. Registered nurses are responsible for administration of medicines and complete annual medication competencies and education. The medicines records reviewed include documentation of allergies and sensitivities and special instructions for specific medications. There is an improvement required around GP prescribing of 'as required' medications.

The activities programme is facilitated by an activities coordinator. The activities programme provides varied options and activities that meet the consumer group. Each resident has an individualised activity plan. Links with the community are encouraged and van outings are arranged on a regular basis. All food is cooked on site by the cook. All residents' nutritional needs are identified and accommodated with alternative choices provided. Meals are well presented, homely and the menu plans have been reviewed by a dietician. Food and fridge temperatures are recorded.

*1.4 Safe and Appropriate Environment*

There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme approval.

The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. The buildings, plant and equipment comply with legislation, with documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Residents interviewed state the facility is warm, comfortable and has a homely atmosphere. External areas are safe for residents and family members. Documented systems are in place for essential, emergency and security services. The facility has a civil defence kit. Staff interviews and files evidence current training in relevant areas. Alternative energy and utility sources are maintained, an appropriate call bell system is available and security systems are in place. There are improvement required around maintenance issues.

*2 Restraint Minimisation and Safe Practice*

There is a restraint minimisation and safe practice 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 an enablers register. There are three residents requiring bedrails as restraint and three residents with identified enablers. Restraint assessments are based on information in the care plan, discussions with residents/relatives and on staff observations of residents. Staff are trained in restraint minimisation and restraint competencies are completed regularly. Restraint is reviewed for each individual at least three monthly and as part of the multidisciplinary review. Multidisciplinary reviews include family/whanau.

*3. Infection Prevention and Control*

Radius Lester Heights has an infection control programme that complies with current best practice. There is a dedicated infection control coordinator who has a role description. The infection control coordinator collates monitoring data and reports through to the weekly 'Heartbeat' meetings and outcomes are reported to staff through nursing and staff meetings. The infection control programme is reviewed annually. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided includes an evaluation of the session and content delivered. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

**Summary of Attainment**

* 1. ***Consumer Rights***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:0 CI:0 FA: 12 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA:23 PA:0 UA:0 NA: 0 |

* 1. ***Organisational Management***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:22 PA:0 UA:0 NA: 0 |

* 1. ***Continuum of Service Delivery***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Low | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 11 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:20 PA:1 UA:0 NA: 0 |

* 1. ***Safe and Appropriate Environment***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | FA | 0 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | PA Low | 0 | 2 | 1 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 5 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:16 PA:1 UA:0 NA: 0 |

1. ***Restraint Minimisation and Safe Practice***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:9 PA:0 UA:0 NA: 0 |

1. ***Infection Prevention and Control***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | FA | 0 | 1 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 48 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 99 **PA:** 2 **UA:** 0 **N/A:** 0 |

**Corrective Action Requests (CAR) Report**

Provider Name: NNNM Enterprises Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:24-Jun-13 End Date: 24-Jun-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.12 | 1.3.12.1 | PALow | **Finding:**Seven out of 10 medication charts sampled had no reason documented for the administration of prn medications. **Action:**Ensure a reason is prescribed for the administration of PRN medications. | 3 months |
| 1.4.2 | 1.4.2.4 | PALow | **Finding:**a) The communal showers/toilets have paint peeling off the wet surface areas posing an infection control risk. b) One shower chair is rusting around the wheels causing the equipment to become unsafe to use. c) There is an area of carpet that has lifted (from underneath) near the main entrance that is a potential slip, trip or fall hazard. Action:a) Ensure walls and wet areas surfaces are constructed for ease of cleaning to reduce infection control risk. b) Remove the unsafe shower chair. c) Eliminate the identified hazard of uneven carpet in the entrance way.  | 3 months |

**Continuous Improvement (CI) Report**

Provider Name: NNNM Enterprises Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:24-Jun-13 End Date: 24-Jun-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

**1. 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**

Consumers receive services in accordance with consumer rights legislation.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is an implemented code of rights policy and procedure. Discussions with three healthcare assistants and one registered nurse identified their familiarity with the code. Interviews with five of five residents and three relatives confirmed service is provided in line with the code of rights. Code of rights/advocacy/complaints training was last provided in July 2012 (30 attended). The new owner has been in aged care for five years and is familiar with the code of rights when interviewed. She reports having attended training provided by the Health and Disability Advocates Trust.

**Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service provides information to residents that includes the code of rights, complaints and advocacy information. There is access interpreter services if required. Information is given to next of kin or EPOA to read to and/or discuss with the resident. Interviews with five of five residents and three relatives identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Monthly resident/relative meetings (minutes sighted) are held providing the opportunity to raise concerns in a group setting. There is a monthly newsletter available to residents and families.

Advocacy pamphlets are included in the information pack. Advocacy service pamphlets available in facility that include contact details. The service has an advocacy policy that includes a definition of advocacy, objectives and process/procedure/guidelines.

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

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service has policy aligned with the requirements of the Privacy Act and Health Information Privacy Code - including: Confidentiality, privacy & dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.

Discussions with five of five residents and three relatives confirmed personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.

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.

The spiritual and religious beliefs policy guides practice from an organizational perspective. Interdenominational services are held regularly. Contact details of any spiritual/religious advisors are available to staff. Religious dietary requirements identified through assessment and care planning and met as required. All relatives interviewed (three) and five of five residents confirm the service is respectful.

A client satisfaction survey is carried out annually to gain feedback. In the survey completed in September 2012 2 respondents indicated they were satisfied that cultural and spiritual/religious needs are being met.

D4.1a: Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

The information pack provided to residents and their families includes the home's philosophy of care. Discussions with five of five residents and three relatives confirmed that residents are able to choose to engage in activities and access community resources. Residents and family members confirmed that they have adequate rights to choose within the constraints of the service, for example, meal times.

Five care plans reviewed identified specific individual likes and dislikes.

The abuse & neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Training is an annual requirement. All facilities are required to have a copy of the "Elder Abuse & Neglect - a Handbook for those working with Elder Abuse" from aged concern.

Code of rights training was last conducted in July 2012 and abuse and neglect training occurred in January 2012 with 17 staff attending. Discussions with management and three healthcare assistants and one registered nurse reported no incidents of abuse/neglect.

**Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.4 Recognition Of Māori Values And Beliefs**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a specific Maori Health care plan and a culturally safe care policy. Discussions with three healthcare assistants and one registered nurse confirm an understanding of the different cultural needs of residents and their whānau. There is a section in the assessment tool and care plan that includes spirituality, religion and culture, psycho-social needs and family and significant others. In addition there is a Maori care plan available if the individual resident wishes. The one Maori resident at Lester Heights has a documented Maori health plan. There is information and websites provided within the Maori Health Plan to provide quick reference and links with local Maori Healthcare Providers regionally within New Zealand.

D20.1 i:The service also utilises a resident who is a kaumatua and his whanau as a Maori cultural advisor. He has links with Nga Pui and has strong links with the Ratana church.

The Maori Health plan states that staff training sessions will be provided two yearly for all staff. Cultural safety training was provided January 2011. The service has documentation relating to culturally appropriate responses in particular settings.

The Maori health care plan includes reporting on significant others to be involved in care such as iwi affiliations and advocates. Interviews with three healthcare assistants and one registered nurse confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau.

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Care planning includes consideration of spiritual, psychological and social needs. Five of five residents and indicated that they are involved in the identification of spiritual religious and or cultural beliefs. Three relatives interviewed stated that they felt they were valued, consulted and kept informed. Family involvement is encouraged e.g. invitation to facility functions such as the dance that was being advertised at the time of the audit.

D3.1g The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by three healthcare assistants and one registered nurse.

D4.1c Care plans reviewed included the residents social, spiritual, cultural and recreational needs.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is an implemented discrimination and harassment policy that includes all aspects of this criterion. There is a staff policy in relation to gifts and gratuities and the management of external harassment. The following policies also support keeping residents safe from exploitation: code of residents rights, abuse and neglect, and complaints. Annual training is provided to staff across a number of topics such as: code of rights (July 2012) and communication (June 2012). Five of five residents interviewed informed they were not exposed to exploitation.

A staff employment handbook and orientation package includes a code of behaviour. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Interviews with three healthcare assistants and one registered nurse informed an understanding of professional boundaries.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. Policies are reviewed and approved by the clinical management committee at an organizational level. The good practice policy supports staff in ensuring good practice is intrinsic to care delivery. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The human resource manual includes pre-employment, the requirement to attend orientation and on-going in-service training.

Lester Heights facility manager oversees the internal audit and in-service education programmes with support from senior staff. Staff are informed when external training is available and financial support is considered. There is support available for those wishing to pursue post-graduate qualifications (appropriate to the area of work). There is access to computer and internet resources and search engines. There is organizational membership to Bug Control for infection control updates / training and expert advice.

 Five of five residents and three relatives interviewed spoke positively about the care and support provided. Three healthcare assistants and one registered nurse have a sound understanding of principles of aged care and state that they have been supported by the service for on-going education.

A2.2: Services are provided at Lester Heights that adhere to the Heath & Disability Services Standards (2008). There is an implemented quality improvement programme that includes performance monitoring.

D1.3 All approved service standards are adhered to.

D17.7c.There are implemented competencies for caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

It should be noted that the proposed new owner will be changing the policies and procedures and quality and risk management system to one she has purchased from a quality consultant.

**Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is an open disclosure policy. The communication with resident’s policy includes procedures to ensure that staff communicate well with residents and family members. There are monthly resident/relative meetings facilitated by the activities staff allowing residents/relatives to raise issues. Five of five residents stated they were welcomed on entry and were given time and explanation about services and procedures.

Nine incident reports were reviewed across the service. All recorded family notification. Three relatives interviewed informed they are notified of any changes in their family member’s health status. The facility manager who investigates incidents, informed there are processes in place to support family notification of events.

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: All three relatives stated that they are informed when their family members health status changes.

The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.

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

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Policies and training support staff in providing care and support to enable residents to make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with three health care assistants identify that consents are sought in the delivery of personal cares. Written consent includes the signed admission agreements and consent for transporting, outings, photographs, release of health information, transfer of medical records, consent for procedures, use of restraint and/or enablers and provision of care. All five resident files reviewed has signed consent forms signed by the family/whanau/EPOA. Advanced directives/ resuscitation policy is implemented in five resident files reviewed. All advance directives are completed by the resident where able. A medically indicated resuscitation status is made by the GP in consultation with family members/EPOA where a resident is deemed incompetent to make a decision.

D13.1: There were five admission agreements sighted and signed on the day of admission.

D3.1.d: Discussion with three family members identified that the service actively involves them in decisions that affect their relative’s lives.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is an advocacy policy and procedure that includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and advocacy pamphlets are available at reception.

D4.1e; The resident file includes information on residents family/whanau and chosen social networks

Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.

D4.1d; Discussion with three relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The client information pack informs visiting can occur at any reasonable time. Interviews with five of five residents and three relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life is documented in the care plans and there is a family communications/contact sheet in resident files where staff document when family have been contacted.

The service has strong community support and engagement and residents are frequently engaged in outings.

D3.1.e Discussion with five of five residents and three relatives verified they are supported and encouraged to remain involved in the community and external groups. There are a number of ways Lester Heights support on-going access to community services, for example: RSA, community activities.

D3.1h: Discussion with three family that they are encouraged to be involved with the service and care.

**Criterion 1.1.12.1 Consumers have access to visitors of their choice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The complaints policy and procedure states that clients/family/whanau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Residents/family can lodge formal or informal complaints through verbal communication, written, resident meetings, complaint forms or via suggestion box.

A clients complaint procedure flow chart is included in the policy and is included in the information pack for residents on entry. Policy states that complaints process is to be visible and available in public areas.

Interviews with five of five residents and three relatives were familiar with the complaints procedure and state all concerns /complaints are addressed.

The complaints log/register includes date of incident, complainant, summary of complaint, signature off as complete. There have been four complaints in 2013 to date. All have documentation of full investigation and resolution including communication with complainants is documented for all complaints. One of the complaints in September 2012 was received via the Health and Disability Commissioner regarding the care of a now deceased resident. The complaint letter from the commission was dated 4 September and the facility manager provided a full response with comprehensive information. The commission sent a letter acknowledging receipt of the information dated 20 November 2012. The complaint remains open.

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

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Lester Heights is part of the Radius Residential Care Group. Lester Heights care for up to 32 residents requiring hospital level care. On the day of the audit there were 17 residents receiving hospital level care.

The facility is being purchased by a new owner. The new owner has developed a business plan and has hired a quality consultant to provide policies and procedures and a quality and risk management system for the service after the change of ownership. The quality consultant has provided a quality system for a large number of aged care providers in New Zealand. The new owner reports that the quality consultant will initially visit the site weekly. The new owner has owned three aged care facilities previously and has worked in the industry since 2008. In May 2013 they purchased another facility in Tauranga. The prospective owner has not developed a transition plan and reports there is no transition period between the old and new manager proposed. This is an area requiring improvement prior to the sale being completed. The new owner states 'they understand that they need to have a transition plan which they are working on. They are meeting with the current owner, staff and residents tomorrow which will allow them to get a better idea of which of the staff will re-apply for their position and which staff they need to replace'.

The current facility manager reports monthly to the Regional Manager on a range of operational matters in relation to Lester Heights including strategic and operational issues, incidents and accidents, complaints, health and safety. Radius mission statement states that:

"We deliver a quality lifestyle with an innovative approach to care that enables us to maintain the wellbeing, dignity and independence of our residents"

The current facility manager is a registered nurse who has worked in aged care management roles for the past 13 years. She has been in the current role for 10 months. The organisation provides annual conferences for their managers and annual regional conferences.

ARC, D17.4b (hospital), The manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

Updates from the prospective owner 15 July 13 included an updated transition plan. The plan identifies that the facility will be managed by the current clinical manager from 1 August until 9 September. An experienced clinical manager is appointed and commences on the 9th of September. She will be supported by experienced RN’s employed and receive monthly clinical supervision. They have defined a clear job description for each position including authorities and responsibilities.

The existing policies and procedures will stay in place but will eventually be replaced by a complete Quality Assurance Programme. Staff will be trained on these new P&P in the first 6 months.

Current employees have re-applied for their position and have been interviewed and will be provided with individual Employment Agreements and job descriptions including responsibilities and authorities. Each position/shift is accompanied by a task schedule. The current roster will be maintained.

The updated transition plan includes a schedule of events/responsibilities from 5 July until end of 2013. A preventative maintenance schedule has been developed and will be maintained by delegated person

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

During the temporary absence of the manger, Lester Heights is managed by a senior registered nurse with support from other local Radius facility managers and the regional manager.

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

Information provided by the prospective owner 15 July 13 stated that, a senior RN who has worked at Lester Heights for a number of years will deputise for the Facility Manager in her absence.

**Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There are organisational policies to guide each facility to implement the quality management programme including (but not limited to); continuous quality improvement programme policy, continuous quality improvement methodology policy, quality indicator data collection policy and internal audit timetable. There is evidence that the quality system continues to be implemented at Lester Heights. Staff have designated portfolios including incidents and accidents, training, restraint, health and safety and infection control. Interviews with three healthcare assistants and one registered nurse confirmed that quality data is discussed at monthly staff meetings (staff and RN meeting minutes reviewed). The facility manager advised that she is responsible for providing oversight of the quality programme. There is also a weekly 'Heartbeat' meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff.

The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level by the clinical managers group with input from facility staff every two years. Clinical guidelines are in place to assist care staff with such issues as constipation, delirium, congestive heart failure, diabetes, dementia, falls prevention, incontinence, nutrition and hydration, skin care and wound management. Assessment tools completed linked with resident care plans and were reviewed six monthly. There is an annual staff training programme that is implemented and based around policies and procedures. Internal audits are completed for care delivery compliance, care plans compliance, clinical records, medications, hand washing, privacy.

A resident satisfaction survey was last completed in September 2012. Results were collated and corrective action plans developed.

D5.4 The service has the appropriate policies and procedures to support service delivery;

There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly. New/updated policies are sent from head office . New policies/procedures are put in the staff room with a signing sheet for staff to sign once they have read and understood the documentation (verified at interview with six healthcare assistants and two registered nurses). Staff have access to manuals (nurses stations and staff room). Policies are up to date and are located electronically on 'P' drive.

Monthly reports by the facility manager to the regional manager are provided on service indicators. The 'Heartbeat' meetings are minuted and with a set agenda including (but not limited to): health & safety, incident and accidents, complaints/compliments. Information is taken to staff through the various meetings, staff notice boards.

The prospective owner 15/7/13 confirmed that the existing policies and procedures will stay in place but will eventually be replaced by a complete Quality Assurance Programme. Staff will be trained on these new policies and procedures in the first six months.

a) There are monthly accident/incident reports completed by the facility manager that break down the data collected across the service.

b) The service has linked the complaints process with its quality management system. Monthly manager reports to the regional manager include complaints. Staff meeting minutes identify discussion of complaints.

c) There is an infection control data collection form which records all infections for each month. Infection control rates, outbreaks and results of internal audits are reported to the staff meeting and through clinical indicator reports for benchmarking. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the staff, and registered nurse meetings.

d) Health and safety is an agenda item of the staff meeting. Any new hazards are discussed.

e) Advised that the restraint committee report through the staff and restraint meetings, feedback is provided to staff and RN meetings. Restraint use is also fed back to the organization through the clinical indicator reports. Restraint internal audits are completed yearly and results are also forwarded through monthly manager meetings

Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. Further evidence may be requested by the regional manager when indicators are above the benchmark. The service collects internal monitoring data (internal audits) with the audit schedule being implemented at Lester Heights by the Facility Manager. The audit programme includes (but not limited to); care plans, care delivery compliance, health and safety, IC, medications, code of rights, informed consent, vehicle compliance and restraint. Quality improvement data such as incidents /accidents, hazards, internal audit, infections are collected and analysed/evaluated at the quality meeting and staff are informed through the registered nurses and staff meetings. Minutes of RN meetings verified audit results are discussed.

 Radius policy informs a corrective action plan is required where compliance is under a predetermined threshold. Corrective action plans were developed for incident reports (sighted) and all audits where there has been less than 95% conformity.

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 aggregating data monthly that includes considering time of occurrence

There is emergency and disaster planning in place around earthquakes, fire, emergencies and other disasters. This includes training and education for staff, monthly building compliance checks, six monthly evacuation trials, and ensuring adequate staffing in the event of an emergency. There is an organisational risk register that includes identified risk and risk rating, identified action to prevent or minimize risk and persons responsible and covers areas such as clinical risk, human resources related risks, health and safety risks, environment/service related risks and financial risk. Each facility personalises to their site. Radius has a terms of reference for the H&S committee defining membership to include healthcare assistants and a household representative.

When the ownership changes the current Radius quality and risk management system will cease being used. The new owner intends to implement a quality and risk management system developed by a well-known quality consultant in aged care services.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

As part of risk management and health and safety framework, there is an accident/incident reporting and open disclosure policy/procedure. There was evidence of indicator month by month data collection including (but not limited to): falls (no injury, soft tissue, fractures), skin tears, medication and pressure areas.

When an incident occurs the healthcare assistant (or staff discovering the incident) completes the form and the RN will undertake an initial assessment. The RN will notify family and GP as required. The facility manager collects incident reports daily and review both the incident and actions taken. Where the action taken is not considered to have been comprehensive, the facility manager will investigate and escalate to the regional manager. Nine incident forms sampled evidence detailed investigations and corrective action plans following incidents.

Monthly data is taken to the risk management and restraint meeting. The three healthcare assistants and one registered nurse interviewed could describe the process for management and reporting of incidents and accidents.

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

D19.3c Discussions with the service (facility manager) confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications. Public Health was notified of a gastric (not Norovirus) outbreak in February 2013.

Accident/incident analysis includes falls, skin tears, pressure areas, resident behaviour and medication incidents. The service has an incident and accident analysis form that includes name, place, date and time, type, injury/site, cause, resident/staff/visitor, doctor notified, hazards identified and action taken. Monthly aggregation of data is undertaken (falls monthly summary's sighted) and outcomes are discussed at all meetings - Heartbeat, and staff meetings.

Nine incident forms were reviewed across the service and clinical actions were well documented. Actions taken to minimise risk to individual residents are recorded.

**Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Of the five staff files reviewed one was a registered staff - current practicing certificate was able to be reviewed. The facility manager reported a system is in place to check expiry dates. New registered staff are required to provide a practising certificate as part of the recruitment process. Practising certificates are sighted for: GP's, physiotherapist, pharmacy, podiatrist and dietician.

Recruitment, selection and appointment of staff policy is in place. Five staff files were reviewed and three have a current performance appraisal. The other two staff have not yet been at the service for one year.

The organisation has a staff orientation policy. Lester Heights has an orientation programme that is specific to worker type and includes manual handling, health and safety in service and competency testing. The new staff member is then buddied for three shifts with an experienced healthcare assistant (HCA). The facility manager identifies suitably skilled HCA to be the 'buddy'. Interview of three healthcare assistants and one registered nurse informed there is an orientation process provided that included a period of being buddied.

In all five staff files reviewed there was a record that an orientation had been completed.

The service has an internal training programme directed by head office. There is an assigned in-service training manual that includes sessions required at orientation and then yearly. All sessions include a quiz which is used at Lester Heights to embed information from the sessions provided. Challenging Behaviour and dementia are part of the training programme.

In addition to training requirements there are healthcare assistant competencies (hand washing, manual handling, restraint, first aide) with a tracking sheet in place to monitor requirements. Sighted compliance audits of hand washing - signed off by RN and restraint competency quizzes completed for 2013.

D17.7d: RN competencies include: hand washing, manual handling, restraint, medication, syringe driver. As for above a tracking process is in place to monitor requirements.

The proposed new owner reports that he intends to have all staff reapply for their positions and she will go through an interview process with all staff, reappointing those she feels are suitable.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts. The facility manager, a registered nurse works full time.

Staff turnover is moderate. The three healthcare assistants and one registered nurse interviewed stated that there is adequate staffing to manage their workload on any shift.

The GP was interviewed and confirmed that staffing is appropriate to meet the needs of residents.

Five of five residents and three relatives interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent and friendly.

The new owner reports she intends to maintain staff levels as they are while she reviews staffing levels.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual record and service register. These are paper based files.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Informed consent is obtained from residents/family/whanau on admission, for permission to display the resident’s name and taking of photographs.

D7.1 Entries are legible, dates and signed by the relevant caregiver or RN including designation

Care plans and notes are legible and where necessary signed and dated. Policies contain service name. All resident records contain the name of resident and the person completing the form/entry.

Individual resident files kept demonstrate service integration that also contains GP notes and the allied health professionals and specialists records if applicable.

Communication with families is documented in the communication form and this was well used in five files reviewed.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. NASC assessments are required for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the residents hospital level of care requirements. There is a comprehensive information pack provided to all residents and their families for hospital care. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the H&D Code of Rights,' complaints information, advocacy, and admission agreement. Three family members and five residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Five of five had NASC approval and signed service agreements.

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

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

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.

**Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.2 Declining Referral/Entry To Services**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a declining entry section in the admission procedure. The service records document the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is a policy and process that describe resident’s admission and assessment procedures.

D16.2, 3, 4: A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission. Within three weeks the care plan is developed in the four hospital files viewed. In five of five resident files sampled the initial admission assessment and care plan summary were completed and signed off by a registered nurse. In four of five files viewed the long term care plans (LTCP) were completed in three weeks. One resident had recently been admitted.

Medical assessments are completed within 48 hours of admission by the GP. An admission visit is scheduled on the day of audit for a new admission. Six monthly reviews or earlier if resident health changes are completed by the registered nurse (RN) with input from health care assistants (HCA), the GP, the diversional therapist and any other relevant person. Activity assessments and the activities care plans have been completed by the activities coordinator.

A range of assessment tools completed on admission are evident in the five resident files sampled and completed at least six monthly including (but not limited to); a) nutritional and dietary assessments b) Waterlow pressure area risk assessment, c) continence assessment d) mobility assessment e) sleep assessment, f) skin assessment g) pain assessment h) communication assessment and i) behaviour assessment

Care plans are used by nursing staff and HCA's to ensure care delivery is in line with the residents assessed needs. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change).

Handover sheets lists any resident concerns to be communicated to the oncoming staff a handover. 24 hour reports in residents files alert staff to a significant event that has happened to the resident or information the staff need to be made aware of. Three health care assistants and one RN could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

All five files identified integration of allied health including DHB nurse specialist, physiotherapy, dietitian and podiatry. The home GP is contracted to provide medical services for the residents. He visits weekly and the days varies according to his other employment in anaesthetics. The GP is available after hours for visits or telephone advice. He meets with the family to discuss a residents resuscitation status or changes to health status. The Whitecross Doctors are available for emergency care after hours. The GP spoke positively confirming prompt notifications are received from the RNs regarding changes in health status or resident concern. He is complimentary about the quality care of care delivered to his patient. The GP stated the staff excel at providing palliative care.

 Five resident files are sampled as follows: 1) resident with complex needs and challenging behaviours 2) resident admission xxxx with high risk weight loss 3) resident on pain management monitoring and incontinence problem 4) resident with weight loss and on restraint (bed rails) monitoring 5) resident with challenging behaviour.

Tracer Methodology: Hospital resident

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

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

A comprehensive initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs outcomes and goals of residents are identified. A range of assessment tools are completed in resident files and reviewed at least six monthly including (but not limited to; a) nutritional and dietary assessments b) Waterlow pressure area risk assessment, c) continence assessment d) mobility assessment e) sleep assessment, f) skin assessment g) pain assessment h) communication assessment and i) behaviour assessment. Weights and BP's are monitored on a weekly to monthly basis dependant on needs. Assessments are conducted in an appropriate and private manner. All residents interviewed are satisfied with the support provided.

Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Five resident interviews and three family members stated they were informed and involved in the assessment process.

**Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Residents' files include; initial assessment, daily progress notes, BP and weight recordings, short term care plans, long term care plans, risk assessments/nutrition, regular evaluations, GP initial assessment and visits, lab results, NASC assessment, allied health reports, activities, consents, advance directives, letters, referrals and archived notes.

Care plans are individually developed with the resident and family/whānau involvement is included where appropriate. Four care plans reviewed were evidenced to be up to date. One long term care plan is not yet due. Goals and outcomes are identified and agreed and how care is to be delivered is explained.

All residents have an individualised care plan that is comprehensive and goal oriented. The long term care plan that covers all areas of need identified as follows: current medical problems, communication, cultural, elimination, end of life needs, hygiene and personal care needs, memory/cognition/behaviour, mobility/falls prevention, nutrition/hydration, pain management, physiological requirements, psychological requirements, rest and sleep, sexuality/emotional, spiritual, family/significant others and other needs. There is an ADL daily checklist.

Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health including district nurses, dietitians, hospice, DHB nurse specialist, physiotherapy and podiatry. There is evidence that residents are seen by their GP at least three monthly. Notes are well maintained. Significant events and communication with families are well documented on the communication with family record form. A Maori Heath care plan is in place for one Maori resident.

D16.3k: Short term care plans are in use for changes in health status including infections, skin tears, weight loss, loss of skin integrity, pain management, agitation and behavioural management.

D16.3f: All five resident files reviewed identified that family were involved.

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.5.3 Service delivery plans demonstrate service integration.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service provides services for residents requiring hospital level care. Individualised care plans are completed. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. The three HCA's and RN interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including hoists, electric beds, pressure relieving mattresses and cushions, shower chairs, transfer belts, wheelchairs, gloves, aprons and masks. Adequate supplies of continence and wound care products were sighted in the medication room.

 AD18.3 and 4 Dressing supplies are available and the medication room holds adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.

Wound assessment and wound management plans are in place for wounds. Wound assessments include medical history, nutrition, blood tests, allergies, mobility and other factors. Body maps, graphs and photos of wounds were sighted. Wound dressing plans are used to monitor healing and frequency of dressings. Minor wound charts are used for skin tears and minor abrasions. A short term care plan was sighted for a reddened sacral area with appropriate management. There is evidence of a wound nurse involvement and discharge summary in resident file sampled.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. A three day continence monitoring form is used for continence problems to identify cause or corrective action. Specialist continence advice is available as needed and the RN on duty could describe the referral process.

There is a pain assessment tool used to assess a resident’s type, location, severity of pain, treatment and review. There is a specific pain assessment tool for dementia clients. The pain monitoring record details time, pain score, respiration rate, nausea, antiemetic required, blood pressure and oxygen saturation levels if appropriate.

All falls are reported on the resident accident/incident form. Falls risk and mobility assessments are done on admission. The physiotherapist carries out a Berg balance assessment on referral. An action plan for residents who fall frequently sighted. The action plan details frequency/pattern, contributing factors, action plan to reduce risk of repeated falls.

Palliative care is delivered with support from Northhaven Hospice nurses and specialists as required. Liverpool care pathway is implemented and medications for pain relief and comfort is kept in the hospital unit CD safe.

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The sole activities coordinator was a caregiver prior to being employed as an activities co-ordinator. The activities coordinator works 25 hours a week. There is organizational support and networking available through attendance at diversional therapy branch meetings. The activities coordinator completes an occupational/activity assessment with every new resident which includes a life role/hobbies and interests. The activity care plan is developed with resident/family/whanau involvement as evidenced by the signatures on the care plans. Activity care plans are individualised and activity attendance records are kept. A written evaluation is completed at least six monthly or earlier if there are changes to residents function and/or physical abilities. Activities are appropriate to the resident group and delivered in the two lounges (Frank and Dolly ) and reflect the cognitive abilities of the residents. Activities provided are meaningful and reflect ordinary patterns of life. Activities include musical entertainers and sing-alongs, arts and crafts, newspaper reading, cooking bread, exercises (balloon therapy), movies (residents choose DVD's) and pampering activities such as nail care and hand massage. The activities person spends one on one time with the hospital residents daily. There are shared activities that the two groups of residents attend such as happy hour and movies. Outings and drives occur every Tuesday. The van is shared between the Radius facilities and has two wheelchair spaces.

There are library and RSA visits to the home. Festive occasions and birthdays are celebrated. Currently the residents are celebrating Matariki - Maori new year over June/July. Spiritual needs are met according to preferences. The home has an elder Kaumatua (resident) who takes church when able. Staff assist where able to ensure religious needs are met. A chaplain from the DHB visits and takes services. One resident goes out to church weekly with family.

Three family members and five residents interviewed stated that activities are appropriate and varied enough for the residents.

D16.5d: Four of five resident files reviewed identified that the individual activity plan is reviewed when at care plan review. One resident file viewed had been in the facility less than six months.

**Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

All initial care plans were developed by an RN within three weeks of admission and evaluated at least six monthly or if there is a change in health status. There is a three monthly review by the GP. There was documented evidence that care plan evaluations were up to date in four of five resident files sampled. One residents care plan is not due for an evaluation. Overall changes in health status are documented and followed up. Care plan reviews are signed as completed by an RN. A letter is sent to the family and the resident informed of an upcoming evaluation of the long term care plan. There is a three monthly review by the GP. GP's review residents medication at least three monthly or when requested if issues arise or health status changes. Short term care plans are evaluated, resolved or added to the long term care plan if the problem is on-going.

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

D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.9 Referral To Other Health And Disability Services (Internal And External)**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service facilitates access to other medical and non-medical services. The GP interviewed confirms RNs inform him of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted: Dietitian, eye clinic, hospice, medical outreach service, audiometrist, radiology, physiotherapy.

There is information available pre-admission and in the admission documentation on the health and disability code of rights, advocacy, health practitioners code of conduct and informed consent. Follow up occurs as appropriate.

D16.4c: The service currently have no residents awaiting a NASC reassessment. The GP and RN stated hospital level residents rarely are re-assessed to another level of care.

D 20.1: Discussions with the registered nurse on duty identified that the facility has direct access to services including DHB nurse specialists, district nurses, wound care nurses, hospice nurses and specialists, podiatrist and physiotherapy services.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer**

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

ARC D21 ARHSS D21

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy of which is kept on the resident’s file. There is a DHB transfer to hospital from aged care "yellow envelope “system. This was sighted in one resident file transferred to hospital. A transfer form accompanies residents to receiving facilities. There is evidence in the communication with family record form that relatives are informed of transfers and discharges as sighted in two of five residents records sampled. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals and collects the returns. The facility uses the robotic roll system. Medications are checked by an RN on delivery with a reconciliation form completed. Any discrepancies are fed back to the pharmacy. The RN's receive annual education and undergo an annual medication competency including administration of oral and subcutaneous medications and oxygen therapy. Designated medication staff sign on the signing sheet register.

There is a policy and process that describes self-administered medicines. There are currently no residents who self-administer medication. The medication room is adequately stocked with supplies of ointments/treatments. Medications are in locked cupboards and trolleys. Controlled drugs are kept in a locked safe. There are weekly controlled drug checks. There are Liverpool Care Pathway medications available. Medication administration observed; all practice is appropriate. The medication fridge temperature checks recorded are within acceptable ranges.

Ten resident medication charts and signing sheets sampled identified all charts medication charts had photo identification and allergies/adverse reactions noted. There is evidence of three monthly GP review of medications. All signing sheets are correct and prn medications are dated, timed and signed. Seven out of 10 medication charts sampled had no reason documented for the administration of prn medications. The medication manual contains information on the type, description and use of medications, allergic reactions, and palliative care guidelines. Standing orders are not used. Verbal telephone orders sighted are signed off by the GP. There is an emergency kit available for GP use which contains glucagon, frusemide and Solucortef medications. Expiry dates of medications, ointments and eye drops are all current.

There is an improvement required around the prescribing of prn medications to include a reason for administration.

D16.5.e.i.2: Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

**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.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals and collects the returns. The facility use the robotic roll system. Medications are checked by an RN on delivery with a reconciliation form completed. Any discrepancies are fed back to the pharmacy. The RN's receive annual education and undergo an annual medication competency including administration of oral and subcutaneous medications and oxygen therapy. Designated medication staff sign on the signing sheet register.

**Finding Statement**

Seven out of 10 medication charts sampled had no reason documented for the administration of prn medications.

**Corrective Action Required:**

Ensure a reason is prescribed for the administration of PRN medications.

**Timeframe:**

3 months

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service employs two cooks and three kitchen hands to provide meal services over seven days a week. There is a rotating four weekly menu with associated recipes books. The organizational chef/dietitian have input into the menu reviews. Dietary needs are met such as soft/pureed/diabetic/high calorie diets as required. There are specialised drinking cups, lip plates and large grip utensil as required. An RN completes each resident’s nutritional profile on admission with the aid of the resident and family. Copies of residents nutritional profiles are kept in the kitchen and any changes are communicated to the food services. There is a food services communication diary. Food safety information and a kitchen manual is available in the kitchen. Resident’s likes and dislikes are known. Residents requiring extra support to eat and drink are assisted, this was observed during lunch. Meals are served from a bain marie. Food served on the day of audit was hot and well presented. Residents and relatives interviewed are satisfied with the food services and choices offered. Hot and cold food temperatures are monitored at each meal. Recordings show temperatures are within acceptable ranges. The service has a well equipped kitchen with delivery, storage, baking and food preparation, serving and dishwashing areas. There are gas hobs and electric oven for cooking. A barbeque is available for summer barbeques and as an alternative cooking source in the event of an emergency. The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. Fridge/freezer temperatures are checked daily. A new freezer has a visual temperature thermometer. Food in the chiller are covered and dated. The kitchen is clean and all food is stored off the floor. Cleaning schedules and duties lists are in place. All chemicals are locked away. Ecolab conduct internal audits on the dishwasher, chemicals in use and provide training as required. Food audits are carried out as per the yearly audit schedule.

D19.2: Kitchen staff have been trained in safe food handling and chemical safety. One cook has completed HSI (Hospitality service industry ) units in April 2013 and the other cook is booked to attend.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**STANDARD 1.4.1 Management Of Waste And Hazardous Substances**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident / accident reports reviewed involving waste, infectious material, body substances or hazardous substances.

There are Ecolab safety data sheets available in service areas where chemicals are stored. All chemicals are correctly labelled and stored safely. There is a chemical spills kit centrally located in the administration area. Emergency flip charts include instructions for chemical spills and are displayed throughout the facility. There is an emergency plan to respond to significant waste or hazardous substance management. Waste management/chemical safety training occurs annually. Sufficient gloves, aprons, and goggles are available for staff. Waste management has the contract for the collection of general and infectious waste. Incontinent products are double bagged before disposal into general waste. There is recycling of cardboard and plastic containers. There is a pest control programme in place. The maintenance person is an approved handler for pesticides and attends to any ant, spider concerns and weed spraying. There is protective wear provided such as heavy duty gloves, boots, respirator and masks to carry out the duties. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Three health care assistants, one laundry supervisor and maintenance person interviewed were able to describe hazard management.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

 The building holds a current warrant of fitness which expires on 1 December 2013. Fire equipment checks are conducted by an external fire safety contractor.

The maintenance person has attended an electrical testing course and carries out checks on essential equipment two yearly. Testing tags were sighted for March 13. There is a maintenance requisition form is checked daily (curtain rails, heaters, handrails requests sighted) and in most cases the issue can be repaired or resolved on the same day. There is a list of preferred contractors for electrical, plumbing, building and other requirements. A sample of hot water temperatures in resident areas are taken monthly and these are maintained at 43 degrees (no recordings over 45 degrees). All call bells are checked monthly. The maintenance person has completed Health and Safety courses and Site Safe certificate previous to current employment. He has a background in landscaped gardening and tends to the gardens and grounds. The outdoor areas are well maintained with safe paving, outdoor seating and shade sails in the summer. There is an outdoor resident designated smoking area.

The facility's amenities, fixtures, equipment and furniture are appropriate for hospital care residents. There is sufficient space to allow the movement residents around the facility using the mobility aids or lazy boy chairs. The hallways are wide and have hand rails appropriately placed.. There is non-slip flooring in the showers and toilet areas throughout the facility. The communal showers/toilets have paint peeling off the wet surface areas posing an infection control risk. One shower chair is rusting around the wheels causing the equipment to become unsafe to use. These are areas requiring improvement.

The main hallways and living areas are carpeted. There is an area of carpet that has lifted (from underneath) near the main entrance that is a potential slip, trip or fall hazard.

ARC D15.3;The following equipment is available, pressure relieving mattresses, electric beds, shower chairs, two hoists (last checked 15/8/12),chair scales (last calibrated 27/6/12) , walking frames, over bed tables, wheelchairs, shower tilting chair, resident transferring aids. Equipment is maintained annually by an external contractor.

The prospective owner advised that they will hire a suitable van to ensure that residents’ activities are not negatively impacted.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The facility's amenities, fixtures, equipment and furniture are appropriate for hospital care residents. There is sufficient space to allow the movement residents around the facility using the mobility aids or lazy boy chairs. The hallways are wide and have hand rails appropriately placed. There is non-slip flooring in the showers and toilet areas throughout the facility.

**Finding Statement**

a) The communal showers/toilets have paint peeling off the wet surface areas posing an infection control risk. b) One shower chair is rusting around the wheels causing the equipment to become unsafe to use. c) There is an area of carpet that has lifted (from underneath) near the main entrance that is a potential slip, trip or fall hazard.

**Corrective Action Required:**

a) Ensure walls and wet areas surfaces are constructed for ease of cleaning to reduce infection control risk. b) Remove the unsafe shower chair. c) Eliminate the identified hazard of uneven carpet in the entrance way.

**Timeframe:**

3 months

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

All resident rooms have direct access to a hand basin. Communal toilets and showers are spacious enough to be able to use mobility aids, shower chairs and other appropriate equipment to tend to hospital level of care residents personal hygiene requirements. There are privacy slide signs on the toilet/shower doors. Hand sanitizer gel is provided throughout the facility. The five residents interviewed state the staff are respectful and ensure their privacy and dignity is maintained when attending to their personal hygiene requirements.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is adequate space in all bedrooms for residents and staff. Three health care assistants were asked if there was sufficient room and they confirmed they were able to move freely to provide cares. Doorways into residents' rooms and communal areas are wide enough for wheelchair, hoist and bed access. Bedrooms viewed are personalized, spacious and fixtures and carpets well maintained. There are built in wardrobes. Five residents interviewed are happy with their rooms.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service is divided into wings. The main wings (Frank and Dolly) have their own dining room and lounge areas. Dining and recreational needs are delivered to meet the resident’s cognitive and physical abilities, promote independence and maintain their dignity. The areas are welcoming and the décor provides a homely atmosphere. Seating is appropriate and placement allows for group or individual activities to take place.

**Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There are cleaning policies and processes. Internal and external (Ecolab) cleaning audits occur. Corrective actions required are followed through the quality/risk management and staff meetings. The laundry manager (interviewed) is a Health and Safety representative.

The laundry is located downstairs. There is keypad access only for staff. The dirty linen is delivered in colour coded bags and get sorted on arrival in the laundry. Lester Heights is the main laundry for linen and personals for another two other facilities (Rimu Park and Potter Home). The laundry operates from 7am to 8pm daily. Each home has its own linen. Adequate linen supplies are available (as sighted) within the Lester Heights complex. Washing is delivered by van with a clean and dirty area for transport. There are large commercial auto feed washing machines and dryers. There is a clean and dirty area within the laundry. The laundry has a clothes and linen labelling machine. The main chemicals are stored in a locked room within the laundry. All chemicals sighted had correct manufacturer labels. Ecolab safety data sheets are readily available. Each wing has a sluice room for the disposal of soiled water or waste. There is appropriate protective clothing available. Cleaners trolleys are well equipped. Mop heads and cleaning equipment are colour coded for the different areas. Cleaning staff observed are wearing correct protective wear to carry out their duties. All staff hold a current first aid certificate and have attended Ecolab chemical safety training.

With the change of owner, advised 15/7/13 that laundry service will be unaffected as it was agreed with Radius Residential Care that they will continue to operate the laundry from Lester Heights and provide services for Lester Heights and its own two sites in Whangarei. The laundry staff will also remain on site.

**Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence box is available (sighted). The facility manager stated that they have spare blankets and alternative cooking methods if required (viewed). There is sufficient water stored to ensure for three litres per day for three days per resident.

The staffing level provided adequate numbers of staff to facilitate safe care to hospital level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme on 21 July 2001. Fire drills have occurred six monthly and the last drill occurred on 7 June 2013.

There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse on site and available to all residents 24 hours per day, seven days per week.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.8 Natural Light, Ventilation, And Heating**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

General living areas are appropriately heated with skope heaters and econoheats along the corridors. The bedrooms have individual skope heating units. The residents (five) and families (three) interviewed confirmed the environment is warm and comfortable. There is adequate ventilation throughout the facility. All bedrooms and communal areas have at least one external window.

**Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Restraint Minimisation and safe practice policy & procedure includes; a) definitions, b) Use of restraint is a last resort only, c) methods of restraint permitted within Radius, d) use of enablers, e) enablers permitted with radius, f) client rights, g) assessment, discussion & restraint alternatives, h) restraint alternatives are not effective, i) restraint care, j) monitoring and removal, k) restraint episode evaluation, l) risks associated with restraint, m) restraint coordinator, n) staff training, o) restraint meetings, and p) maintenance.

Related forms include: restraint assessment, discussion and alternatives form; restraint discussion and consent form; restraint monitoring form; enabler assessment and consent form; restraint register; enabler register; care plan for client requiring restraint; restraint episode evaluation form.

The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.

There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed.

There are three residents with enablers in the form of bedsides. Bedsides are in use while the resident is in bed and two hourly monitoring is conducted while the bedsides are in position. These were requested by the residents.

The restraint minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whanau, development of an enabler care plan, monitoring, reduction, removal and evaluation of enablers.

The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of the file of the resident with an enabler.

There are three residents using restraint.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes responsibilities for key staff at an organisational level and a service level. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. Individual approved restraint is reviewed at least three monthly at Lester Heights and as part of the care plan review and multidisciplinary review that involves family/whanau. This had occurred for each of the three files reviewed for residents using restraint.

**Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. All assessments are reviewed by the registered nurse as sighted in the three files sampled for residents who use restraints.

Assessments are completed as required for individual residents. The three files sampled identified that a restraint assessment, discussion and alternatives form and restraint discussion and consent form were completed for the three residents requiring restraint and an enabler assessment and consent form is completed for the three residents requiring an enabler whose files were sampled.

**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;

 (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.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The restraint team includes the restraint co-ordinator who is a registered nurse and overseen by facility manager, the resident's general practitioner and family/whanau. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service.

There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe.

The restraint assessment identifies specific interventions or strategies to try (as appropriate) before using restraint.

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and its outcome that aligns with a) - g) in this criterion. Restraint monitoring forms include type of restraint used, risks associated with type of restraint, times restraint on/off, toileting, wheelchair lap belt use and repositioning of a resident when in bed. Forms include assessment, monitoring, risks, consent and alternatives to restraint.

Three files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. Monitoring forms were completed. A monthly evaluation of restraint and enablers was completed. The service has a restraint register and an enabler register that records sufficient information to provide an auditable record of restraint use.

**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.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The files reviewed of residents requiring restraint have been evaluated three monthly. Family/whanau participate in evaluations and also at the residents' multidisciplinary review. Use of restraint is discussed at monthly staff meetings. The restraint evaluation includes the areas identified in 2.2.4.1 a) – k).

Restraint practices are reviewed on a formal basis in the staff meetings and quality meetings. A restraint evaluation is completed of the restraint care plan three monthly. Evaluation timeframes are determined by risk levels. Family/whanau is involved in review at residents' annual multidisciplinary review.

**Criterion 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.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Approved restraint for each individual is reviewed at least three monthly by the restraint approval group and as part of the annual multidisciplinary review with family/whanau involvement.

Restraint usage across the facility is monitored monthly and advised that it is discussed at monthly staff and three monthly at restraint meetings. Restraint usage is also benchmarked across the organisation and is reviewed at the organisational level .

**Criterion 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.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**STANDARD 3.1 Infection control management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is an Infection Control (IC) programme for 2013 that includes documented goals, success factors, education, surveillance and antimicrobial usage. The programmes content and detail is appropriate for the size and complexity of the services. There are IC policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. IC is part of the Radius benchmarking programme.

The IC programme is reviewed annually for the Radius group with the content and detail being designed to be appropriate for the size and complexity of the organisation. The facility manager and IC coordinator are responsible for the development of site specific IC goals.

The IC coordinator could describe how an outbreak would be managed and reported. There was a gastro outbreak (not Norovirus) in February 2013. The Public Health Department was notified and the outbreak was contained to six residents in one wing. There are guidelines and staff health policies for staff to prevent the spread of infection. These include, but not limited to; outbreak management policy and flow chart, pandemic plan and policy, food handlers sickness policy and hand hygiene policy.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The IC coordinator (a registered nurse) collates monitoring data and reports through to the Heartbeat and infection control three monthly meetings. Outcomes are reported to staff through nursing and staff meetings. The IC coordinator receives on-going education and attended a Bug Control training day in early 2012. In the event of the IC coordinator requiring advice this is available through the GP, Pathlab or Bug Control.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. Policies include; antimicrobial guidelines, decontamination, food handlers sickness policy, hand hygiene, management of staff with communicable diseases, MRO, outbreak management, pandemic plan, respiratory hygiene, scabies management, single use items, transmission based precautions, UTIs, waste management. Associated policies include. Wound management policy, continence policy, laundry and kitchen policies. There are comprehensive Infection Control policies that support the Infection Control Standard SNZ HB 8134:2008. The infection control policies link to other documentation and uses references where appropriate.

Infection control policies are reviewed as part of the policy review process by Radius input is sought form facilities when reviewing policies.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The IC coordinator undertook Bug Control training in early 2012. The IC coordinator ensures training is provided to staff. Informal education is also provided - availability of education was confirmed by three healthcare assistants interviewed.

The orientation package includes specific training around hand washing and standard precautions. Training on infection control was last provided in November 2012. Hand washing is an annual competency.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved.

**Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme - IC surveillance audit was last undertaken in March 2013 (98% compliance). The service submits data monthly to Radius head office where benchmarking is completed. There were no corrective action requirements from the audit programme.

The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory and skin. This data is reported to the Heartbeat meetings and also to staff meetings. Additionally it is discussed at three monthly infection control meetings. Monthly data was seen in staff areas.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**