**Presbyterian Support Central - Willard Elderly Care**

**Current Status:** **18-Jul-13**

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

**General overview**

Willard Elderly Care rest home is part of the Presbyterian Support Central organisation (PSC). The facility provides rest home level care for up to 44 residents. There were 41 rest home residents on the day of audit. The service has well established quality and risk management systems. The organisation has committed resources and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service is commended for achieving continuous improvement ratings around good practice, Maori healthcare and the recreational programme. This audit identified improvements required around aspects of nursing documentation.

**Audit Summary AS AT** **18-Jul-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit18-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Organisational Management** | Day of Audit18-Jul-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit18-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit18-Jul-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit18-Jul-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit18-Jul-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Audit Results AS AT** **18-Jul-13**

**Consumer Rights**

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on notice boards. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents' and/or their family/whānau. Residents and family interviewed spoke very positively about care provided at PSC Willard Elderly Care Home. Complaints processes are implemented and complaints and concerns are managed. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. The service has attained a rating of continuous improvement around good practice and Maori healthcare.

**Organisational Management**

Willard Elderly Care rest home is part of the Presbyterian Support Central organisation. The service is managed by a registered nurse with significant aged care management experience.

Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and external benchmarking programme that is being implemented at Willard.

Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. There is a monthly quality committee meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings, two monthly resident wellbeing meetings and six monthly family meetings.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times. A continuous improvement rating has been awarded around human resource management.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

**Continuum of Service Delivery**

The service has a policy for admission and entry for rest home, hospital or dementia care. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement is discussed with them. The registered nurse is responsible for each stage of service provision. The assessments and support plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, objectives/goals have been identified in the long term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the three monthly reviews. There is an improvement required around the use of short term care plans and the frequency of pain assessment tools. Resident files are integrated and include notes by the GP and allied health professionals.

The activities/recreation programme is facilitated by a recreational officer and volunteers and reflects the Eden philosophy and principles. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged; van outings are arranged on a regular basis. A rating of continuous improvement has been awarded in recognition of the improvements made to the activities/recreation programme.

Education and medicines competencies are completed by all staff responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration.

Food services and all meals are provided on site. Resident’s individual food preferences, dislikes and dietary requirements are met. There is dietician review and audit of the menus. All staff are trained in food safety and hygiene.

**Safe and Appropriate Environment**

The buildings have a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised and have a hand basin. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activity. The dining and lounge seating placement encourages social interaction. Other outdoor areas are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely in the kitchen and the laundry is well equipped. The cleaning service maintain a tidy, clean environment.

**Restraint Minimisation and Safe Practice**

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. PSC Willard Elderly Care maintains a restraint and enabler free environment. Staff received training around maintaining a restraint free environment, including the management of behaviours that challenge in February 2013.

**Infection Prevention and Control**

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented for discussion. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (a registered nurse) takes overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations. There is an online infection register in which all infections are documented monthly.

Willard Elderly Care

Presbyterian Support Central

Certification audit - Audit Report

Audit Date: 18-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

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| **Provider Name** | Presbyterian Support Central |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Willard Elderly Care | 17 Russell Street |       | Palmerston North |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| **Type of Audit** | Certification audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 18-Jul-13 **End Date:** 19-Jul-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

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| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXX | RN, Auditor certificate | 16.00 | 8.00 | 18-Jul-13 to 19-Jul-13 |
| Auditor 1 | XXXXXX | RN, Auditor certifiacte | 16.00 | 6.00 | 18-Jul-13 to 19-Jul-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXX |       |       | 2.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 32.00 | **Total Audit Hours off site** *(system generated)* | 16.00 | **Total Audit Hours** | 48.00 |
| **Staff Records Reviewed** | 7 of 34 | **Client Records Reviewed** *(numeric)* | 7 of 41 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 7 |
| **Staff Interviewed** | 14 of 34 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 7 of 41 | **Number of Medication Records Reviewed** | 14 of 41 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXX (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 15 day of August 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

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|  |  |  |  | **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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Willard Elderly Care | 44 | 41 |       | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Willard Elderly Care rest home is part of the Presbyterian Support Central organisation (PSC). The facility provides rest home level care for up to 44 residents. There were 41 rest home residents on the day of audit. The service has well established quality and risk management systems. The organisation has committed resources and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service is commended for achieving continuous improvement ratings around good practice, Maori healthcare and the recreational programme. This audit identified improvements required around aspects of nursing documentation.

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1.3 Continuum of Service Delivery

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1.4 Safe and Appropriate Environment

The buildings have a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised and have a hand basin. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activity. The dining and lounge seating placement encourages social interaction. Other outdoor areas are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely in the kitchen and the laundry is well equipped. The cleaning service maintain a tidy, clean environment.

2 Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. PSC Willard Elderly Care maintains a restraint and enabler free environment. Staff received training around maintaining a restraint free environment, including the management of behaviours that challenge in February 2013.

3. Infection Prevention and Control

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented for discussion. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (a registered nurse) takes overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations. There is an online infection register in which all infections are documented monthly.

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 | CI | 1 | 2 | 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 | CI | 1 | 0 | 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:2 FA: 10 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:2 FA:21 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 | PA Low | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | PA Low | 0 | 1 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | CI | 1 | 0 | 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 | FA | 0 | 4 | 0 | 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:1 FA: 9 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: 0Criteria (of 51): CI:1 FA:18 PA:2 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 | FA | 0 | 3 | 0 | 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: 8 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 36): CI:0 FA:17 PA:0 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 | Not Applicable | 0 | 0 | 0 | 0 | 1 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 1 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 3 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 2 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 1 | 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: 5 CI:0 FA: 1 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:1 PA:0 UA:0 NA: 8 |

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:** 5 **CI:** 3 **FA:** 40 **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:** 3 **FA:** 88 **PA:** 2 **UA:** 0 **N/A:** 8 |

# Corrective Action Requests (CAR) Report

Provider Name: Presbyterian Support Central

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:18-Jul-13 End Date: 19-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.3 | 1.3.3.3 | PALow | **Finding:**Two of seven residents files sampled did not have an evaluation of their pain assessment completed three monthly as directed in the long term support plan. **Action:**Ensure evaluation of pain assessments are completed as directed. | 3 months |
| 1.3.5 | 1.3.5.2 | PALow | **Finding:**(i) A resident with unintentional weight loss did not have a short term care plan in place. The long term support plan states residents behaviour is socially acceptable. Two recent reports in progress notes documents disturbing behaviour. There is no behavioural assessment or short term care plan in place for the disturbing behaviour. (ii) One resident has had two admissions to hospital with abdominal hernia and acute pain. The hernia remains an active problem yet this is not identified in the long term care plan.**Action:**(i) Ensure short term care plans are developed and implemented for acute/ short term needs. (ii) Ensure long term care plans reflect the care required.  | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Presbyterian Support Central

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:18-Jul-13 End Date: 19-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXX

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| **Std** | **Criteria** | **Evidence** |
| 1.1.4 | 1.1.4.3 | **Finding:**The service identifies the need for staff to be trained in delivering appropriately cultural services. Treaty of Waitangi education has been provided to staff at caregiver's and RN/EN study days occurring on February, March and April 2013 with a total of 42 staff attending from PSC Willard Elderly Care and PSC Brightwater. When a resident identifies as Maori appropriate Iwi, Runanga support is accessed (if required). Whanau support is encouraged during all support including death and dying. Rooms are made available for whanau to meet and stay on site. Family/Whanau involvement is actively encouraged through all stages of service delivery. Whanau are invited to discuss the planning of resident care during admission and at six monthly resident review forums and visiting is encouraged. Maori Cultural advisors within Enliven staff are available to provide expertise and guidance. There is a Maori recreational officer on site with large Iwi/whanau links. The manager is involved in the Maori Managers group. The facility has a Manager that is Maori who with links to local Iwi. There is resident involvement in the recruitment of staff. There are staff available who speak Te Reo Maori. Since the last certification audit PSC Willard has created "The Eden Cottage". This part of the facility is made available for whanau to stay on site and to meet. The Cottage which is attached to the rest home provides family/whanau with; one furnished bedroom, a kitchen, lounge, toilet and showering facilities. There is the option of placing additional beds/mattresses in a room in the cottage that is currently used as an office if this is required. The cottage also has a computer and Wi-Fi internet which family/whanau can access in the lounge.  |
| 1.1.8 | 1.1.8.1 | **Finding:**PSC Willard has robust quality and risk management systems and these are implemented at the facility supported by a number of meetings held on a regular basis including (but not limited to); management, clinical, quality, staff, IC, restraint, residents, kitchen, health and safety. Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of a robust education programme. Extensive annual education programme in place, including internal and external education sessions, core competency assessments and orientation programmes have been implemented. A new Education coordinator focuses on targeted training including staff one–on-one. Competencies are completed for key nursing skills, registered nurses regularly access training and are supported to attain PDRP at the DHB. All staff are encouraged to take post graduate studies and engage in external training. PSC run a RN/EN study day and a care giver/healthcare assistant training day, which is repeated to capture all staff. There is a strong commitment to staff development by way of education and in-service training. Education is supported for all staff and a number of health care assistants have enrolled or completed a national qualification. Implementation of evidenced best practice and legislation requirements are reflected in clinical policies. PSC Willard has a number of quality projects running including; . A Nurse Practitioner is available as part on GP service Care planning is holistic and integrated. Benchmarking with QPS, gives meaningful data and report results are provided to Presbyterian support central office. Quality Improvement alerts are identified to minimise potential risks occurring and the facility is required to complete an action plan. PSC Willard is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints . One quality action form was initiated 01-July- 2013 around a resident with increased falls. In depth analysis of the falls was completed (sighted ) which included times and location of falls. Falls trends emerged that showed evenings and overnight were the highest risk periods. Action plan detailed the reassessment of residents mobility, GP and physiotherapy assessment were also requested as resident had recently had a change to medication which had caused an increase in falls when the residents was previously prescribed. Staff were advised of changes to plan of care. A comprehensive list of signs , symptoms and behaviours were documented that staff were requested to monitor. An action plan was sighted for improvement in all care documentation which was commenced in June 2013. This was around the internal audit process as PSC Willard is part of a pilot to make quality the responsibility of all staff members.  |
| 1.3.7 | 1.3.7.1 | **Finding:**There is a recreational officer and a group of volunteers that deliver the seven day per week recreational programme. Activities take place in the lounges, gardens (weather permitting) and dining areas. The recreational officer also provides one on one input in residents rooms when required. On the two days of audit residents were observed being actively involved with a variety of activities. The programme is developed weekly and displayed in large print. Residents have a copy of the programme displayed on the wall in their rooms. The recreational officer has attended education on the Eden Principles and is an Eden Associate. The programme includes networking within the community with social clubs, churches and schools. D16.5d The resident social history taken and information from this is fed into the recreation plan and this is reviewed three monthly as part of the support plan review/evaluation. A record is kept of individual residents activities and progress notes completed. The seven resident files reviewed also includes how the resident likes to spend their day. The resident/family/whanau as appropriate is involved in the development of the recreation plan. There is a wide range of activities offered that reflect the resident needs and interests. Residents are supported to maintain links with the community. Residents described going out for afternoon tea to the RSA or a local cafe and for fish 'n' chip lunches at the park or at the beach. There are volunteers available three days per week and they assist with outings and other activities. Entertainers visit the facility three times per month. There are links with the local school which is next door to the facility. Children visit the facility each Thursday during term time and read to residents or residents read to the children or participate in craft activities. Other local rest homes are invited to social events/ sports activities. The facility provides support for resident’s to attend local church activities and worship. The local library supply a selection of books each month. This has been recently introduced and the residents report that they enjoy having a fresh selection of books to choose from each month. Community projects e.g. knitting teddies, blankets for hospital ward, participating in sowing seeds for schools and creating crafts items for sale to raise funds for charity groups. There are several pets at the facility which is in line with the Eden philosophy. Residents enjoy the companionship of the animals and are involved (where possible) in their care. Games days including petanque, bowls and mini golf are enjoyed by the male residents. There are six male volunteers who assist with providing activities that are more related to the interests of the male residents. Residents well-being meetings are held two monthly. There are Whanau learning circles. Family/whanau meetings are held six monthly. Resident/family newsletters are published. Family members are encouraged to participate in the activities programme. Resident / relative surveys completed annually present residents and family with an opportunity to provide feedback on the recreational/activity programme. Residents report they are very satisfied with the recreation programme offered to them by the facility and residents report they can attend local churches and participate in activities of choice. Residents interviewed described that on weekends the recreational officer will come in and take residents out to local concerts, the movies and other events of interest. Eden learning circles are implemented where residents have input into programme. The recreational officer has created a large Eden Garden display on one wall in the facility. Each flower represents a resident. Residents and staff are able to write on a post it notes words or acts of kindness that each resident has experienced or expressed that day or month. This is in line with the Eden philosophy. The recreational officer described that one resident who loves to cook for her family is supported by staff to use the kitchen in the Eden Cottage to make lunch for her family/friends when they come to visit. Residents used to purchase greeting cards etc. from local shops. Residents are now encouraged to make their own greeting/birthday cards. A selection of handmade cards are available for sale on the craft stall in the facility.  |

**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

The service has available information on the Code of Health and Disability Services Consumers’ Rights. The Code was evident around the facility.

There is a resident rights policy in place.

Discussion with six health care assistants could describe ways in which residents rights are acknowledged and incorporated in their day to day work such as obtaining informed consent, resident choice and complaints procedure. Code of Rights poster is displayed in the reception area and in hallways of the facility. Code of Rights training was last completed on 08-May-13 with 21 staff attending.

**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

Residents rights information is available, and large posters are displayed on the walls. The code of rights and advocacy pamphlets are located at the main reception.

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

Service information provided to residents and/or their families/whanau prior to entry and this documentation is available in larger print format.

The interpreter service information is also available in the resident orientation pack.

The Code of Health and Disability Consumers' Rights is available in formats appropriate to the communication preferences or needs of residents, such as on DVD, tape or video.

Staff will read information to residents and explain it (e.g. informed consent and CoR). Information is also given to next of kin or EPOA to read to or with the resident and discuss in private.

On entry to the service the manager or clinical manager discusses the information pack with the resident and the family/whanau. This includes the Code of Rights, complaints and advocacy. Seven residents interviewed state they are well informed about the Code of Rights.

**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 and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records. During the tour of the facility respect for privacy and personal space was demonstrated. Interviews with six health care assistants could explain ways resident privacy is maintained.

There is a comprehensive resident records policy that includes; a) integrated resident records, b) information requirements, and c) integrity of computerised records. Resident files were observed to be held in the locked nurses’ office/station in each area.

Discussions with seven residents and three family members identified that personal belongings are not used as communal property.

The staff were respectful of entering a resident’s room and gained permission before doing so.

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.

D5.4p There is a sexuality and intimacy policy. The service includes within its care planning assessment and directions for emotional wellbeing and this includes sexuality and intimacy.

D4.1a Cultural and religious beliefs are considered through the admission and assessment process with a cultural assessment completed for all residents. Family involvement is actively encouraged through all stages of service delivery (confirmed on interview). There is a chaplain appointed who provides pastoral care to residents their family/whanau and staff. The chaplain works 10 hours per week across PSC Willard Elderly Care and PSC Brightwater.

Discussion with six health care assistants could describe examples of giving residents choice including, what time they would like to get up, choices on food, and what they would like to wear.

The service implements the Eden Philosophy and staff could describe a more resident-focused approach to care instead of a task orientated approach to care.

There is an elder abuse and neglect policy and abuse or neglect reporting process. Elder abuse and neglect training is compulsory annually and is included in the health care assistants study day which last occurred 20-Mar-13. Discussions with the manager, six health care assistants, clinical manager and registered nurse identified that there were no incidents of abuse or neglect and that there is a culture of reporting.

Three family members and seven residents interviewed were very positive about the quality of care and support provided to residents at PSC Willard Elderly Care.

**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:** CI

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). The Presbyterian Support wide Maori Health plan that has been reviewed and updated through the Maori Health plan Wellington Group.

Cultural and spiritual practice is supported. The service has developed a link with the Maori Health Advisory Unit based at Wellington Hospital.

Willard Elderly Care has developed its own Maori Health Plan 2013-2014 which encompasses the PSC Maori Health Plan but personalises it to the facility.

The service identifies the need for staff to be trained in delivering appropriately cultural services. Treaty of Waitangi education has been provided to staff at caregiver's and RN/EN study days occurring on February, March and April 2013 with a total of 42 staff attending from PSC Brightwater and PSC Willard.

When a resident identifies as Maori appropriate Iwi, Runanga support is accessed (if required). Whanau support is encouraged during all support including death and dying. The Eden Cottage is made available for whanau to stay on site and to meet.

Maori Cultural advisors within Enliven staff are available to provide expertise and guidance. There is a Maori RN on site with large Iwi/whanau links

The manager is involved in the Maori Managers group. The facility has a Manager that is Maori with links to local Iwi.

Residents/whanau and the facility have support from the Maori Disability Support Officer for Best Care Whakapai Hauora Charitable Trust which operates under the Rangitaane Mandated Iwi Authority.

There is currently one resident who identifies as Maori. One file reviewed of resident who identifies as Maori included Cultural consideration/needs and involvement of whanau. Discussions with staff identify that have responded appropriately to the cultural needs of residents and their whānau. Family/Whanau involvement is actively encouraged through all stages of service delivery. Whanau are invited to discuss the planning of resident care post admission and at annual resident review forums and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau

A Family/Whanau contact sheet is also used by staff to show contact with family/whanau regarding aspects of their loved one’s stay/care.

Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety. Staff identify that they are aware of how to obtain support so that they respond appropriately.

**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:** CI **Risk level for PA/UA:**

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). The Presbyterian Support wide Maori Health plan that has been reviewed and updated through the Maori Health plan Wellington Group.

Cultural and spiritual practice is supported. The service has developed a link with the Maori Health Advisory Unit based at Wellington Hospital.

**Finding Statement**

The service identifies the need for staff to be trained in delivering appropriately cultural services. Treaty of Waitangi education has been provided to staff at caregiver's and RN/EN study days occurring on February, March and April 2013 with a total of 42 staff attending from PSC Willard Elderly Care and PSC Brightwater. When a resident identifies as Maori appropriate Iwi, Runanga support is accessed (if required). Whanau support is encouraged during all support including death and dying. Rooms are made available for whanau to meet and stay on site. Family/Whanau involvement is actively encouraged through all stages of service delivery. Whanau are invited to discuss the planning of resident care during admission and at six monthly resident review forums and visiting is encouraged. Maori Cultural advisors within Enliven staff are available to provide expertise and guidance. There is a Maori recreational officer on site with large Iwi/whanau links. The manager is involved in the Maori Managers group. The facility has a Manager that is Maori who with links to local Iwi. There is resident involvement in the recruitment of staff. There are staff available who speak Te Reo Maori. Since the last certification audit PSC Willard has created "The Eden Cottage". This part of the facility is made available for whanau to stay on site and to meet. The Cottage which is attached to the rest home provides family/whanau with; one furnished bedroom, a kitchen, lounge, toilet and showering facilities. There is the option of placing additional beds/mattresses in a room in the cottage that is currently used as an office if this is required. The cottage also has a computer and Wi-Fi internet which family/whanau can access in the lounge.

**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

The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. There is a spirituality, religion, faith and culture section in the care plan.

There is a chaplain who provides pastoral care for residents, family/whanau and staff. The chaplain works 10 hours per week between PSC Willard Elderly Care and its sister site PSC Brightwater.

The chaplain is available for one on one visits with residents.

There are four other chaplains who provide weekly church services at PSC Willard Elderly Care.

D3.1g: The service provides a culturally appropriate service by identifying individual needs.

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

Seven residents and three family members interviewed confirmed they were satisfied that staff considered their individual values and belief.

**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 a code of ethics policy. Staff employment policies/procedures include confidentiality, house rules and staff expectations. Code of conduct policies also includes respect for personal belongings. Job descriptions include responsibilities of the position. Signed copies of all employment documents are included in staff files. one registered nurses interviewed were able to describe appropriate boundaries between staff and residents and their families. Interviews with seven residents confirmed that staff were very caring. D16.5e: Health care assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with six health care assistants could describe how they build a supportive relationship with each resident.

The orientation booklets provided to staff on induction includes a section on professionalism and standards of conduct, harassment prevention policy and gifts. Understanding the code of conduct is signed as part of orientation. Completed orientation packages were sighted in seven of seven staff files sampled.

**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:** CI

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s ongoing progress around quality improvement.

Policies and procedures cross-reference other policies and appropriate standards. RN’s are encouraged and supported to continue education. There is an appointed education coordinator that supports caregivers to complete Careerforce or unit standards.

The service has implemented a number of improvements since the previous audit. These include:

a) Recreation programme now offered seven days a week, b) Nutritionally assessed full five week vegetarian menu now available with recipes, c) New food IT system that allows automatic food ordering and recipes to be printed with quantities linked to actual number of meals required. This minimises wastage from cooking too much and also ensures that there is enough food. On line recipes also allow relief cooks to have access to recipes for dishes they are unsure of. “Special week” menus and recipes are also available to substitute for the standard weeks, e.g. queens’ anniversary week menu. There are a number of ethnic recipes e.g. Indian, Chinese available; d) Administrators manual developed and updated as required with all links to appropriate sites to ensure compliance with statutory changes are communicated and available when required, e) First version of managers manual completed and available on line, f) Cooks teleconferences started on a bi-monthly basis to review any issues around the menu, deliveries and to share ideas for resident involvement, g) Residents involved in recruitment of new staff, h) Clinical nurse specialist available to work with registered nurses who require additional support, i) Relatives and friends information booklet printed, j) Admission agreement reviewed and simplified so that residents and families can follow it, k) Cleaning staff registered and undergoing Level 2 cleaning and caregiving certificate, l) Kitchen staff registered and undergoing level 2 food preparation certificate, m) six men from the local community volunteer with recreational activities for the men, n) Environmental changes increase resident independence and autonomy e.g. kitchenettes set up with tea, coffee, o) Eden group increasing resident choice and autonomy – residents and families involved with the gardening, staff aware of the Eden Alternative and spend time without repercussion enjoying resident social needs, p) On line incident, medication error, complaints and infection registers with associated user manual and q) review of quality monitoring programme with new draft audit templates.

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

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

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

A2.2 Services are provided at PSC Willard that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for health care assistants and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. The facility has attained five of the ten Eden principles.

**Finding Statement**

PSC Willard has robust quality and risk management systems and these are implemented at the facility supported by a number of meetings held on a regular basis including (but not limited to); management, clinical, quality, staff, IC, restraint, residents, kitchen, health and safety. Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of a robust education programme. Extensive annual education programme in place, including internal and external education sessions, core competency assessments and orientation programmes have been implemented. A new Education coordinator focuses on targeted training including staff one–on-one. Competencies are completed for key nursing skills, registered nurses regularly access training and are supported to attain PDRP at the DHB. All staff are encouraged to take post graduate studies and engage in external training. PSC run a RN/EN study day and a care giver/healthcare assistant training day, which is repeated to capture all staff. There is a strong commitment to staff development by way of education and in-service training. Education is supported for all staff and a number of health care assistants have enrolled or completed a national qualification. Implementation of evidenced best practice and legislation requirements are reflected in clinical policies. PSC Willard has a number of quality projects running including; . A Nurse Practitioner is available as part on GP service Care planning is holistic and integrated. Benchmarking with QPS, gives meaningful data and report results are provided to Presbyterian support central office. Quality Improvement alerts are identified to minimise potential risks occurring and the facility is required to complete an action plan. PSC Willard is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. One quality action form was initiated 01-July- 2013 around a resident with increased falls. In depth analysis of the falls was completed (sighted ) which included times and location of falls. Falls trends emerged that showed evenings and overnight were the highest risk periods. Action plan detailed the reassessment of residents mobility, GP and physiotherapy assessment were also requested as resident had recently had a change to medication which had caused an increase in falls when the residents was previously prescribed. Staff were advised of changes to plan of care. A comprehensive list of signs, symptoms and behaviours were documented that staff were requested to monitor. An action plan was sighted for improvement in all care documentation which was commenced in June 2013. This was around the internal audit process as PSC Willard is part of a pilot to make quality the responsibility of all staff members.

**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

Discussions with seven residents and three family members all stated they were welcomed on entry and were given time and explanation about services, procedures etc. Resident meetings occur monthly and the Manager and has an open-door policy.

A review of incident forms from June 2013 identified that relatives are informed in all cases where appropriate.

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: Three relatives stated that they are always informed when their family members health status changes.

D 13.3: Seven files reviewed included completed admission agreements.

Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry.

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

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs.

The residents and relatives survey conducted in 2012 evidenced 97.4% resident overall satisfaction of the home and 95% relative/whanau overall satisfaction of the home.

**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 so that residents can 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. Residents' Rights training was last provided 20-Mar-13. Interviews with six health care assistants, identify that consents are sought in the delivery of personal cares and this is confirmed by eight residents interviewed. A sample of seven resident files all included signed consent forms for storage of personal information; to deliver care and support based on assessed needs; to take photograph for the purpose of health information; to have care delivered by supervised students; to be transported on outings; to involve family/whānau in assessment, planning and delivery of care. There is a resuscitation consent policy and a resuscitation consent form. Residents who are deemed competent to sign a resuscitation decision form indicate whether or not they wish to be resuscitated. A sample of seven resident files identified resuscitation consent forms were completed as appropriate.

D13.1: there were seven admission agreements sighted and all had been signed on the day of admission.

D3.1.d: Discussion with three family identified that the service actively involves them in decisions that affect their relatives 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

Client right to access advocacy and services is identified for residents and posted on the service notice-boards. The information identifies who the resident can contact to access advocacy services. Information provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Staff was very aware of the right for advocacy and how to access and provide advocate information to residents if needed. The welcome booklet includes a section around ‘client advocates’.

D4.1d; Discussion with three family members 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

Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident or care/medical issues or complaints arise. Registered nurse and clinical manager interviewed demonstrated their responsibility to notify family/whānau of any incident/accident that occurs. The manager has an open-door policy D16.4b Three relatives stated that they are always informed when their family members health status changes. Access to interpreter services is identified, includes language support and access to the DHB.

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.

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

**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 service has a clearly documented process for making complaints and this is communicated to residents/family/whānau. There is a copy of the process documented in a notice-board in the service and a complaints box in both facilities.

Documentation including follow up letters and resolution demonstrates that complaints are overall well managed. Verbal complaints are also included and actions and response are documented. Discussion with seven residents and three relatives confirmed they were provided with information on complaints and complaints forms. Complaint forms were visible for residents/relatives in various places around the facility.

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

There is a complaints folder and register that includes complaints verbal and written and includes sign-off. All complaints formal and informal are included on the complaints register and the PSC templates are used. The complaints folder and register has been kept up to date and all complaints are included on the register with evidence of follow up and resolution. The one written complaint received in 2013 was reviewed. The complaint was well documented including investigation, follow up, feedback (verbal and letter) and resolution.

**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

Willard is part of the Presbyterian Support Central organisation. The facility provides rest home level care for up to 44 residents. There were 41 beds occupied at the time of audit. The service has well established quality and risk management systems. The organisation has committed resources management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director.

PSC Willard Elderly Care has a documented mission statement, vision, values, corporate commitment and older person’s services goals.

There is a local risk management plan for 2013.

There is an Enliven PSC Willard Elderly Care business plan that provides a mission, vision and values and goals. An action plan has been implemented to meet those goals.

The service has a robust structure that supports the continuity of management and quality of care and support (including staff management).

The manager is a registered nurse with over 30 years’ experience. PSC provides care manager orientation training and support at least every two months across the organisation. Enliven also provides a two day education seminar annually for all care managers to ensure that all care managers receive at least eight hours annual professional development activities related to overseeing clinical care.

The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

**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 a temporary absence, the clinical manager covers the manager's role. The clinical manager provides clinical support to both PSC Willard Elderly Care and PSC Brightwater.

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

**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

The service has a current business and a quality and risk management plan for 2013 -14. The service has continued implementing their quality and risk management system since previous certification and a number of quality improvements have occurred to address shortcomings in previous contract and certification audits.

Presbyterian Support Services Central has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and QPS benchmarking programme that is being implemented at PSC Willard Elderly Care Home. There has been a review of the Quality Monitoring Programme with new draft audit templates introduced. The new templates have been in use since January 2013.

The Manager works across both PSC Willard Elderly care and PSC Brightwater facilities. The manager provides a balanced scorecard report to central office.

All staff are involved in quality improvements. The quality committee includes key staff from all areas of the service. Quality reports are provided to the committee by members of the quality committee and include (but not limited to); a) quality coordinators report, b) kitchen monthly report, c) health & safety monthly report, d) laundry monthly report, e) IC monthly report, f) restraint monthly report, g) clinical monthly report, h) managers monthly report, i) chaplains monthly report, j) activities monthly report, k) education monthly report, l) Eden monthly report, m) domestic/cleaning monthly report and n) administrative monthly report.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. There is a policy review date schedule, and terms of reference for the policy review group. New/updated policies/procedures are included in the "What’s New" manual for staff.

The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s ongoing progress around quality improvement. The internal audit schedule has been combined to include QMP and QPS monitoring.

The service completes quarterly reports of the IC programme and the H&S programme to PSC Quality Coordinator.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Monthly accident/incident/near miss reports are completed by the health and safety officer for each site that breaks down the data collected across the facility and staff incidents and accidents. These are also compared with the last month. The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents. There is a new online database for recording accidents and incidents with medication errors reported separately.

Incidents and accidents are also reported to PSC clinical director monthly.

The service has linked the complaints process with its quality management system. This occurs through the QPS benchmarking programme and the identification of complaints against a benchmark of the service peers. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Monthly manager reports include compliments and complaints.

There is an IC register in which all infections are documented monthly. A monthly IC report is completed and provided to quality meeting. The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. Infections are also being documented on the newly introduced electronic database.

QPS data analysis includes: Competency testing for IC, Wound Infection Rate, skin infection rate, Infection rate, UTI’s, Respiratory Tract Infections, ENT rates and GI rates graphed quarterly. A benchmarking report from the 3 month data is prepared for staff and displayed on notice boards. Internal infection control audits are planned and undertaken during the year. The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. PSC Willard Elderly Care is currently restraint free.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident an hazard management

D19.2g Falls prevention strategies such as falls risk assessments, exercise programmes and the use of sensor mats.

**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

The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services.

Twenty incident forms for June 2013 were reviewed. All show the form has been fully completed and reviewed by a registered nurse. Three family members interviewed confirmed they are informed of any incidents/accidents relating to their relative residing in the facility.

All have ongoing review and where appropriate actions to prevent recurrence completed by the registered nurse or clinical manager.

Senior Team monthly meetings evidenced discussion around falls management and preventative measures to be implemented.

Quality meeting minutes include a comprehensive analysis of incident and accident data and analysis. A monthly incident accident report is completed which includes an analysis of data collected.

The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents.

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

D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

Following this incident at a recent Enliven Managers meeting notifications to DHB and MOH were discussed. Part 31 (5) of the Health and Disability Services (safety) Act 2001 Documents that "A person certified to provide health care services of any kind must promptly give the Director-General written notice".

A review of PSC policy has been proposed at the Enliven Managers meeting held on16-Jul-13 to change the word "promptly" currently used in its Incident Management Policy which refers to DHB and MOH reporting timeframes to the word " immediately".

**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

The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity.

A copy of practising certificates including RNs, EN's, pharmacists, the dietitian, the physiotherapist, occupational therapist and GPs are kept.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (one recreation officer, one cook, one registered nurse and four health care assistants). Each folder had a file checklist and documentation arranged under personal information, correspondence, agreement, education and appraisals.

A comprehensive orientation programme is in place that provides new staff with relevant information for safe work practice. This was described by staff and records are kept. A buddy system supports new staff.

There are two comprehensive orientation books that include checklists for completion in files reviewed. There is an implemented specific RN orientation book.

There is a documented in-service programme for education and a specific staff educator who works across both PSC Willard Elderly Care and PSC Brightwater. Competencies are identified and completed.

Health care assistants are encouraged and supported to undertake external education. The education folder evidences that 90% of health care assistants have ACE of Careerforce qualifications. Careerforce training is supported. The organisations policy is that after three months of employment all caregivers must be enrolled in Careerforce. D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for health care assistants/caregivers. PSC Willard Elderly Care has provided health care assistant and RN/EN compulsory training according to the framework.

Monthly reporting of training completed and percentages of staff attending is reported to the regional manager and clinical director monthly.

**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

Staff requirements are determined using an organisation service level/skill mix process and documented. Staffing levels are benchmarked against other PSC facilities. Staff levels/skill mix are meeting contract and industry norm requirements.

New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. Advised that the roster is able to be changed in response to resident acuity. The QPS benchmarking quarterly report states that staff hours remain consistently above the mean.

Currently there is a trial being completed of a clinical manager role. The clinical manager currently working in this role is an experienced RN who works 20 hours per week at PSC Willard Elderly Care and 20 hours per weeks at PSC Brightwater.

The services have also recently introduced a quality improvement initiative where each registered nurse has one day each month dedicated to documentation responsibilities.

**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

The resident files are appropriate to the service type.

Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure office. Support plans and notes are legible and where necessary signed (and dated) by the registered nurses. Policies contain service name. Resident records reviewed contain the name of resident and the person completing the form/entry. Stamps are utilised to determine some allied staff members.

D7.1 Entries are legible, dates and signed by the relevant health care assistant, enrolled nurse or registered nurse including designation. Individual resident files kept demonstrate service integration with an allied health section that contains GP notes and the allied health professionals and Specialists involved in the care of the resident. There is also an allied health services assessment form with care requirements. For the resident Interdisciplinary assessment, all team members are named on the interdisciplinary assessment form.

**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

Midcentral support links needs assessment coordination service (NASC) ensures all residents are assessed prior to entry for rest home level of care. A placement authority form is sent to the receiving facility. The Clinical Manager (CM) or Registered Nurse (RN) is responsible for the screening of residents to ensure entry has been approved. A pre-admission checklist ensures the potential resident and family receive a tour of the facility, are introduced to staff and stay for a meal if they wish. An information booklet is given out to all residents/family/whanau on enquiry or admission. The information pack includes all relevant aspects of service and associated information such as the H&D Code of Rights and how to access advocacy. There is an admission procedure in place and admission documentation which includes resident and next of kin details. There is an admission process for respite care admissions. The CM and RN interviewed are able to describe the entry and admission process. A suitable time is arranged for admission that ensures a RN is on duty. The CM or RN on duty completes all the admission documentation, relevant notifications of entry to the service and the initial assessment. Signed admission agreements sighted. Seven residents and three relatives interviewed state they received all relevant information prior or on admission. The resident/family/whanau sign an acknowledgement form to state they have received the Enliven booklet, services brochure, admission agreement, copy of consumer rights and complaints pamphlet. The GP is notified of the new admission. The CM and RN state they have a good working relationship with Social Workers at Midcentral DHB.

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

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

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

**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

The service has an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry should this happen. Reasons for declining entry would be if there are no beds available or the potential client did not meet the rest home level of care. The service has not had to decline any clients.

**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:** PA Low

D.16.2, 3, 4: The seven rest home resident files sampled identified that an RN completed an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. All seven files sampled identified that the long term support plan is developed within three weeks. There are written multidisciplinary reviews held three monthly involving the resident/family/whanau, RN and care staff, medical (including medication review) and where applicable allied health input. The RN amends the long term support plan to reflect ongoing changes as part of the review process. There is documented evidence that the care plans are reviewed by a RN and amended when current health changes. All seven care plans evidenced evaluations completed at least six monthly.

In five of seven files allied health professionals involved in the residents care are linked to the support care plan review such as, physiotherapist, podiatrist, hospice and continence nurse (link 1.3.5.2). Resident files sampled included a family/whanau communication form which documented discussions with family/whanau regarding changes to health, incidents, infections, MDT meetings, and GP visits.

 D16.5e: Seven of seven resident files sampled identified that the GP had seen the resident within two working days. It was noted in seven of seven resident files sampled that the GP had examined the resident three monthly, carried out a medication review and stated the resident is stable and for review in three months. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status.

Residents may retain their own GP. The house GP (interviewed) is contracted to provide medical services. He visits each week and receives a list the day before of residents due for their three monthly review and any RN resident concerns for medical attention. The GP states the RN's are able to make very good clinical decisions. The practice nurse prioritises the RN faxes and a GP response if faxed back to the home. The GP visits after hours as necessary which gives him the opportunity to build a relationship with the HCA's on duty. He is available after hours on his mobile. The RN's are able to initiate referrals to allied health professionals with the exception of referrals to specialists. The GP states his medical decisions are respected. After hours medical care is also provided by City Doctors or the emergency department at Palmerston North hospital.

There is a verbal handover period between the shifts to ensure staff are kept informed of residents health status and any significant events. A "whats new" folder contains new/reviewed policies/procedures, memos and any information relevant to the workplace. Staff are to read and sign to indicate their understanding of the information

PSC Willard Elderly Care have achieved five out of ten Eden principles. InterRAI training and assessments are in progress.

Seven rest home resident files sampled. *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:** PA **Risk level for PA/UA:** Low

Tracer Methodology: Resident with frequent falls, pain management and weight loss

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

**Finding Statement**

Two of seven residents files sampled did not have an evaluation of their pain assessment completed three monthly as directed in the long term support plan.

**Corrective Action Required:**

Ensure evaluation of pain assessments are completed as directed.

**Timeframe:**

3 months

**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

Admission information is obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Informed consents for storage and collection of information, delivery of care including procedures for wound, X-Ray and podiatry, photograph for ID and display, students delivering care, transport and outings, family involvement in assessment, care plans and evaluation of care plans and resuscitation. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment , first support plan and long term support care plan within the required timeframes. All resident files sampled evidenced an initial assessment and support care plan with reference to the information gathered on admission. Support care plans in each of the seven resident files sampled reflect risk tools assessments completed on admission. Residents and their family participate in the support care plan and this information is available to other health professionals as needed. Relatives (three) and residents (seven) advised on interview that assessments were completed in the privacy of their single room.

A range of assessment tools is completed on admission and reviewed at least six monthly or earlier if indicated includes (but not limited to);

a) nutritional assessment b) falls risk (adapted from Morse) c) moving and handling assessment. d) Braden pressure area risk assessment, e) continence and bowel assessment f) pain assessment g) wound assessment .

There is a respite care assessment and support plan.

**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:** PA Low

An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term support plan from information gathered over the first three weeks of admission. The resident support plan has categories of care as follows: hygiene and grooming, skin and pressure area care, elimination, mobility, nutrition and fluids, rest and sleep, communication (ability to use call bell, eyesight, memory, behaviour and mood), loneliness (companions), helplessness (socialisation), spirituality/faith and culture, medical (includes medication and pain management). Each individual page for category for care is signed and dated.

The integrated resident file also contains the admission documentation, informed consent forms and advance directives, care documents, risk tools and reviews, medical documents, test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance and other interventions), incident/accident and infection events summary and correspondence. Three residents do not have medical/allied health information linked to the long term support plan, therefore there is an improvement required. Short term care plans are used to document any changes in health needs with interventions, management and evaluations. There is an improvement required around the use of short term care plans.

Three relatives and seven residents advised on interview that they were involved in the development of the resident support plan and informed of any changes to care or health status. (confirmed in sample of files reviewed). D16.3f; Seven resident files reviewed identified that family were involved.

Notes by GP and allied health professionals are evident in seven of seven residents integrated files sampled. Relatives interviewed are positive and complimentary about the staff, clinical and medical care provided. They confirm they are kept informed of any significant events, changes in health status and are involved in the care planning process.

**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:** PA **Risk level for PA/UA:** Low

An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term support plan from information gathered over the first three weeks of admission. The resident support plan details the level of support/interventions required to assist with meeting the desired goals or outcomes. Short term care plans are used to document any changes in health needs with interventions, management and evaluations. Short term care plans are pre-printed for chest, urinary and ear infections, nutritional needs and wounds. Short term care plans sighted are for: respiratory tract infection, falls, lesion, skin graft, skin infection, change in skin integrity, declining mobility, fungal rash. Two residents did not have short term care plans in place for changes in health status.

**Finding Statement**

(i) A resident with XXXXXX did not have a short term care plan in place. The long term support plan states residents’ behaviour is socially acceptable. Two recent reports in progress notes documents disturbing behaviour. There is no behavioural assessment or short term care plan in place for the disturbing behaviour. (ii) One resident has had two admissions to hospital with XXXXXXX and acute pain. The XXXXX remains an active problem yet this is not identified in the long term care plan.

**Corrective Action Required:**

(i) Ensure short term care plans are developed and implemented for acute/ short term needs. (ii) Ensure long term care plans reflect the care required.

**Timeframe:**

3 months

**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

Residents' support plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist nurse consultation. The RN, CM and six HCA's interviewed ( four morning and two afternoon shift) stated that they have all the equipment referred to in support plans necessary to provide care, including hoist, chair scales, pressure relieving cushions, shower chairs, transfer belts, slippery sams, wheelchairs, gloves, aprons and masks. They have access to pressure area relieving mattresses from a central pool of resources. All staff report that there are adequate continence supplies and dressing supplies.

D18.3 and 4 Dressing supplies are available and the rest home treatment room is well stocked. Complex or chronic wound assessment includes contributing health factors, allergies, nutritional status, length of time wound present, blood supply, any infection/systemic infection, malignancy, smoker, sleep disturbance and any diabetes. Wound progress notes and short term care plan is in place for two chronic wounds (one leg ulcer and one non-healing lesion). Short term care plans are used for minor wounds such as skin tears. There is evidence of district nursing involvement in care of the chronic wound. There has been a dietitian referral for one chronic wound however this is not reflected in the wound assessment plan or wound progress notes (link 1.3.5.2)

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. Specialist continence advice is available as needed and the RN and CM interviewed could describe the referral process. Continence management in-services and wound management in-service have been provided.

Pain assessment tools are used if appropriate to assess level of pain, type, location, treatment and review. There is a pain intervention flow chart which describes the time, pain rating, intervention and 30 minutes post intervention pain rate and any side effects experienced form pain relief given. The monitoring of the effectiveness of pain relief is also recorded in the progress notes. The pain assessment tools have not been reviewed three monthly for two residents as per the long term support plan documentation (1.3.3.3)

Palliative care is delivered with support from Arohanui Hospice nurses and specialists as required. Staff have attended palliative care education.

**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:** CI

There is a recreational officer who works 30 hours per week, and a group of volunteers that deliver the seven day per week recreational programme. The recreational officer provides activities in the lounges, gardens (weather permitting) dining areas and also provides one on one input in residents rooms when required. On the two days of audit residents were observed being actively involved with a variety of activities. The programme is developed weekly and displayed in large print. Residents have a copy of the programme displayed on the wall in their rooms.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. Residents report they are satisfied with the activity programme offered to them by the facility

A comprehensive social history is complete on or soon after admission and information gathered is included in the care plan. Residents are quick to feedback likes and dislikes to the recreational officer. The recreational care plan is developed with the relative (and resident as able) and this is reviewed three monthly.

A rating of continuous improvement has been awarded in recognition of the improvements made to the activities/recreation programme.

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

**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:** CI **Risk level for PA/UA:**

There is a recreational officer who works 30 hours per week, and a group of volunteers that deliver the seven day per week recreational programme. The recreational officer provides activities in the lounges, gardens (weather permitting) dining areas and also provides one on one input in residents rooms when required. On the two days of audit residents were observed being actively involved with a variety of activities. The programme is developed weekly and displayed in large print. Residents have a copy of the programme displayed on the wall in their rooms.

**Finding Statement**

There is a recreational officer and a group of volunteers that deliver the seven day per week recreational programme. Activities take place in the lounges, gardens (weather permitting) and dining areas. The recreational officer also provides one on one input in residents rooms when required. On the two days of audit residents were observed being actively involved with a variety of activities. The programme is developed weekly and displayed in large print. Residents have a copy of the programme displayed on the wall in their rooms. The recreational officer has attended education on the Eden Principles and is an Eden Associate. The programme includes networking within the community with social clubs, churches and schools. D16.5d The resident social history taken and information from this is fed into the recreation plan and this is reviewed three monthly as part of the support plan review/evaluation. A record is kept of individual resident’s activities and progress notes completed. The seven resident files reviewed also includes how the resident likes to spend their day. The resident/family/whanau as appropriate is involved in the development of the recreation plan. There is a wide range of activities offered that reflect the resident needs and interests. Residents are supported to maintain links with the community. Residents described going out for afternoon tea to the RSA or a local cafe and for fish 'n' chip lunches at the park or at the beach. There are volunteers available three days per week and they assist with outings and other activities. Entertainers visit the facility three times per month. There are links with the local school which is next door to the facility. Children visit the facility each Thursday during term time and read to residents or residents read to the children or participate in craft activities. Other local rest homes are invited to social events/ sports activities. The facility provides support for resident’s to attend local church activities and worship. The local library supplies a selection of books each month. This has been recently introduced and the residents report that they enjoy having a fresh selection of books to choose from each month. Community projects e.g. knitting teddies, blankets for hospital ward, participating in sowing seeds for schools and creating crafts items for sale to raise funds for charity groups. There are several pets at the facility which is in line with the Eden philosophy. Residents enjoy the companionship of the animals and are involved (where possible) in their care. Games days including petanque, bowls and mini golf are enjoyed by the male residents. There are six male volunteers who assist with providing activities that are more related to the interests of the male residents. Resident’s well-being meetings are held two monthly. There are Whanau learning circles. Family/whanau meetings are held six monthly. Resident/family newsletters are published. Family members are encouraged to participate in the activities programme. Resident / relative surveys completed annually present residents and family with an opportunity to provide feedback on the recreational/activity programme. Residents report they are very satisfied with the recreation programme offered to them by the facility and residents report they can attend local churches and participate in activities of choice. Residents interviewed described that on weekends the recreational officer will come in and take residents out to local concerts, the movies and other events of interest. Eden learning circles are implemented where residents have input into programme. The recreational officer has created a large Eden Garden display on one wall in the facility. Each flower represents a resident. Residents and staff are able to write on a post it notes words or acts of kindness that each resident has experienced or expressed that day or month. This is in line with the Eden philosophy. The recreational officer described that one resident who loves to cook for her family is supported by staff to use the kitchen in the Eden Cottage to make lunch for her family/friends when they come to visit. Residents used to purchase greeting cards etc. from local shops. Residents are now encouraged to make their own greeting/birthday cards. A selection of handmade cards are available for sale on the craft stall in the facility.

**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

There are six monthly written reviews that include the resident’s general recordings and weight, review of risk assessment tools, any issues to be discussed with the GP. The resident/family are notified of the review by letter and invited to attend. The long term support plan is evaluated at least six monthly and changes made as required. The family/whanau communication form has written evidence of discussion held with families regarding care plan reviews. The key worker and resident/family/whanau sign the long term support plan. The GP examines the residents three monthly and reviews the medication chart. A stamp is used in the medical notes to indicate a medical review has been conducted. Monitoring charts such as food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts were evidenced in use.

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

Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to: podiatry, physiotherapy, elder health, community psychiatric nurse, retinal screening, dietitian, eye clinic, ophthalmology, mental health for the older person, consultant physician, massage therapist, geriatrician, district nurses and orthopaedics. Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider. The clinical manager and RN interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

D16.4c; the service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care.

D 20.1 discussions with the registered nurse and clinical manager identified that the service has access to dietitian, physiotherapist, continence, district nursing, palliative care services as required.

**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

The clinical manager and RN interviewed described the documentation and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. Follow up would occur to check that the resident has settled, or in the case of death, communication with the family is made and documented

**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:** FA

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 Douglas medico blister packs. Medications are checked and signed by the RN on delivery. Any discrepancies are fed back to the pharmacy. RN's and HCA's undertake a comprehensive medication competency which includes a self-learning package and supervised rounds for oral medication and insulin administration. Medication competent staff last completed annual education and medication competency with Douglas Medico May-13. The medication fridge is monitored daily and temperatures are all within the acceptable range. The controlled drug medications held have correct pharmacy labelling and prescribed for the resident. The controlled drug register did not evidence weekly CD checks Dec to Jan-13 however the gap was identified and there have been regular weekly controlled drug checks evidenced completed over the last five months. The pharmacist conducts six monthly audits. There are currently no residents who self-administer medication. The medication room is adequately stocked with supplies of ointments/treatments.

Fourteen resident medication charts and signing sheets sampled identified all charts had photo identification and allergies/adverse reactions noted. There is evidence of three monthly GP review of medications. The signing sheets for prn, oral medications and controlled drugs are correctly signed. One resident who has recently been in hospital had the hospital code entered onto the signing sheet. There is a current specimen signing sheet. The medication folder contains the five R's for the administration of medication and information and precautions for specific medications. Duplicate name stickers sighted.

D16.5.e.i.2; Fourteen medication charts reviewed identified that the GP had seen the reviewed the resident ten 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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

Food services policies and procedures manual is in place. The senior cook (qualified) works Sunday to Thursday and is responsible for the ordering of foods. The cook on duty is supported by a morning and evening kitchen hand. There is a five weekly summer and winter menu that is reviewed by the dietitian. A five weekly vegetarian menu with recipes now available. There is a cooks communication diary where any changes to the menu or memos are written for the oncoming cook/kitchen hand. The contracted dietitian is available to the senior cook by email for advice if required. There is a new food IT database system that allows automatic food ordering and access to recipes. All residents have a food and fluid chart completed on admission. Residents food preferences, likes and dislikes, cultural needs and choices are accommodated as well as dietary needs including normal, soft, pureed, diabetic, and high calorie diets as required. Breakfast is delivered to the residents rooms with lunch and tea in the dining room. The hot food temperature is monitored daily. The fridges and freezers in the kitchen are monitored and records sighted. Perishable foods in the fridges are date labelled. All the facility fridges are monitored daily by the domestic staff. There are additional snacks available and tea making facilities for able residents and visitors. The service receives verbal feedback and from the residents meetings. There is good communication between the food services and the clinical areas and the cooks are informed of any residents dietary changes.

The kitchen area is well equipped with gas hobs, combi oven, fridges and freezers. All equipment has a current electrical test date. There is a clean/dirty flow within the kitchen. The pantry is clean and tidy with all dry food containers sealed and labelled. The stock is rotated with each delivery of food items. There are scheduled cleaning schedules in place. Staff observed are wearing protective clothing such as aprons, hats and gloves. Internal audits are undertaken. Ecolab conduct quality control audits on chemical use, dishwasher and provide training as required. The broken lock on the chemical cupboard was replaced on the day of audit. All staff have been trained in food safety and hygiene and chemical safety. Residents interviewed (seven) are happy with the choice and variety of meals.

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

**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. Ecolab provide the chemicals for the auto feed machines in the kitchen and laundry areas. There is an oasis chemical dispenser in one of the sluice rooms. All chemical bottles are correctly labelled with manufacturers labels. There are Ecolab product wall charts, safety data sheets and emergency flip charts readily accessible to staff. There is a chemical spills kit and protective wear available. All chemicals throughout the facility are stored safely. Staff have received education in Chemical safety with an update scheduled on the education planner for July 2013. Ecolab conduct monthly quality control checks on the effectiveness of chemical use. General waste is collected and disposed of into skip bins which are replaced weekly by a private contractor. Recycling is taken off site to the recycling depots. Approved biohazard containers are used for the safe disposal of sharps. Staff interviewed are knowledgeable in waste management and chemical safety.

**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:** FA

The building holds a current building warrant of fitness which expires 03-May-14. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. Fire evacuation approval letter is dated 01-Oct-97. Fire extinguisher and hose reels last checked February 2013. The automatic sliding doors had a service check 07-Mar-13. The rest home has 44 single rooms and these are divided into two wings, Thompson and Hubbard. The Eden cottage has become a family/whanau accommodation area with a bedroom, shower and toilet facilities, separate lounge, dining and kitchenette. The accommodation is used by visiting families and relatives staying overnight. The physical environment with the wide corridors and spacious rooms allow easy access, movement and promotes independence for residents with mobility aids. Handrails are appropriately placed in the corridors and communal areas. There are communal dining and lounge areas, smaller seating areas and alcoves, conservatories, tea making bays, hairdresser room and private telephone area. Staff and visitor amenities are available. There is a replacement programme in place for beds and mattresses and shower upgrades are planned. Adequate storage areas including a wheelchair bay is available. There is a part-time maintenance person who carries out daily maintenance requests and records corrective action in the maintenance book. There are monthly internal building and external building maintenance schedules in place. Water temperature monitoring of different rooms is carried out each month (sighted) and complies with regulations. The grounds are tidy, well maintained and able to be accessed safely. There are outdoor ramps with handrails, outdoor seating, shaded areas and raised garden beds. The one resident who smokes has a designated outdoor smoking area.

D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities.

D15.3; The following equipment is available, pressure relieving mattresses and cushions, shower chairs, hoist, chair scales, transfer belts, slippery sams, wheelchairs.

**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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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 bedrooms have access to a wash hand basin. The bathroom and toilets have appropriate flooring and handrails. There are an adequate number of toilet and showering facilities in each wing. Privacy locks and privacy curtains are in place. There is a Spa bath room available. Vacant/in use signage is on the toilet/shower rooms. Seven residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares.

**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

Bedrooms in all the units are of an adequate size appropriate to the level of care provided. The rest home rooms allow for the resident to move about the room independently with the use of mobility aids. There is adequate space for staff to manoeuvre a hoist is required. The rooms observed are personalised with the resident’s belongings.

Residents interviewed (seven) confirm their bedrooms are spacious and they can personalise them as desired. Relatives interviewed (three) state they are happy with their family members bedroom.

**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

There is a large open plan lounge with a gas log fire, comfortable and appropriate seating that is placed to allow for group and individual activities to occur. There is a smaller lounge available with sky TV. A sunny conservatory area provide an alternative quieter area. The dining room is open plan with tea making facilities and conservatory off the dining area. All the corridors in the building are wide with appropriately placed handrails. Residents requiring mobility aids have easy access to communal areas for relaxation, dining and activities. Residents interviewed (seven) state they are happy with the communal dining and lounge facilities.

D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

**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 is a daily cleaner employed, There is also another cleaner who is designated to clean residents rooms who works three shifts per week. The cleaners trolleys are well equipped and all chemical bottles are labelled. Protective wear including plastic aprons, gloves and goggles are available in the two sluice rooms and laundry. Staff observed on the day of audit are wearing correct protective clothing when carrying out their duties. There is an oasis chemical system in the cleaners room. The laundry operates daily from 10am to 4pm and launders the bed linen, towels and personal clothing. There is a designated laundry worker. All linen bags are colour coded. The laundry has a clean/dirty flow. Ecolab provides the chemicals, safety data sheets and chemical safety training as required. The laundry is locked after hours. Ecolab conducts quality control checks on the effectiveness of the cleaning and laundry chemicals. There is feedback received from resident and staff meetings on the service. Seven residents interviewed state they are happy with the cleanliness of their rooms and the staff take great care of their clothing.

**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

Appropriate training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. There is a staff member with a current First Aid certificate on duty on each shift.

D19.6 There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Emergency flip charts are visible. There is an approved evacuation plan dated 01-OCt-97. The facility is well prepared for civil emergencies and has civil defence kits (readily accessible) that are checked monthly. Emergency supplies include torches, batteries and radio. The backup generator is run for half an hour monthly. Emergency lighting is checked. There is a barbeque and gas bottles for alternative cooking source. The kitchen holds at least three days of food. There are twelve x 20 litres of water stored that is changed as per the civil defence checklist. There is at least three days of incontinence products held in storage and adequate supplies necessary to manage a pandemic. Calls bells are accessible and within reach in the resident bedrooms, shower and toilet facilities and communal areas. The call bells are checked monthly as part of the monthly maintenance schedule. Seven residents interviewed stated their bells are answered in a timely manner.

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

All bedrooms, communal rooms and conservatories have large windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated appropriately and maintained at a comfortable temperature. Seven residents interviewed confirmed the environment and their bedrooms are warm and comfortable.

**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

There is a restraint minimisation and safe practice policy that is applicable to the service. This includes a restraint protocol for the steps from assessment, approval and into the support plan. The aim of the policy and protocol is to minimise the use of restraint and any associated risks.

The service currently has a restraint free environment. There is a restraint approval group at an organisation level that reviews restraint across all services.

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0

**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:**

**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

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is a QPS benchmarking system in place. The scope of the infection control programme policy and infection control programme description are available. There is an established and implemented infection control programme that is linked into the risk management system.

The infection control coordinator is a senior registered nurse who works closely with the staff. The infection control committee includes a cross section of staff all areas of the service as part of the quality committee. The committee and the governing body is responsible for the development of the IC programme and its review.

Staff are well informed about infection control practises and reporting. They can contact the infection control co-ordinator if required and concerns can be written in progress notes and the communication book. For after hour’s requirements, the R.N. on duty at PSC Brightwater is available along with the infection control coordinator.

Suspected infections are confirmed by laboratory tests and results are collated monthly. Each quarter statistics are sent to the Australian QPS benchmarking programme. Summaries/graphs of these results are feedback to PSC Brightwater and compared with other PSC homes and homes of equivalent size in Australia.

There are guidelines and staff health policies for staff to follow ensuring prevention of the spread of infection. There is a risk factors for nosocomial infection policy, an accidental infectious exposure, TB, management of staff found positive for MRSA, guidelines for staff visiting overseas, risks and exposures for the pregnant healthcare worker, work restrictions for healthcare personnel exposed to or infected with infectious diseases, handling deceased residents with communicable diseases, guidelines for isolation, transferring of residents with an infection , isolation policy, and procedure for when an outbreak of infection occurs. There is evidence (signage) of recent preventative measures have been taken to prevent client exposure to infectious diseases such as Norovirus and influenza.

**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 infection control criteria policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings are combined with quality meetings.

The infection control committee is made up of a cross section of staff from all areas of the service including; care giving, kitchen, cleaning and laundry and professional nurses. The facility also has access to the DHB infection control nurse, Pubic Health, Med Lab, G.P's and expertise within the organisation.

**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

The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.

Other policies included (but not limited to) a) definition of infection for surveillance, b) IC programme description, c) standards for IC practice – cleaning, food service, linen service, waste management, d) policy and guidelines for antimicrobial usage, e) standard precautions, f) risk management of blood, g) hand hygiene, h) hand care procedures, i) UTI’s, j) clinical indicators of infection, k) Hep A & B & C, l) Inoculation/ contamination emergency response, m) risk assessment plan, n) accidental needle stick blood exposure, o) TB, p) MRSA, q) documentation of suspected and actual infections, r) isolation, s) disinfection, t) outbreak procedure, u) cleaning, disinfection and sterilisation guidelines, v) single use equipment, w) waste disposal policy, and x) notification of diseases.

There is also a scope of the infection control programme, standards for infection control and infection control preparation, responsibilities and job descriptions, waste disposal, notification of diseases and educational hand-outs.

**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

There is an infection control coordinator is a registered nurse. The PSC infection control nurse peer support day in April 2013 which included a variety of speakers including Bug Control.

The infection control coordinator also has access to the microbiologist, pharmacist, and Med Lab for additional education for both the co-ordinator and the staff.

Staff were last provided with infection control education in June 2013. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education around influenza.

**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. The infection control coordinators use the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and Med lab that advise and provide feedback /information to the service.

The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. Systems in place are appropriate to the size and complexity of the facility.

Infection control data is collated monthly and reported to the monthly quality meeting. The meetings include the monthly infection control report and QPS quarterly results as available.

All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. An action plan developed in May 2013 around the reduction of respiratory infections was sighted. Thirty four of forty four residents consented to receiving the Flu vaccine. Good Hand hygiene practices were evidenced discussed at handover meetings on each shift. Families were advised not to visit if they were unwell. Staff were advised to stay at home if they were unwell.

Since the last certification audit there has been one outbreak of Norovirus. Outbreak management plan and action taken to minimise risk of infection to residents, staff and visitors were sighted. Regional manager, Public Health and DHB were informed at time of outbreak.

**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:**