**Marton Edale Home Trust Board**

**Current Status:** **26-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**

Marton Edale is governed by a community trust board of combined local organisations and churches and provides care for up to 30 rest home and dementia residents (21 rest home beds and nine dementia beds). On the day of audit, the home had no vacant beds. There is a quality management system that includes key and relevant aspects of service delivery. The business manager has been in the role for five months and she is supported by the clinical nurse leader who is a registered nurse and he has been in the role for two months. He is currently mentored by a facility manager from a local aged care facility. Family and residents interviewed all spoke positively about the care and support provided.

Improvements are required around emergency preparedness, implementation of the quality system, documentation of the medication management system and care plan evaluations.

**Audit Summary AS AT** **26-Jul-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  26-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. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit  26-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit  26-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 medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit  26-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  26-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 Audit  26-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** **26-Jul-13**

**Consumer Rights**

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

**Organisational Management**

Marton Edale has a current business plan and a quality assurance and risk management programme that outlines objectives for the next two years. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Quality information is reported to three monthly combined staff and quality meetings. There is an improvement required around staff/quality meeting minutes. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Marton Edale has an annual performance appraisal system for staff. There is an improvement required around staff job descriptions. There is an annual in-service training programme that has been implemented for the year. The service has a documented rationale for determining staffing and caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

**Continuum of Service Delivery**

Resident's needs are assessed prior to entry by the local needs assessment service and upon entry to the service by the clinical nurse leader.

There is sufficient information gained through the initial assessment, specific assessments, the short-term care plan, and the long term care plan to guide staff in the safe delivery of care to residents. Residents' care plans are completed by the clinical nurse leader or the RN and they are consistent in relation to the initial assessments and risk assessment findings. Short term and comprehensive long term care plans address all care needs.

Caregivers interviewed are aware of the residents' current needs and the most up to date interventions. The medication management system includes medication management policy and procedures that follow recognised standards and guidelines for safe medicine management practice. Staff responsible for medication administration are competent.

The activities officer designs and implements the diversional therapy programmes for rest home and the dementia unit. Some of the activities program is also directed by the caregivers. Dementia level care residents have one on one time with the activities officer and they also join rest home activities. Marton Edale adopted a spark of life approach in dementia care and they are in the process of developing patient centred spark of life care plans.

Food is cooked on site and there is regular dietician input into the menu and nutritional assessments. There were improvements identified around documentation of medication management systems and care plan evaluations.

**Safe and Appropriate Environment**

Marton Edale has a current building certificate and a scheduled maintenance program is carried out. There is sufficient space in all areas for the safe manoeuvring of mobility aids. Safety rails are appropriately placed. Dementia unit has a key pad security system on entry and exit. There are security cameras to monitor corridors in the dementia unit. There is a safe and secure outside area that is easy to access.

Residents have access to communal areas as appropriate. Effectiveness of the laundry and cleaning services are monitored and identified corrective actions are completed. Cleaning and laundry equipment are stored safely and staff have access to these areas as required.

Documented systems are in place for essential, emergency and security services. The home has civil defence equipment. Staff interviews and files have evidence of current training in relevant areas. There are alternative energy and utility sources. There is an improvement required around stored water. An appropriate call bell system and security systems are in place.

**Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There is currently one resident requiring restraint and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour.

**Infection Prevention and Control**

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

Marton Edale Home

Marton Edale Home Trust Board

Certification audit - Audit Report

Audit Date: 26-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Marton Edale Home Trust Board |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Marton Edale Home | 30 Bond Street |  | Marton |

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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:** 26-Jul-13 **End Date:** 26-Jul-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RN, Health Audit Cert | 8.00 | 7.00 | 26-Jul-13 |
| Auditor 1 | XXXXXXX | RN, Dip HEd, BSc, Health Auditor | 8.00 | 6.00 | 26-Jul-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXX |  |  | 2.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 15.00 | **Total Audit Hours** | 31.00 |
| **Staff Records Reviewed** | 7 of 38 | **Client Records Reviewed** *(numeric)* | 6 of 29 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 6 |
| **Staff Interviewed** | 9 of 38 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 10 |
| **Consumers Interviewed** | 7 of 29 | **Number of Medication Records Reviewed** | 15 of 29 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 21 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Marton Edale Home | 30 | 29 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Marton Edale is governed by a community trust board of combined local organisations and churches and provides care for up to 30 rest home and dementia residents (21 rest home beds and nine dementia beds). On the day of audit, the home had no vacant beds. There is a quality management system that includes key and relevant aspects of service delivery. The business manager has been in the role for five months and she is supported by the clinical nurse leader who is a registered nurse and he has been in the role for two months. He is currently mentored by a facility manager from a local aged care facility. Family and residents interviewed all spoke positively about the care and support provided.

Improvements are required around emergency preparedness, implementation of the quality system, documentation of the medication management system and care plan evaluations.

1.1 Consumer Rights

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Quality information is reported to three monthly combined staff and quality meetings. There is an improvement required around staff/quality meeting minutes. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Marton Edale has an annual performance appraisal system for staff. There is an improvement required around staff job descriptions . There is an annual in-service training programme that has been implemented for the year. The service has a documented rationale for determining staffing and caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

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1.4 Safe and Appropriate Environment

Marton Edale has a current building certificate and a scheduled maintenance program is carried out. There is sufficient space in all areas for the safe manoeuvring of mobility aids. Safety rails are appropriately placed. Dementia unit has a key pad security system on entry and exit. There are security cameras to monitor corridors in the dementia unit. There is a safe and secure outside area that is easy to access.

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2 Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There is currently one resident requiring restraints and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour.

3. Infection Prevention and Control

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

Summary of Attainment

* 1. Consumer Rights

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

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

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Low | 0 | 7 | 1 | 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 | PA Low | 0 | 3 | 1 | 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: 5 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  Criteria (of 34): CI:0 FA:20 PA:2 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 | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Low | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 9 PA Neg: 0 PA Low: 2 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:18 PA:3 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 | PA Low | 0 | 4 | 1 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 44 **PA Neg:** 0 **PA Low:** 5 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 95 **PA:** 6 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Marton Edale Home Trust Board

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:26-Jul-13 End Date: 26-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.3 | 1.2.3.6 | PA  Low | **Finding:**  Three monthly staff/quality meeting minutes do not fully reflect data collated and results from the quality programme including issues identified for a) medication, b)safety and c) cleaning audits. Resident issues identified from surveys are not reflected in staff/quality three monthly meeting minutes. Closure of issues from previous meetings are not documented.  Action:  Ensure meeting minutes reflect issues identified from audits and residents meetings. Ensure issues are documented as either closed or remain open from previous meetings. | 3 months. |
| 1.2.7 | 1.2.7.3 | PA  Low | **Finding:**  Six of seven staff files do not have a signed job description. On interview the business manager stated the service is currently reviewing this issue and have planned the implementing of all job descriptions into staff files.  **Action:**  Ensure all staff files contain signed job descriptions. | 3 months |
| 1.3.3 | 1.3.3.1 | PA  Low | **Finding:**  Follow up recommendations from the public hospital was not fully completed and referral to the podiatrist had not been made. A nail technician is a non-registered professional who is not qualified to complete such an assessment.  **Action:**  Ensure that specialist recommendations are followed up and assessments are completed by an appropriate provider. | 3 months |
| 1.3.8 | 1.3.8.2 | PA  Low | **Finding:**  In the dementia unit, three files were reviewed, one was not due for a review, the other one was a respite care resident. One file had completed care plan evaluations but the evaluation did not include any changes in the residents' current health status or achievement against identified goals. Most aspects of evaluations had no changes written, however the progress notes and the medical notes showed a declined health status. In the rest home three resident files were reviewed-one was not due for a review and the other two had several components of the care plan evaluations where progress towards meeting the desired outcomes or non-achievements were not recorded.  **Action:**  Ensure that care plan evaluations reflect resident's response to the interventions or progress towards meeting the desired outcome. . | 3 months |
| 1.3.12 | 1.3.12.6 | PA  Moderate | **Finding:**  For the rest home- eight medication records are reviewed. 1) one chart had incidences of staff not signing of non-packed regular medication.2) one chart had a medication crossed out but not signed by the GP. For the dementia unit - seven medication charts are reviewed . 1) one medication chart had a missing recording of a regular charted insulin . This is discussed with the medicine competent caregiver who is unable to confirm if this was administered or not.  **Action:**  Ensure that medication is signed as administered and any reason for non-administration of medicine is recorded. Ensure that discontinued medications are signed by the prescriber. | 3 months |
| 1.4.7 | 1.4.7.4 | PA  Low | **Finding:**  There are currently 30 residents at Marton Edale and 200 litres of water stored. There is currently insufficient water stored to ensure for three litres per day for three days per resident.  **Action:**  Ensure there is sufficient water stored to ensure for three litres per day for three days per resident. | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Marton Edale Home Trust Board

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:26-Jul-13 End Date: 26-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXX

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

There is a code of rights policy. On interview all staff (four caregivers (two rest home and two dementia) and one clinical nurse leader were aware of consumers rights and were able to describe how they incorporated consumer rights within their service delivery. Code of Rights is discussed at resident and staff meetings. Seven of seven rest home residents and 10 of 10 family members (six rest home and four dementia unit), interviewed spoke highly of the staffs respect of all aspects of the Code of Rights. Code of rights training including: advocacy, informed consent, privacy, confidentiality and open disclosure was last carried out in Feb 2013.

**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

There are posters of the code of rights on display throughout the facility and leaflets in the foyer of the facility. On entry to the service residents receive an information pack that includes a code of rights information and a service agreement. Large format and Maori information is also available. On interview all staff (four caregivers (two rest home and two dementia), and one clinical nurse leader), stated that they take time to explain the rights to residents and their family members. Seven rest home residents and 10 family members (six rest home and four dementia unit) confirmed that they had received information about their rights on entry to the service.

The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service the clinical nurse leader or an RN discusses the information pack with the resident and the family/whānau. This includes the Code of Rights, complaints and advocacy. On interview seven of seven rest home residents and ten of ten family members (six rest home and four dementia unit) were able to state their understanding of the code of rights.

Health and disability advocacy service leaflets are on display on the notice board in the foyer and throughout the facility. A brochure advertising the service is also included in the information pack provided to new residents. The service can access local Maori advisory services should this be requested. Education on advocacy services was provided.

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

**Criterion 1.1.2.3 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

Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of personal property. All seven rest home residents and ten family members (six rest home and four dementia unit) interviewed indicated staff were highly respectful and maintained resident’s privacy especially when discussing personal issues and that personal belongings are not used as communal property. Privacy training as part of code of rights training occurred in February 2013.

The resident’s initial assessments and care plans comprehensively detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. All seven rest home residents interviewed stated their needs were met. All six resident files (three rest home and three dementia unit), have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this.

There is a policy that describes spiritually care. There are various churches locally and residents are encouraged to attend these. Multidenominational services are conducted in the facility at least once a week. All residents and family members interviewed indicated that resident’s spiritual needs are being met when required. On interview all seven rest home residents stated staff respect their rights. There are currently no married couples resident in the facility. The service includes emotional wellbeing in the care planning process.

Resident preferences are identified during the admission and care planning processes and family involvement is documented. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered. On interview all seven rest home residents stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview all four caregivers (two rest home and two dementia) described how they encouraged residents to engage in activities in the facility and to link with community activities including school and church groups.

There is a policy that describes abuse and neglect and the topic is covered at orientation and has been addressed at staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Abuse and neglect training occurs as part of code of rights training which last occurred in February 2013. Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. Seven rest home residents and 10 family members (six rest home and four dementia unit) were complementary of the care provided and stated staff were very approachable and friendly.

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

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

E4.1a Four of four dementia unit families state that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

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

Staff training includes cultural safety at orientation. There is one resident in the dementia unit who identifies as Maori at Marton Edale. The resident has an appropriate cultural assessment and information in their care plan which included whanau input. On interview the family member of the resident stated that they were happy with the care provided and that staff respected the residents cultural needs. The facility identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health policies.

Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and ongoing assessment is undertaken by the clinical nurse leader or an RN, with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual’s service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with one clinical nurse leader (RN) and four caregivers (two rest home and two dementia) confirm that they are aware of the need to respond to cultural differences. On interview all staff were able to identify how to obtain support so that they could respond appropriately.

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

D20.1i: The service has developed a link with local iwi.

**Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service has established cultural policies aimed at helping meet the cultural needs of its residents. There is a Maori health plan. All residents and family members interviewed reported that they were satisfied that their cultural and individual values were being met.

Family are involved in assessment and the care planning process. Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on. Agreement is reached by all parties involved in the consultation process and the care plan is implementation within the service delivery.

D3.1g: The service provides a culturally appropriate service by ensuring initial assessments fully capture residents information regarding culture and beliefs

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

**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

The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes covers harassment and exploitation. All residents interviewed reported that the staff respected them. Elderly abuse prevention training occurs at orientation and as part of code of rights training and includes professionalism and standards of conduct. The RN's supervises staff to ensure professional practice is maintained in the service.

The orientation and employee agreement provided to staff on induction includes a code of conduct.

**Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

The service has policies to guide practice that align with the health and disability services standards. There is a quality framework that is being implemented that supports an internal audit programme. The caregivers are encouraged to complete Career force NZQA level training, hospice palliative care training and an internal in-service training programme is implemented. The business manager and the clinical nurse leader attend external training sessions appropriate for their positions.

A2.2: Services are provided at Marton Edale 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 registered nurses and caregivers. There are clear ethical and professional standards and boundaries within one of seven job descriptions viewed in staff files (link 1.2.7.3).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

Accident/incidents, complaints procedure and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incidents/accidents forms were viewed for July 2013. The forms includes a section to record family notification. All 15 forms indicated family were informed or if family did not wish to be informed. On interview

seven rest home residents, 10 family members (six rest home and four dementia unit) and four caregivers (two rest home and two dementia)

all stated that family are informed following changes in the residents’ health status.

Staff record contact with family/whanau in residents files. Contact records were documented in all files reviewed.

Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

A residents/relatives meeting occurs three monthly, (link 1.2.3.6) re issues arising from the meeting, fed back to staff meetings.

There is a policy that describes the availability of interpreter services when required.

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

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

D16.4b:Ten family members (six rest home and four dementia unit) stated that they are always informed when their family members health status changes.

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

**Criterion 1.1.9.1 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

Consent forms and advance directive forms are evident on six resident files ( three rest home and three dementia) reviewed and were appropriately signed and dated.

Discussions with four caregivers confirmed that they are familiar with the requirements to obtain informed consent for daily cares being proposed to residents. The home is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights.

Residents, with support from their GP and staff, complete an advanced directive consent form which states their decision regarding resuscitation. In two files out of six, the GP assessed the resident's competence where the resident deemed as not competent, medical decision around resuscitation status is noted. These two files includes documented evidence of family consultations.

Discussions with the clinical nurse leader identified that only the resident (deemed competent) could sign the advance directive.

On interview seven rest home residents, 10 family members (six rest home and four dementia unit), all stated that informed consent and advanced directives information is made available on admission and discussions continued thereafter.

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

D3.1.d Discussion with 10 families 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

There is an advocacy policy. Staff receive training on advocacy services. Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with four caregivers (two rest home and two dementia), seven rest home residents and 10 family members (six rest home and four dementia unit) informed they are aware of advocacy and how to access an advocate.

D4.1d; Discussion with 10 family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.

ARC D4.1e: The resident file includes information on resident’s family/whānau and chosen social networks.

**Criterion 1.1.11.1 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

Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview all staff (four caregivers (two rest home and two dementia), and one clinical nurse leader), stated that residents are encouraged to build and maintain relationships. On interview all residents and family members confirmed this.

D3.1h; Discussion with 10 family members (six rest home and four dementia unit) stated that they are encouraged to be involved with the service and care.

D3.1.e: Discussion with all staff (four caregivers (two rest home and two dementia), and one clinical nurse leader), seven rest home residents and 10 family members (six rest home and four dementia unit) confirm that resident are supported and encouraged to remain involved in the community and external groups such as church groups.

**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 complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with seven rest home residents and 10 family members (six rest home and four dementia unit) inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints

There is a complaints register. Complaints for 2013 were reviewed. Verbal and written complaints are documented. There has been one complaint recorded on the register for this time period.

All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants.

Discussions with all seven rest home residents and 10 family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with four caregivers (two rest home and two dementia) stated that concerns/complaints were discussed at three monthly staff / quality meetings.

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

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

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy..

**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

Marton Edale is a purpose built rest home and dementia facility and is part of a larger complex of serviced apartments. The service provides care for up to 30 rest home and dementia residents (21 rest home and nine dementia unit). The current occupancy is 30 residents (21 rest home residents and nine dementia unit residents).

Marton Edale is governed by a community trust board of combined local organisations and churches. The 13 board members are elected. The board meets monthly. The clinical nurse leader and the business manager write a monthly report for the board. The business manager reports directly to the board and meets monthly with them.

Marton Edale has a 2013-2015 business plan, a strategic plan and a quality assurance and risk management programme. The business goals in the current business plan are: a) expand premises, b) refurbishment of rest home, c) new roofing, d) upskill staff, e) motivation of staff, f) raising the communication skills of staff.

The quality process being implemented includes regularly review of policies, an internal audit programme and a health and safety programme that includes hazard management. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Three monthly staff /quality / infection control/ health and safety/restraint meetings discuss key components of the quality system and any issues are reported (minutes viewed). On interview the business manager stated that extraordinary meetings are also held for specific issues when required. There is an internal audit schedule implemented and a corrective action planning is used to manage shortfalls.

The business manager has been in the role for five months. She holds a diploma in business and management and has previously worked for an aged care organisation as a retirement village business manager. She is supported by the clinical nurse leader who is a registered nurse (RN). He has been in the role for two months and was the previous RN in the facility. He is currently mentored by a facility manager from a local aged care facility. There has been staffing changes since the previous audit however the business manager stated the workforce is now stable. The clinical nurse leader and the RN share on-call. The business manager and the clinical nurse leader have completed ongoing training appropriate to their positions.

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

D17.3di (rest home) The business manager and clinical nurse leader have maintained at least eight hours annually of professional development activities related to managing a rest home and dementia unit.

**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

In the absence of the business manager the clinical nurse leader oversees the management of Marton Edale.

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

**Criterion 1.2.2.1 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:** PA Low

Marton Edale has a quality framework that is being implemented. The business manager is directly involved in operations at the facility and the clinical nurse leader (RN) supports her in this role. There is a current business plan and strategic plan that includes goals and a quality assurance programme which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (four caregivers and one clinical nurse manager) inform an understanding of the quality activities undertaken at Marton Edale.

Resident meetings occur three monthly (minutes viewed).

Seven rest home residents interviewed are aware meetings are held. Satisfaction surveys are given to residents and families who attend the three monthly residents meetings. The business manager collates the feedback. There is an improvement required around residents feedback in staff/quality meeting minutes. All residents and relatives interviewed stated they are asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service.

D5.4 The service has the following policies/ procedures to support service delivery; Policies and procedures align with the client care plans.

1D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.

D19.2g: Falls prevention strategies such as physiotherapy reviews, instruction around prevention in care plans and ACC vitamin D in management of

falls training

Policies and procedures are in place with evidence of review. The business manager and the clinical coordinator manage quality systems. There is a quality team which includes staff. The quality programme is reviewed annually and is being implemented. Information is reported through the three monthly staff /quality meetings. There is an improvement required around meeting minutes.

Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility.

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. Marton Edale has one resident with restraints and no residents with enablers.

There is a 2013 internal audit programme which includes (but not limited to); medication (Mar), laundry (May), cleaning (May), clinical files (Jun) and infection control (Jun). All issues found in the 2013 audits have resolutions identified.

Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits is reported through to monthly board meetings (minutes and reports viewed). Incident and infection analysis is reported to three monthly staff/quality meetings (minutes viewed). Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme.

Marton Edale has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be utilised. Four caregivers (two rest home and two dementia), interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

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

There is a 2013 internal audit programme which includes (but not limited to); medication (Mar), laundry (May), Cleaning (May), clinical files (Jun) and infection control (Jun). All issues found in the 2013 audits have resolutions identified. Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits are reported through to monthly board meetings (minutes and reports viewed). Incident and infection analysis is reported to three monthly staff/quality meetings (minutes viewed).

**Finding Statement**

Three monthly staff/quality meeting minutes do not fully reflect data collated and results from the quality programme including issues identified for a) medication, b)safety and c) cleaning audits. Resident issues identified from surveys are not reflected in staff/quality three monthly meeting minutes. Closure of issues from previous meetings are not documented.

**Corrective Action Required:**

Ensure meeting minutes reflect issues identified from audits and residents meetings. Ensure issues are documented as either closed or remain open from previous meetings.

**Timeframe:**

3 months.

**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

There is an incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the business managers or clinical nurse leader who monitor issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to three monthly staff /quality meetings.

Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. Police were contacted regarding an incident concerning a staff member and medication in July 2013. DHB have been notified regarding this incident. Incidents/accidents for July 2013 were viewed and 15 forms were viewed from this time. Incidents are collated monthly onto a reporting sheet to monitor issues and trends. Preventative and corrective actions are documented as required. Actions are reflected in residents long term care plans (LTCP). If risks are identified these are also processed as hazards.

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

**Criterion 1.2.4.2 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:** PA Low

Seven staff files were reviewed. Appointment documentation is seen on file including signed contracts, orientation, training and reference checking. There is an annual appraisal process in place and appraisals are current in all files reviewed. There is a job description in one of seven staff files that describe staff roles, responsibilities and accountabilities. There is an improvement required around job descriptions. The clinical nurse leader has an infection control job description as this is part of his portfolio. The service maintains copies of other visiting practitioner’s certification including GP, pharmacist and physiotherapist.

There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with four caregivers (two rest home and two dementia) described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. This was verified by the clinical nurse leader. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Interview with four caregivers (two rest home and two dementia) inform there is access to sufficient training. Medication competencies are completed for all RN's and caregivers who administer medication. These are checked by the clinical nurse leader.

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

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

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

E4.5f There are 10 caregivers who work in the dementia unit, seven have completed the required dementia standards and three caregivers are in the process of completing.

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

Seven staff files were reviewed. Appointment documentation is seen on file including signed contracts, orientation, training and reference checking. There is an annual appraisal process in place and appraisals are current in all files reviewed. There is a job description in one of seven staff files that describe staff roles, responsibilities and accountabilities.

**Finding Statement**

Six of seven staff files do not have a signed job description. On interview the business manager stated the service is currently reviewing this issue and have planned the implementing of all job descriptions into staff files.

**Corrective Action Required:**

Ensure all staff files contain signed job descriptions.

**Timeframe:**

3 months

**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

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All family members interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that an RN will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The clinical nurse leader covers the business manager during absences and holidays. Residents and relatives interviewed stated they felt there were sufficient staff to meet the needs of residents.

The daily roster states that there are the following staff on each day: Rest home am – one RN and one RN (Thurs-Fri) who cover both rest home and dementia unit and two caregivers, pm – two caregivers, nights- one caregiver. Dementia unit: am - two caregivers, pm – two caregivers, nights- one caregiver. The diversional therapist -10am to 4pm Mon-Fri. A contractor physio attends the facility as required.

**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

Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate).

All resident files are hard copy files. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident’s files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home and dementia setting. The service keeps a resident register.

Marton Edale has a control of documents and records process that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Hard copy resident files are stored securely and protected from unauthorised access by being held at the nurses’ station in a secured cabinet. Old files are individually archived and locked in a secure area for 10 years.

Resident records are up to date and reflect residents’ current overall health and care status. Records can be accessed only by relevant personnel.

Care plans and progress notes are legible, signed, dated and contain designation. Medical notes and allied health input are signed and dated appropriately.

D7.1: Entries are legible, dated and signed by an RN or caregiver including designation.

**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

The home has a well-developed assessment process around entry criteria, screening and assessment process. Resident’s needs are assessed prior to entry by the local need assessment service and on entry to the service by the clinical nurse leader. Information gathered at admission is retained in the resident’s records and communicated to residents and their families.

Seven rest home residents and 10 families (six rest home and four dementia) interviewed were satisfied that they were given accurate and comprehensive information.

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

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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

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

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

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

**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

Discussions with the manager and clinical nurse leader confirmed that the home would refer a declined person back to the referring agency, family members who often make the inquiry or provide guidance on suitable alternative options.

**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

There is sufficient information gained through the initial assessment, specific assessments, the short-term care plan, and the long term care plan to guide staff in the safe delivery of care to residents.

D16.2, 3, 4:Six resident files reviewed (three rest home and three dementia), identified that in all six files an assessment was completed within 24 hours and all six files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan were reviewed by an RN and amended when current health changed. All six care plans evidenced evaluations completed at least six monthly.

D16.5e: All six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly.

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); falls assessment, pain assessment, continence assessment, Norton skin care assessment with a pressure sore prediction, moving and handling assessment, nutrition assessment and wound assessment.

Tracer Methodology x1 : Dementia

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

Tracer Methodology x 2- Rest home

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

The clinical nurse leader oversees each stage of service provision and share on call duties with the RN who both leave onsite. They are supported by a nurse manager with considerable knowledge and expertise in aged care. The clinical nurse leader enrolled in the PDRP framework and completed 'competent level of practice" and attended several training programs including but is not limited to, first aid, wound care, syringe driver, infection control, medication management and gerontology study day. The clinical nurse leader is responsible for the day to day management of clinical care in the rest home and the dementia unit.

**Finding Statement**

Resident file showed that follow up recommendations from the public hospital was not fully completed and referral to the podiatrist had not been made. A nail technician is a non-registered professional who is not qualified to complete such an assessment.

**Corrective Action Required:**

Ensure that specialist recommendations are followed up and assessments are completed by an appropriate provider.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

Six resident files (three dementia, three rest home) reviewed, all had their needs and goals identified and documented via the assessment process. All residents' files had initial assessments, risk assessments and care plans documented.

A range of assessment tools where completed in resident files on admission and at least six monthly including (but not limited to); falls assessment, pain assessment, continence assessment, Norton skin care assessment with a pressure sore prediction, moving and handling assessment, nutrition assessment and wound assessment. The RN or the clinical nurse leader complete weight charts, observation charts and blood sugar monitoring charts as required.

ARC E4.2; Three resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

Residents' care plans are completed by the clinical nurse leader or the RN. Six residents' files reviewed ( three rest home and three dementia) are all consistent in relation to the initial assessments and risk assessment findings. Short term and comprehensive long term care plans that address all care needs. These reflect variances in resident health status. Initial care plans are completed within 24 hours of admission and long-term care plans are developed within three weeks of admission. To maintain resident focus approach, Marton Edale adopted a spark of life approach in dementia care and they are in progress of developing patient centred spark of life care plans.

Caregivers interviewed are aware of the residents' current needs and the most up to date interventions.

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

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

D16.3f; All six resident files reviewed identified that family were involved.

**Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

Service delivery plans demonstrate appropriate interventions based on the assessed needs, desired outcomes or goals of the residents.

The staff are responsive to residents’ changing health needs and progress notes include reporting up any concerns that staff found. Interview with the clinical nurse leader and the GP showed good evidence obtaining specialist advice and support when it was appropriate. GP responses are timely. Seven rest home residents interviewed confirmed their current care and treatments they are receiving meet their needs. Review of medical notes( three rest home and three dementia) showed when residents' health status changed, there were more frequent visits by the GP and resident files included a specialist input as required. Families interviewed (six rest home and four dementia unit) all are supportive of the care provided and the needs of their family members being met.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

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 this could be described.

Continence management in-services( Nov 2012) and wound management in-service ( June 2013 ) have been provided. One of the staff also attended wound care training provided by the local DHB.

Wound assessment and wound management plans are in place for four residents. There are one wound in the dementia unit and three wounds in the rest home and one of these wounds is managed by the wound care specialist.

The clinical nurse leader interviewed described the referral process and the related form should they require assistance from a wound specialist or continence nurse. There is currently one resident in the rest home with a surgical wound that is managed by the wound care specialist. Another rest home resident with a wound also had input from an experienced registered nurse and a manager of another facility in Marton and she mentors the clinical nurse leader. The mentor's input is documented in the progress notes.

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The activities officer designs and implements the diversional therapy programmes for rest home and dementia unit. Some of the activities program is also directed by the caregivers. The activities officer is studying towards obtaining a national qualification in diversional therapy and on interview she stated that there are two more modules remaining.

An assessment of residents likes and dislikes, social history, routines and interests are recorded for all residents in both the rest home and dementia unit and activities offered are appropriate for the residents.

Resident interviews ( seven rest home residents) and family interviews (six rest home and four dementia unit) confirmed that activities are varied, flexible to meet the needs of residents and enjoyable.

A weekly activities timetable is given to each resident and posted on the community notice board and consists of individual and group/team activities both in the rest home and the dementia unit. Dementia residents have one on one time with the activities officer Monday to Friday between 2.45pm to 4 pm. Dementia care residents also join rest home activities in the morning. This is observed on the day of the audit.

The home had adopted the spark of life program for their dementia care service and they are in the process of developing patient centred spark of life care plans. Resident files reviewed two out of three had completed spark of life diversional plans.

D16.5d Six resident files( three from each area) reviewed identified that the individual activity plan is reviewed when at care plan review.

Caregivers were observed various times through the day diverting residents from behaviours. .

Caregivers were observed at various times throughout the day diverting residents from behaviours. On the day of audit, four residents were transferred to the main dining room and they participated in the activities and dined in the rest home. Staff supervise the residents at all times when they are in the rest home. Staff interview ( two caregivers each from rest home and the dementia unit and one activities coordinator) and family interview confirmed that this occurs.

There are 22 volunteers ( friends of Edale) who provide support, fundraising, reception duties and help with activities.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated but care plan evaluations lacked information around degree of achievement against interventions or progress towards the meeting of desired outcomes at both rest home and the dementia unit.

Review of six resident files ( three from each area )and the GP interview confirmed that residents ‘health status changes are communicated with the GP and appropriate actions are taken. Referral to other health professionals recorded in the residents ‘file. One rest home and one dementia unit file included most recent transfer to the public hospital for acute intervention and investigation. GP interview also confirmed appropriate and timely referrals and evaluation of resident's medical and nursing care plans and implementation of new interventions.

Seven residents interviewed (rest home), all confirm that they are asked for feedback for the care plan reviews and required changes made.

Improvement is required to document all care needs to ensure the degree of achievement or response to interventions is considered.

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

Care plan evaluations are completed at least six monthly.

**Finding Statement**

In the dementia unit, three files were reviewed, one was not due for a review, the other one was a respite care resident. One file had completed care plan evaluations but the evaluation did not include any changes in the residents' current health status or achievement against identified goals. Most aspects of evaluations had no changes written, however the progress notes and the medical notes showed a declined health status. In the rest home three resident files were reviewed-one was not due for a review and the other two had several components of the care plan evaluations where progress towards meeting the desired outcomes or non-achievements were not recorded.

**Corrective Action Required:**

Ensure that care plan evaluations reflect resident's response to the interventions or progress towards meeting the desired outcome. .

**Timeframe:**

3 months

**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

Referrals to other health and disability services occur, sampled file review, resident and family interview confirmed this.

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 clinical nurse leader identified that the service has access to a dietician, psychogeriatric team, med lab, podiatrist, the specialists from the local DHB and Alzheimer’s NZ.

**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

Residents' file review showed that transition exit, discharge or transfer of residents are planned and coordinated. Progress notes and medical notes include communication with other health providers and family.

**Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice.

The service uses the medico blister system which is dispensed from the local pharmacy on a four weekly basis. Blister packs are kept in the locked room in both units. Medications are checked on arrival and any pharmacy errors are fed back to the supplying pharmacy. Medication errors are included in incident reporting. The registered nurse or the clinical nurse leader in the morning shift and medicine competent caregivers in the afternoon and night duty administer medication in the rest home and medicine competent caregivers (four) in the dementia unit administer medication. All controlled drugs are managed from the rest home for all residents and control drug register is checked and found to be correct.

A stock of non-pack medication is regularly monitored. Expired medications go back to the pharmacy. Identification of allergies occurs this is documented on the drug charts. Medication audit has been completed in 2013 and shows 93 % compliance and non-signing of administered medication was an issue. Staff received training around medication administration and medicine administration competencies are current. Four caregivers interviewed two rest home and two dementia), all stated that they receive on-going training and they have completed the medicine competency assessment.

There are currently no residents self-administering medications. Sampled medication charts ( seven dementia and eight rest home) included residents who receive insulin and warfarin treatment. Warfarin was administered on a sliding scale and a recording of this found to be correct. Insulin administration was also correct except one missing signing record in the dementia unit. Medication reconciliations are conducted and recorded. Medication rounds at lunch times and evenings are observed on the day of audit and staff are compliant with the current legislative requirements and medicine management guidelines.

Audit identified an improvement required around documentation of medicine management.

D16.5.e.i.2; 15 medication charts (seven dementia and eight rest home) reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.

**Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.**

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

15 medication records were reviewed. There are some issues identified concerning recording of the medication management information.

**Finding Statement**

For the rest home- eight medication records are reviewed. 1) one chart had incidences of staff not signing of non-packed regular medication.2) one chart had a medication crossed out but not signed by the GP. For the dementia unit - seven medication charts are reviewed . 1) one medication chart had a missing recording of a regular charted insulin . This is discussed with the medicine competent caregiver who is unable to confirm if this was administered or not.

**Corrective Action Required:**

Ensure that medication is signed as administered and any reason for non-administration of medicine is recorded. Ensure that discontinued medications are signed by the prescriber.

**Timeframe:**

3 months

**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

There is a four weekly rotating seasonal menu and dietician review was last obtained in 17 May 2013. The kitchen is located next to the dining room and meals directly served from the kitchen for rest home residents and delivered in to the dementia unit.

Food, fridge and freezer temperatures are monitored. There is a cleaning schedule and cleaning tasks have been completed. Kitchen cleaning audits occur monthly.

Resident's nutritional assessment is completed for all residents on admission and residents' likes and dislikes and any special dietary requirements are recorded and catered for. Review of the resident's nutritional profiles and an interview with the cook revealed that the home provides a gluten free diet, diabetic diet and dairy free diet, soft diet, thickened fluids, pureed meals.

Seven resident interviews and 10 family interviews (six rest home and four dementia) all were happy with the quality and variety of the food served.

Resident's weight is monitored and regular monitoring of individual’s consumer’s weight and nutritional needs occur. The home has regular dietician input and clinical team leader stated that the dietician visits the home three monthly. Two out of six residents files reviewed had the dietician input recorded in the file (one dementia and one rest home).

The kitchen has a certificate of registration by the Rangitikei District Council valid until 31th July 2014.

E3.3f, ARHSS D15.2f: there is evidence that there is additional nutritious snacks available over 24 hours

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

**Criterion 1.3.13.1 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

There is a hazard register that identifies potential and actual hazards. Incidents or accidents regarding chemical use or management of waste are captured through the incident reporting process. Personal protective equipment are available as required by staff. Staff interviewed (two caregivers from each area) confirmed this.

**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 home has a current building certificate that expires on 20 June 2014 and maintenance is carried out. There is sufficient space in all areas for the safe manoeuvring of mobility aids. Safety rails are appropriately placed. Dementia unit has a key pad security system on entry and exit. Since the previous audit, the home installed security cameras to monitor the corridors in the Unit. The security monitor is located in the nursing office which also has visual access to the main lounge and dining area.

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

ARC D15.3;The following equipment is available, pressure relieving mattresses, shower chairs, two hoists, mobility aids and a sitting scale. Interviews with four caregivers ( two from each unit) confirmed that there was adequate equipment.

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

E3.4.c; There is a safe and secure outside area that is easy to access. The Marton Edale completed the required corrective actions from the previous audit including the installation of side barriers by the door and the lawn maintained even.

**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

There are adequate numbers of accessible toilets and bathrooms that are conveniently located in close proximity of residents rooms, dining and living areas.

**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

Resident bedrooms are of sufficient space to ensure care and support to be provided and for the safe use of mobility aids.

**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 main lounge and dining area and separate lounge areas for residents and visitors in the rest home. Residents have access to communal areas as appropriate. Resident interview confirmed this.

E3.4b:Dementia unit has adequate space to allow maximum freedom of movement while promoting safety for those that wander. There is a combined dining and lounge area.

There is also a separate lounge which is located outside to the unit next to the locked exit doors which opens to the rest home area. Staff escort and supervision is provided when the residents are transferred to the second lounge.

**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

Laundry and cleaning services audits are scheduled and occurred. Identified corrective actions are completed. Cleaning and laundry equipment are stored safely and staff have access to these areas as required.

**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:** PA Low

Fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence equipment is available (sighted). The business manager stated that they have spare blankets and alternative cooking methods if required. There are currently 30 residents at Marton Edale and 200 litres of water stored. There is an improvement requires around stored water.

The staffing level provided adequate numbers of staff to facilitate safe care to rest home and dementia level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme on 26 November 1999.

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

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

**Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Emergency equipment is available. Civil defence equipment is available (sighted). The business manager stated that they have spare blankets and alternative cooking methods if required. There are sufficient food provisions for three days.

**Finding Statement**

There are currently 30 residents at Marton Edale and 200 litres of water stored. There is currently insufficient water stored to ensure for three litres per day for three days per resident.

**Corrective Action Required:**

Ensure there is sufficient water stored to ensure for three litres per day for three days per resident.

**Timeframe:**

3 months

**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

Living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas.

**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 policy and procedure. There is a restraint manual applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers. Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy and manual that includes responsibilities for staff The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. Individual approved restraint is reviewed at least three monthly and as part of the care plan review and multidisciplinary review that involves family/whanau. Staff were familiar with the policy and the definition of enablers. The restraint manual determines that enablers are voluntary and the least restrictive option. There are no enablers in use in Marton Edale and one restraint (bed sides) in the rest home. The one enabler file reviewed included a consent and assessments.

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

**Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

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

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

Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. All assessments are reviewed by the clinical nurse leader as sighted in the one file sampled for the residents who uses restraints.

Assessments are completed as required for individual residents. The file sampled identified that a restraint assessment, discussion and alternatives form and restraint discussion and consent form were completed for the one residents requiring restraint.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

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

**Criterion 2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:**

(a) Any risks related to the use of restraint;

(b) Any underlying causes for the relevant behaviour or condition if known;

(c) Existing advance directives the consumer may have made;

(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

(f) Maintaining culturally safe practice;

(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

(h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

The restraint manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. The one file reviewed had a completed assessment form and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the one file reviewed. The file reviewed have a consent form detailing the reason for restraint and the restraint to be used. In the one resident file reviewed, monitoring forms had been completed. Assessments are completed. A three monthly evaluation of restraint is completed that reviews the restraint episode. The service has a restraint and enablers register for the facility that is up dated each month.

**Criterion 2.2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:**

(a) Only as a last resort to maintain the safety of consumers, service providers or others;

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

(d) When the environment is appropriate and safe for successful initiation;

(e) When adequate resources are assembled to ensure safe initiation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:**

(a) Details of the reasons for initiating the restraint, including the desired outcome;

(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

(c) Details of any advocacy/support offered, provided or facilitated;

(d) The outcome of the restraint;

(e) Any injury to any person as a result of the use of restraint;

(f) Observations and monitoring of the consumer during the restraint;

(g) Comments resulting from the evaluation of the restraint.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). In the one restraint file reviewed, evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner.

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

**Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:**

(a) Future options to avoid the use of restraint;

(b) Whether the consumer's service delivery plan (or crisis plan) was followed;

(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

(d) Whether the desired outcome was achieved;

(e) Whether the restraint was the least restrictive option to achieve the desired outcome;

(f) The duration of the restraint episode and whether this was for the least amount of time required;

(g) The impact the restraint had on the consumer;

(h) Whether appropriate advocacy/support was provided or facilitated;

(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

(j) Whether the service's policies and procedures were followed;

(k) Any suggested changes or additions required to the restraint education for service providers.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

Approved restraint process for individuals is to be reviewed at least three monthly by the restraint approval group and as part of the annual multidisciplinary review with family/whanau involvement. Restraint usage across the facility is monitored monthly and advised that it is discussed at three monthly staff/quality meetings.

**Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:**

(a) The extent of restraint use and any trends;

(b) The organisation's progress in reducing restraint;

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

(g) Whether changes to policy, procedures, or guidelines are required; and

(h) Whether there are additional education or training needs or changes required to existing education.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The role of the infection control (IC) coordinator is held by the clinical nurse leader who has been in the role for two months. The IC coordinator can access external specialist advice from GP's, laboratories and DHB IC specialists when required. The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the coordinator and external expertise when required. IC is a standing agenda item at the three monthly staff meetings (agenda viewed). Staff are informed about IC practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC coordinator and entered into the infection register.

There are job description for the IC coordinator including the role and responsibilities of the infection control coordinator. IC is part of the audit schedule. There are policies and an infection control manual to guide staff to prevent the spread of infection.

**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 clinical nurse leader (RN) is the IC coordinator. IC matters are taken to all staff meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. He is responsible for reviewing the IC programme annually. The coordinator complies with the objectives of the infection control policy and work with all staff to facilitate the programme. The IC coordinator has undertaken a Ministry of Health infection control on-line e-learning course. Staff complete annual infection control education. Access to specialists from the DHB, laboratories and GP’s is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.

**Criterion 3.2.1 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

Marton Edale has infection control policies and an infection control manual which reflect current practise. The IC programme defines roles and responsibilities of the IC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator. The IC programme is reviewed annually by the IC coordinator and he can access external specialist advice to do this.

D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections.

**Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The IC coordinator is the clinical nurse leader (RN). He has undertaken a Ministry of Health infection control on-line e-learning course. All new staff receive infection control education at orientation including hand washing and preventative measures. Annual infection control education occurs. The training file records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.

**Criterion 3.4.1 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

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Marton Edale are appropriate to the acuity, risk and needs of the residents.

The IC coordinator enters infections on to the infection register and carry out a monthly analysis of the data. The analysis is reported to three monthly staff / quality meetings (minutes viewed). The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility.

Internal audit of infection control is included in the annual programme and occurs monthly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility, primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting.

**Criterion 3.5.1 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:**