**The Napier District Masonic Trust**

**Current Status:** **25-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**

The Taradale Masonic Residential Home & Hospital is overseen by a trust board representing the Masonic constituency. There is a general manager who is supported by a facility manager and a clinical leader. The service is a 74 bed facility providing services for up to 44 residents at rest home level of care and 30 residents at hospital level of care. At the time of the audit, there were 29 hospital residents and 37 rest home residents residing at the facility.

There are improvements required by the service around; admission agreements, advance directives, advocacy, care plan interventions and evaluations, medication documentation, self-medicating documentation and maintenance.

**Audit Summary AS AT** **25-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 Audit25-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. |  | **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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| **Organisational Management** | Day of Audit25-Jul-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit25-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 Audit25-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 medium or high risk and/or unattained and of low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit25-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 Audit25-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** **25-Jul-13**

**Consumer Rights**

Taradale Masonic Residential Home & Hospital has a clear focus on understanding and respecting the rights of the residents in the home. Staff receive training on resident rights on orientation. Care giving staff are studying aged care modules that also reinforce the rights of residents. Each year all staff must attend compulsory training about resident rights, understanding cultural needs and identifying elder abuse.

Residents and families reflect that resident’s rights are respected by staff in the home. Resident’s individual needs are identified and they are free to receive visitors and attend events in the community.

There is a complaints management system in place in the home. All complaints are responded to within the required timeframes. Information in respect of the complaints management system is provided to residents and their families when they enter the service. Information on resident rights is on display throughout the home.

Consent is obtained from the resident or representative for the provision of services to the resident.

There are improvements required around residents' resuscitation orders, health and disability advocacy services and admission agreements. There are systems in place to ensure residents and their family are being provided with information to assist them to make informed choices and give informed consent. During interviews, staff demonstrate good understanding of informed consent processes. Residents and family members interviewed confirm they have been made aware of and understand the informed consent processes and that appropriate information is provided.

**Organisational Management**

Taradale Masonic Residential Home & Hospital has a quality management system in place. The Board provides governance to the service, which is managed by a management team. The board and management have developed plans to operate the business and provide strategic leadership for the organisation. The management team works closely with staff to ensure communication occurs in a timely way. There has been a recent improvement initiative to update and simplify systems. This has resulted in documented policies and procedures being updated. The storage of records has also been improved since the last audit.

Incidents and accidents are recorded, monitored and analysed for trends. Family members state they are informed when an incident, such as a fall, occurs to their family member.

Staff receive education and training, as part of the orientation and on-going training processes. There is a registered nurse on site at all times. The roster provides a sufficient number of staff to deliver the service. Residents and family interviewed state they are satisfied with the number and availability of staff.

There is a health and safety programme in place in the facility. Staff are able to identify work place hazards such as manual handling and the steps they must take to manage them.

Satisfaction with the service is measured annually. Where an area for improvement is identified by the survey this is addressed by the management team. There is an internal audit programme to monitor performance against policy and procedure.

**Continuum of Service Delivery**

The Taradale Masonic Residential Home & Hospital has documented entry criteria, which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Registered nurses are responsible for each stage of service provision. Staff training records detail appropriate qualifications and/or experience and staff interviewed confirm they are trained and in their view competent to perform expected tasks. Residents and family interviewed confirm their input into care planning and access to a typical range of life experiences and choices.

Documentation and observations made of the provision of services demonstrate that consultation and liaison is occurring with other services. Residents interviewed confirm that service delivery is consistent with meeting their needs.

A sampling of residents' clinical files validates the service delivery to the residents. Residents and family interviewed confirm their participation in care plan evaluations. Where progress is different from expected, the service responds by initiating changes to the long term care plan or recording a short term care plan.

There are four areas requiring improvement that relate to service delivery timeframes, resident's cultural aspects to be assessed on admission and this is to be recorded on the initial care plan, all resident's care needs and required interventions are to be noted on care plan and care plan evaluations are to be conducted six monthly.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. There is a therapeutic element included the activities programme with input from a physiotherapist.

An appropriate medicine management system is documented. Policies and procedures clearly detail service provider's responsibilities. Staff responsible for medicine management have current medication competencies.

There are two areas requiring improvement that relate to providing evidence three monthly medication reviews are recorded on medicine charts, discontinued medications are dated and signed, PRN medicines record route of administration maximum doses and indications for use and administration of nutritional supplements is recorded and residents who self-administer medicines do so according to policy.

The facility has a central kitchen and on site staff that provide the food service. Kitchen staff have completed food safety training. The menu has been reviewed by a Dietician. Residents' individual needs are identified, documented and reviewed on a regular basis.

**Safe and Appropriate Environment**

There are policies and procedures for waste management, cleaning and laundry and emergency management. Visual inspection provides evidence of availability and use of protective equipment and clothing. Review of documentation and visual inspection provides evidence there are appropriate systems in place to ensure residents' physical environment and facilities are fit for their purpose.

Residents' room sizes allow for the use of mobility aids, lifting aids as well as care staff, as are the size of the corridors and communal areas. Lighting and ventilation is by external opening windows in residents' rooms and communal areas. All bedrooms have wash hand basins, some have toilet ensuite and some rooms have full ensuite or shared on suite facilities. There are an adequate number of communal toilet and shower facilities. External areas are available for use and shade is provided in these areas. An appropriate call bell system is available and security systems are in place.

The service provides appropriate information, training and equipment to respond to emergency situations.

There are three areas requiring improvement that relate to chemical safety, maintenance and ensuring approval is obtained for the updated fire evacuation plan.

**Restraint Minimisation and Safe Practice**

The service evidences there are nine restraints and five enablers utilised by residents at the facility on audit days. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are the least restrictive.

The service has processes in place at both governance level and facility level for determining restraint approval and restraint processes.

Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed and each episode of restraint is being evaluated. Restraint approval review processes are conducted.

Staff interviews and staff records evidence that staff have received training on restraint management and management of challenging behaviour and have current restraint education.

**Infection Prevention and Control**

An infection control programme is developed and implemented at Taradale Masonic Residential Home & Hospital. It is appropriate to the size and type of service provided. The infection control co-ordinator is responsible for recording all infections, trends identified and corrective action taken if necessary. The infection control committee and board are also involved in monitoring infection control data. If extra support or information is needed the infection control co-ordinator can access the laboratory microbiology staff, the GP or the district health board staff for advice.

There are policies and procedures in place to guide infection control practice at the facility. Staff receive training in infection control procedures, at orientation, through their training modules and on-going through compulsory annual training.

Taradale Masonic Residential Home & Hospital

The Napier District Masonic Trust

Certification audit - Audit Report

Audit Date: 25-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | The Napier District Masonic Trust |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Taradale Masonic Residential Home & Hospital  | 15 Devonshire Place  | Taradale | Napier |

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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:** 25-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, Lead Auditor, BHSc | 16.00 | 8.00 | 25-Jul-13 to 26-Jul-13 |
| Auditor 1 | XXXXXXX | Medical technologist, MBA lead auditor | 16.00 | 4.00 | 25-Jul-13 to 26-Jul-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 3.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 32 | **Total Audit Hours off site** *(system generated)* | 15 | **Total Audit Hours** | 47 |
| **Staff Records Reviewed** | 6 of 90 | **Client Records Reviewed** *(numeric)* | 8 of 66 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 8 |
| **Staff Interviewed** | 18 of 90 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 6 |
| **Consumers Interviewed** | 6 of 66 | **Number of Medication Records Reviewed** | 20 of 66 | **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 25 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Taradale Masonic Residential Home & Hospital  | 74 | 66 | 0 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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1.1 Consumer Rights

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1.2 Organisational Management

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Satisfaction with the service is measured annually. Where an area for improvement is identified by the survey this is addressed by the management team. There is an internal audit programme to monitor performance against policy and procedure.

1.3 Continuum of Service Delivery

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Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Registered nurses are responsible for each stage of service provision. Staff training records detail appropriate qualifications and/or experience and staff interviewed confirm they are trained and in their view competent to perform expected tasks. Residents and family interviewed confirm their input into care planning and access to a typical range of life experiences and choices.

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There are two areas requiring improvement that relate to providing evidence three monthly medication reviews are recorded on medicine charts, discontinued medications are dated and signed, PRN medicines record route of administration maximum doses and indications for use and administration of nutritional supplements is recorded and residents who self-administer medicines do so according to policy.

The facility has a central kitchen and on site staff that provide the food service. Kitchen staff have completed food safety training. The menu has been reviewed by a Dietitian. Residents' individual needs are identified, documented and reviewed on a regular basis.

1.4 Safe and Appropriate Environment

There are policies and procedures for waste management, cleaning and laundry and emergency management. Visual inspection provides evidence of availability and use of protective equipment and clothing. Review of documentation and visual inspection provides evidence there are appropriate systems in place to ensure residents’ physical environment and facilities are fit for their purpose.

Residents' room sizes allow for the use of mobility aids, lifting aids as well as care staff, as are the size of the corridors and communal areas. Lighting and ventilation is by external opening windows in residents' rooms and communal areas. All bedrooms have wash hand basins, some have toilet ensuites and some rooms have full ensuite or shared on suite facilities. There is an adequate number of communal toilet and shower facilities. External areas are available for use and shade is provided in these areas. An appropriate call bell system is available and security systems are in place.

The service provides appropriate information, training and equipment to respond to emergency situations.

There are three areas requiring improvement that relate to chemical safety, maintenance and ensuring approval is obtained for the updated fire evacuation plan.

2 Restraint Minimisation and Safe Practice

The service evidences there are nine restraints and five enablers utilised by residents at the facility on audit days. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are the least restrictive.

The service has processes in place at both governance level and facility level for determining restraint approval and restraint processes.

Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed and each episode of restraint is being evaluated. Restraint approval review processes are conducted.

Staff interviews and staff records evidence that staff have received training on restraint management and management of challenging behaviour and have current restraint education.

3. Infection Prevention and Control

An infection control programme is developed and implemented at Taradale Masonic Residential Home & Hospital. It is appropriate to the size and type of service provided. The infection control co-ordinator is responsible for recording all infections, trends identified and corrective action taken if necessary. The infection control committee and board are also involved in monitoring infection control data. If extra support or information is needed the infection control co-ordinator can access the laboratory microbiology staff, the GP or the district health board staff for advice.

There are policies and procedures in place to guide infection control practice at the facility. Staff receive training in infection control procedures, at orientation, through their training modules and on-going through compulsory annual training.

Summary of Attainment

* 1. Consumer Rights

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | PA Low | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | PA Moderate | 0 | 2 | 1 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | PA Low | 0 | 0 | 1 | 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: 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: 0Criteria (of 48): CI:0 FA:20 PA:3 UA:0 NA: 0 |

* 1. Organisational Management

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

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

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | PA Moderate | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | PA Low | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | PA Moderate | 0 | 1 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | 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 | 2 | 2 | 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: 7 PA Neg: 0 PA Low: 2 PA Mod: 3 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:15 PA:6 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 | PA Moderate | 0 | 1 | 1 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | PA Low | 0 | 2 | 1 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 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: 6 PA Neg: 0 PA Low: 1 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:14 PA:3 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **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 |

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

1. Infection Prevention and Control

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **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 |

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

|  |
| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 40 **PA Neg:** 0 **PA Low:** 5 **PA Mod:** 5 **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:** 89 **PA:** 12 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: The Napier District Masonic Trust

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:25-Jul-13 End Date: 26-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.9 | 1.1.9.1 | PALow | **Finding:**ARC D16.1.b.ii Nine admission agreements were reviewed. In three of nine admission agreements were signed by another person than the resident, however there was no evidence that the person signing the agreement had Enduring Power of Attorney (EPOA) of the resident. One admission agreement does not evidence resident or EPOA sign off.**Action:**Provide evidence admission agreements are signed by the resident or legal EPOA on day of admission to the facility as per ARC contract D16.1.b.ii | 6 months |
| 1.1.10 | 1.1.10.7 | PAModerate | **Finding:**Three of nine files reviewed had inconsistencies in the recording of residents' resuscitation orders.**Action:**Provide evidence residents' resuscitation orders are consistent, signed by the resident and the GP and are communicated correctly in the residents' clinical files. | 3 months |
| 1.1.11 | 1.1.11.1 | PALow | **Finding:**Advocates are not mentioned when the service is responding to a complaint.**Action:**Ensure the health and disability advocacy service is brought to the attention of complainants. | 6 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.3 | 1.3.3.3 | PAModerate | **Finding:**Service provision timeframes for initial care plans and assessments, risk assessments, activities care plans and weight are not adhered to as per policy and ARC contract. **Action:**Provide evidence timeframes are adhered to as per policies and the ARC contract. | 3 months |
| 1.3.4 | 1.3.4.2 | PALow | **Finding:**The initial care plan/ assessment conducted on admission to the facility does not cover cultural aspects of residents' needs.**Action:**Provide evidence resident's cultural aspects are assessed on admission and this is recorded on the initial care plan.  | 6 months |
| 1.3.5 | 1.3.5.2 | PAModerate | **Finding:**All eight resident files reviewed identified lack of interventions to support the care required to manage the risks identified via the assessment process**Action:**Provide evidence all resident's care needs and required interventions are identified on the care plan. | 3 months |
| 1.3.8 | 1.3.8.2 | PALow | **Finding:**Care plan evaluations are not always conducted six monthly as per policy and ARC contract, D16.4a., sighted in one of eight files reviewed.**Action:**Provide evidence care plan reviews are conducted six monthly. | 3 months |
| 1.3.12 | 1.3.12.1 | PAModerate | **Finding:**Medicine charts evidence three monthly reviews are not recorded on the medication charts, discontinued medicines are not dated and signed, PRN medicines do not always record route of administration, maximum doses and indications for use and administration of nutritional supplements are not recorded.**Action:**Provide evidence three monthly medication reviews are recorded on medicine charts, discontinued medications are dated and signed, PRN medicines record route of administration maximum doses and indications for use and administration of nutritional supplements is recorded.. | 3 months |
| 1.3.12 | 1.3.12.5 | PAModerate | **Finding:**There are three residents who self-administer medicines. Residents' clinical and medication charts evidence there are no residents' competency assessment, omission of administration on signing sheets and medicines are not safely stored in three of three residents' files.**Action:**Provide evidence residents who self-administer medicines do so according to policy. | 3 months |
| 1.4.1 | 1.4.1.1 | PAModerate | **Finding:**Visual inspection of the facility provides evidence that hazardous substances /containers do not comply with labelling requirements in line with legislation. Material Safety Data Sheets (MSDS) are available for some, but not all cleaning chemicals and product user guides are not current. The wooden shelving in both the chemical dispensing room and the chemical storage room is damaged.**Action:**Ensure chemical containers comply with labelling requirements in line with legislation, Material Safety Data Sheets and product user guides are available for all chemicals used at the facility and storage areas are able to be cleaned. | 3 months |
| 1.4.2 | 1.4.2.4 | PALow | **Finding:**(I) The rest home communal showers, have wooden seats of bare timber making the surface permeable to micro-organisms, posing a risk of infection to residents. (ii) Carpet in rest home hallways is stretched and taped at joints. **Action:**(i) Ensure all surfaces that residents come in contact with are maintained to prevent the spread of infections and the fixtures are constructed from materials that can be easily cleaned. (ii) Ensure stretched carpet and taped carpet areas minimise risk to mobilising residents, staff and visitors.  | 6 months |
| 1.4.7 | 1.4.7.3 | PALow | **Finding:**The fire evacuation scheme has not yet been approved.**Action:**Approval needs to be secured for the updated fire evacuation plan. | 1 month |

# Continuous Improvement (CI) Report

Provider Name: The Napier District Masonic Trust

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:25-Jul-13 End Date: 26-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

Interviews with staff identified understanding around resident rights. Training records sighted record all staff attend compulsory training in resident rights on orientation to the service and at annual intervals thereafter. This training was last provided to staff on 20 March 2013.

Resident interviews confirm their rights are respected at the facility.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

The Code of Rights and information on the advocacy service are on display and available throughout the home. Families and residents interviewed are aware of The Code and the role the advocates can play in supporting them. Family members and residents discuss the information they receive at admission into the facility. The Code of Rights leaflets are provided to residents prior to entry to the home. The Code is also discussed in the written information provided to the resident, their family members and others involved in resident's care. Where an enduring power of attorney is present this person also receives the information.

The health and disability advocacy service is promoted throughout the home, as the brochures are on display. The information is also provided in the information pack provided to prospective residents and their families.

The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. Eight admission agreements were reviewed and all are found to contain this level of information.

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

Residents are treated with respect by staff, observed on audit days. Staff receive regular training on abuse / neglect, so they know how to identify and report any concerns they might have. The last training for staff was provided 10 June 2013. Over the course of the year all staff attend the mandatory training modules. Rights, culture and elder abuse are mandatory for all staff. Staff are observed to knock before entering residents' rooms and to keep doors closed when attending to residents. Activities in the community are encouraged. Residents can attend community events, clubs and churches. They are encouraged to maintain their hobbies. Where a resident wishes to continue with their hobbies or self-cares this is encouraged. Family members and residents interviewed confirm, that this is the case.

Values, beliefs and cultural aspects of care are recorded in the social assessments, performed by the diversional therapist. Family and residents interviewed stated that values, beliefs and cultural aspects of care are respected by the staff. The home provides for residents to attend church services in the community, they are also provided in the home. One resident is Chinese and has the support of family to provide interpreter services and also food on special occasions.

The facility is secure and night time lock up checks is performed by staff. The environment is safe.

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

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

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

Two residents in the home identify as Maori. Their social care plans record what considerations should be given to their cultural care. The home has two policies that describe the service provided to Maori residents, the Maori health plan and the Maori values and beliefs policy.

Family are encouraged to participate in the residents' care. One example was noted where a Maori resident was supported to travel to see their family.

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

D20.1i;The service has developed a link with Ngati Kahunguu.

**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 facility ensures it understands the cultural requirements of residents through its care planning processes. Residents have input into the care planning and cultural preferences are taken into consideration, confirmed at staff, resident and family interviews. However, link improvements identified in 1.3.3.

D3.1g; The service provides a culturally appropriate service by celebrating events in the community such as Easter and Christmas. Birthdays are also celebrated.

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

**Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

Staff receive training at orientation and then annually about residents' rights. Staff are observed to treat residents respectfully on audit days. Elder abuse training to allow staff to identify abuse and discrimination occurs annually, last provided on 20 March 2013. Staff are able to discuss knowledgeably the professional boundaries they must maintain when caring for residents.

**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

Staff interviewed confirm understanding of professional boundaries and practice. The home maintains professional links with industry associations and networks. The infection control manual, recently purchased from Bug Control represents an example of industry good practice. Policies and procedures record current good practice and reference to legislation and guidelines.

A2.2; Services are provided at Taradale Masonic Residential Home & Hospital, 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 careworkers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions

**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:** PA Low

Residents interviewed state staff and management communicate well with them. Family members interviewed also state communications are thorough and that they are informed of changes in health status.

Interpreter services are available. Residents are informed of these services on admission.

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. Nine admission agreements were reviewed and this was clearly communicated in each agreement. In three instances where agreements were signed by another person, there was no evidence that the person signing the agreement had Enduring Power of Attorney (EPOA) of the resident.

D16.4b ; Relatives state 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.

There is one area requiring improvement that relates to admission agreements to be signed by the resident or legal EPOA on day of admission to the facility as per ARC contract D16.1b.ii

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

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

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. Nine admission agreements were reviewed. In three of nine admission agreements were signed by another person than the resident, however there was no evidence that the person signing the agreement had Enduring Power of Attorney (EPOA) of the resident. One admission agreement does not evidence resident or EPOA sign off.

**Finding Statement**

ARC D16.1.b.ii Nine admission agreements were reviewed. In three of nine admission agreements were signed by another person than the resident, however there was no evidence that the person signing the agreement had Enduring Power of Attorney (EPOA) of the resident. One admission agreement does not evidence resident or EPOA sign off.

**Corrective Action Required:**

Provide evidence admission agreements are signed by the resident or legal EPOA on day of admission to the facility as per ARC contract D16.1.b.ii

**Timeframe:**

6 months

**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:** PA Moderate

Nine additional files to the eight files sampled, were reviewed for records pertaining to informed consent processes. All nine additional residents' files have records of consent to share information and for outings. One file has the GP and a next of kin sign for resuscitation, as the resident is deemed not competent by the GP. There is on record in the resident file or administration file of Enduring Power of Attorney for the person who signed. Second resident's file has a not for resuscitation order, signed only by the GP, but not by the resident, as the resident is deemed not competent. Third resident's file has the resident signing as not for resuscitation on advance directive form, however it is recorded that the resident is for resuscitation in the planning document, the overall file was labelled not for resuscitation.

D13.1; There are nine admission agreements sighted and 8 had been signed on the day of admission.

D3.1.d Discussion with family identifies that the service actively involves them in decisions that affect their relatives lives.

There is one area requiring improvement that relates to residents' resuscitation orders to be consistent, signed by the resident and the GP and to be communicated correctly in the residents' clinical files.

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

Nine additional files to the eight files sampled, were reviewed for records pertaining to informed consent processes. All nine additional residents' files have records of consent to share information and for outings. One file has the GP and a next of kin sign for resuscitation, as the resident is deemed not competent by the GP. There is on record in the resident file or administration file of Enduring Power of Attorney for the person who signed. Second resident's file has a not for resuscitation order, signed only by the GP, but not by the resident, as the resident is deemed not competent. Third resident's file has the resident signing as not for resuscitation on advance directive form, however it is recorded that the resident is for resuscitation in the planning document, the overall file was labelled not for resuscitation.

**Finding Statement**

Three of nine files reviewed had inconsistencies in the recording of residents' resuscitation orders.

**Corrective Action Required:**

Provide evidence residents' resuscitation orders are consistent, signed by the resident and the GP and are communicated correctly in the residents' clinical files.

**Timeframe:**

3 months

**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:** PA Low

The Advocacy service is promoted through information and leaflets available throughout the facility. Information is also provided in the information pack given to prospective residents and their family members. It is noted that when the service is responding to a complaint the role of the Advocates is not mentioned in the response letter.

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

ARC D4.1e;The resident files include information on residents family/whanau and chosen social networks.

There is one area requiring improvement that relates to health and disability advocacy service to be brought to the attention of complainants.

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

The Advocacy service is promoted through information and leaflets available throughout the facility. Information is also provided in the information pack given to prospective residents. It was noted that when the service is responding to a complaint the role of the advocates is not brought to the attention of the complainant.

**Finding Statement**

Advocates are not mentioned when the service is responding to a complaint.

**Corrective Action Required:**

Ensure the health and disability advocacy service is brought to the attention of complainants.

**Timeframe:**

6 months

**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

A review of resident files shows that links to the community are described in the plans developed by the diversional therapist. Resident files also show evidence of attendance at local specialist services such as opticians, dentists and hospital consultants. Visual observation during audit days evidences family visits to the facility

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

D3.1.e; Discussion with seven staff and six relatives that they are supported and encouraged to remain involved in the community and external groups such as visits to local church services and to the RSA.

**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

Residents and family interviewed confirm awareness of the complaints processes and availability of the complaint form. Information is located throughout the facility to allow complaints to be made and recorded. A complaints policy that meets the health and disability code is recorded.

Six complaints for the year to May 2013 are reviewed. All complaints are addressed within required timelines.

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

**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

The service is a 74 bed facility providing services for up to 44 residents at rest home level of care (including six certified serviced apartments) and 30 residents at hospital level of care. At the time of the audit, there were 29 hospital residents and 37 rest home residents residing at the facility. There are no rest home residents in the serviced apartments.

Under the medical component of their certification there are two YPD residents. The service has a physiotherapist for one day a week.

The service also has Short-stay acute admissions under CPO funding (This is a funded/contracted programme by HB Primary Health Organisation). There are currently no residents under on short-stay contracts.

Tara dale Masonic Residential Home & Hospital is operated by a Board of Trustees, who oversee the governance of the home. The Board meet monthly, reports for facilities and quality assurance are sighted. The Board receives briefings from the managers at their meetings. The scope of services to be provided is determined. This is communicated to family, residents and referrers through written and promotional material and a website.

The site is managed by a facility manager, who also takes the role of the quality manager. The clinical leader is a registered nurse, with current practising certificate and experience in aged care.

ARC,D17.3di (rest home), D17.4b (hospital); The manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

**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

The facilities manager holds a Masters in Quality Systems and has worked for the home since April 2011, in the facilities management role since August 2012. The Clinical Manager has 23 years’ experience as a registered nurse and has worked at the home for eleven years. The management team has identified the General Manger to deputise for the facility manager and the RN coordinators for the clinical manager, when they are away.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The facility has documented quality and risk management plan. The plan is reviewed regularly and updates are made to the board on progress.

The organisation's manuals include policies and procedures that cover a broad range of clinical and management topics, such as guidelines for medicines management, culture and values policy, adverse events and guidelines for complaints procedure. These are updated regularly if a need arises and at least every two years. The document control system is described in ndmtp04, retention of records is described in ndmtp05 procedures.

The quality management system includes oversight of events, infections, complaints, health and safety and other issues, as they arise. Discussion of these issues is minuted in monthly management meetings.

Trends are analysed through collection and collation of data, examples noted were falls and events data and infection control data.

The implementation of the quality and risk plan is monitored through internal audits, reports to the board and annual reviews of the plan.

Where corrective action (action plan) is required this is monitored through reviews, following an internal audit, or through follow up to an event or incident. The home also has thorough implementation/project plans in place where an issue poses risks. The emergency management action plan amendments following a building extension were sighted and provide a good example of preventive and corrective action operation.

Risks have been identified, through the health and safety programme and through the care process. The quality and risk plan identifies the approach to be taken to managing risks in service provision.

D5.4 The service has the following policies/ procedures to support service delivery; D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. The manager described a focus on improved falls management with supporting policy, guidelines, follow-up and KPI monitoring. Good Vitamin D prescribing levels. Facility Manager member of the HBDHB Falls Steering Group.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:**

 (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

 (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

The facility has developed an adverse event reporting system described in policy 'adverse event (open disclosure) reporting policy ndmtp10'. Thirty six events for March 2013 are reviewed and show that systems are in place to capture, monitor and follow through on events occurring in the home. Improvements have occurred as a result of the monitoring of events. One noted improvement is the use of cameras to record wounds and plot improvements following treatment. Event forms are noted in resident files. One resident file is selected to review the path events taken from recording to capture on the register and follow up. There events on one resident's file are all found to be recorded on the event register.

The facility staff understand the statutory reporting requirements. This includes a description of notifiable diseases, health and safety reporting and a policy on how to report an unexplained death.

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:** FA

Six staff files and ninety training records were reviewed. All staff had a file that includes records of certificates and specialist training, such as food handling. The files also contain evidence of police and reference checks and the applicants' curriculum vitae. Practising certificates for four enrolled nurses and fifteen registered nurses are sighted and are held on file. Additionally copies of the practicing certificates of the GP, the podiatrist, pharmacist and physiotherapist are also kept up to date on the file. The facility employs a nurse educator, who plans and implements a training schedule that includes mandatory training for all staff. The calendar is on display in staff areas. Staff must attend training and are followed up to ensure all mandatory training has been received in the course of the year. Care givers are studying ACE Aged Care modules. A record of staff progress in achieving the modules is maintained by the nurse educator.

All staff employed by the facility to care for residents hold a clinical qualification or are studying towards their ACE qualifications.

Staff receive orientation on beginning employment, all six files reviewed have a record of orientation.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

The policy 'Taradale Masonic skill mix and education policy ndmt09' describes how staff skills and mix is to be applied to rosters to ensure adequate staff are available to meet resident’s needs. Caregivers describe how the rosters work in the home. Family interviewed and residents state there are sufficient staff to attend to resident’s needs. Rosters for July and August 2013 are sighted for the rest home and the hospital. These reflect the staffing levels described by the staff interviewed. During the day and evening the hospital has at least one enrolled Nurse and one registered nurse and three to five caregivers rostered. At night there is one caregiver and one Registered Nurse on duty. The rest home has one registered nurse and two to five caregivers during the day and evening. At night there are two caregivers fostered.

**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

Resident files sampled evidence, that an entry into the residents' records is made each shift. The entry is clear and the entry is dated and signed. The facility has recently undergone an improvement project to order and arrange its archives. These are now neat and well ordered.

Resident files are integrated and secure.

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

Policies and procedures for entry criteria, assessment and entry screening are documented, sighted. The service’s philosophy is recorded and communicated to residents, family, relevant agencies and staff.

The admission agreement defines scope of service and includes all the contractual requirements, sighted. The facility manager and the clinical leader (RN) interviews confirm access and entry processes are followed. This facility operates 24/7. Resident information booklet/welcome pack was sighted with all relevant information for the resident and family recorded. Residents' files sampled demonstrate all needs assessments are completed for appropriate levels of care. Resident and family interviews confirm their input into the admission process.

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

D14.1; Exclusions from the service are included in the admission agreement.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

Systems to decline resident entry to the service are documented and the resident, and/or their family and agency are informed of the reason for this. The scope of the service provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, the reasons why the service has been declined will be implemented, if required, stated by the facility manager and the clinical leader. The facility manager states resident will be declined entry if not within the scope of the service or if a bed is not available at the time. The facility manager states the resident will be referred back to the NASC service.

**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 Moderate

In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and the service is coordinated to promote continuity of service delivery.

Ten of ten clinical staff (four RNs, three care staff, one staff educator/ clinical nurse leader, one IC coordinator and one restraint coordinator) interviews confirm residents and/or family members are involved in all stages of service provision.

Six of six resident ( four rest home and two hospital) interviews confirm their input into service delivery planning, care evaluations and multidisciplinary reviews, except two residents who have been admitted recently and multidisciplinary reviews have not been required, as yet.

Eight of eight residents' files ( four rest home and four hospital) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations.

Family communication sheets are maintained, sighted in all eight residents' files sampled.

There is a process to identify and respond to variances/trends e.g. accident / incident / unwanted events reporting system.

Documented handovers between shifts were sighted and the auditor evidences verbal briefing from am to pm shift.

One GP provides three on-site clinics per week, at the facility. Residents may retain their own GP, if they prefer. GP interview was conducted and confirms that staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff. Staff competency assessments are current and the staff competency register records competencies for all clinical staff in restraint, staff who administer medicines have current medication competencies and insulin administration, nebuliser and oxygen competencies. RNs also complete wound competencies and all clinical staff are educated in and complete hoist competencies.

D16.2, 3, 4: The ARC requirement is not fully met.

D16.5e: The ARC requirement is not fully met.

There is one area requiring improvement that relates to service delivery timeframes.

Tracer Methodology- Rest Home.

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

Tracer Methodology – Hospital

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

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

1) GP initial assessment is not conducted within two days of admission to the facility as per D16.5ei1. (One of eight clinical files sampled). Post audit, the manager states the resident admission dated noted on the resident's file indicates the day the resident commenced payment for the room, not the actual admission date to the facility (22/4/13). The records /dated obtained from the resident's file on audit day evidence the resident was admitted from their home and the date of admission to be Monday 22/4/13, Date of initial assessment to be 22/4/13. Date of initial care plan is recorded as 26/ 4/ 13. GP initial assessment is recorded at 26/4/13.

 2) Risk assessments are not conducted on admission to the facility, sighted in four of eight files reviewed.

**Finding Statement**

Service provision timeframes for initial care plans and assessments, risk assessments, activities care plans and weight are not adhered to as per policy and ARC contract.

**Corrective Action Required:**

Provide evidence timeframes are adhered to as per policies and the ARC contract.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

The organisation has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer.

Policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.

Four of four rest home and four of four hospital residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider is available and appropriate resources and equipment are available.

The clinical manager (RN) interview confirms that assessments are conducted in a safe and appropriate setting including visits from the doctor.

GP interview confirms GP visits are conducted in a safe and appropriate setting.

Six of six residents interviewed (four rest home and two hospital) confirm their involvement in their assessments, care planning, review, treatment and evaluations of care.

Residents' files evidence risk assessments on admission are not conducted and reviewed six monthly (refer to CAR 1.3.3.3) Initial care plans are not recorded on admission and the long term care plan is not reviewed within the required timeframe, as per ARC contract and policy (refer to CAR 1.3.3.3).

The initial care plan/ assessment conducted on admission to the facility does not cover cultural aspects of residents' needs, as per ARC contract D16.2. Discussion was held with management in respect of this finding and cultural needs were added to the initial care plan of admission on day of audit.

There is one area requiring improvement that relates to resident's cultural aspects to be assessed on admission and this is to be recorded on the initial care plan.

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

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

The initial care plan/ assessment conducted on admission to the facility does not cover cultural aspects of residents, as per ARC contract D16.2. Discussion was held with management in respect of this finding and cultural needs were added to the initial care plan of admission.

**Finding Statement**

The initial care plan/ assessment conducted on admission to the facility does not cover cultural aspects of residents' needs.

**Corrective Action Required:**

Provide evidence resident's cultural aspects are assessed on admission and this is recorded on the initial care plan.

**Timeframe:**

6 months

**STANDARD 1.3.5 Planning**

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

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

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

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

Lifestyle care plans include; nutritional/metabolic patterns; resuscitation status; elimination patterns; self-care ability/activity/ exercise patterns; sleep/rest patterns; cognitive /perceptual patterns, self-concept/emotional/relationship patterns, sexual/reproductive patterns; substance abuse; and value/cultural and belief patterns. additional to the long term care plans staff complete daily flow charts on every shift. The flow charts include; ADL; mobility; nutrition and fluids; skin integrity; elimination; cognition; sleep and rest; restraint; short term needs and pain.

All eight residents' files sampled evidence residents' care plans are individualised, however the care plans do not record appropriate interventions required to cover all residents assessed care needs and risk assessment findings. Residents have input into their care planning and review, confirmed at resident interviews.

Ten of 10 clinical staff interviewed confirm use of residents' care plans.

Residents' files sampled evidence the clinical care/treatment/support or interventions that is to be provided by the staff are not current, the risk assessment findings are not recorded on the care plans. There is evidence of discussions and sign off by residents and family members. The facility ensures access to regular GP care, confirmed at GP interview.

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

D16.3f; Resident files reviewed identify that family are involved.

Lifestyle care plan audit was conducted in March 2013 and corrective actions have been addressed.

There is one area requiring improvement that relates to providing evidence care plans include all required interventions.

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

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

All eight residents' files sampled evidence residents' care plans are individualised, however the care plans do not record appropriate interventions required to cover all residents assessed care needs and risk assessment findings.

The following shortfalls were identified; For example; rest home resident a) Falls risk is rated at medium risk rating, however this finding is not recorded on the care plan. Pressure area risk assessment was conducted in January 2012 and September 2012 and records the risk at a low level. There is no recorded evidence of a pressure area assessment since September 2012 and the findings are not recorded on the care plan.

Hospital resident b) Falls risk is rated at a medium risk level, however this is not recorded on the care plan. Pressure area risk assessment is rated at a low risk level, however the clinical findings record pressure ulcer and ischaemic condition requiring referral to a vascular surgeon. Resident's care plan does not record the resident requires pureed food.

**Finding Statement**

All eight resident files reviewed identified lack of interventions to support the care required to manage the risks identified via the assessment process

**Corrective Action Required:**

Provide evidence all resident's care needs and required interventions are identified on the care plan.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.

Eight of eight residents' files sampled evidence the care plans do not record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents (refer to CAR 1.3.5.2) GPs documentation and records are current.

Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement.

Residents interviewed confirm their current care and treatments they are receiving meet their needs. Family communication sheets record family communications, sighted in all eight residents' files sampled.

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 and wound management in-service have been provided.

Wound assessment and wound management plans are in place for residents that require wound care for skin tears and pressure areas.

The Registered Nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

**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

There are two activities programmes at the facility, one for rest home residents and one for the continuing care wing (CCW). The set programme for the rest home residents evidences activities are planned from Monday morning to Saturday lunch time and includes such activities as daily exercises, quizzes, DVDs, Housie, bowls, crafts, newspaper reading, regular church services, van drives. The CCW activities programme evidences planned activities from Monday to Friday and includes exercises, video viewing, quiz, one on one time, games, reminiscence news music and walk outside. Whiteboards are located throughout the facility and notify residents of daily changes /additions to the activities programme. On days of audit there was evidence of resident active participation in the activities programme. Residents and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.

The activities team produce a monthly newsletter, which includes news from the clinical team, the administration team, any facility news for residents and family and additional activities planned for the month ahead, sighted newsletters from May and July 2013.

Residents' three monthly meeting minutes evidence residents' discussion in relation to the activities programme - sighted minutes from meetings in February and May 2013.

Eight of eight residents' files sampled demonstrate the individual activities service plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being. There is one of eight activities plans sighted that has not been evaluated six monthly as per ARC contract (refer to CAR 1.3.3.3). Residents' activities assessments were sighted in all eight residents files sampled.

 Interview with the staff confirms the activities programme meets the needs of the service group and the service has appropriate equipment.

Residents and family interviewed confirm their past activities are considered and their enjoyment of the activities they choose to participate in. Activities attendance records are maintained and were sighted.

Physiotherapist contracts services to the facility on-site every Monday for the day.

Transport audit was conducted in July 2013 and corrective actions completed, sighted

D16.5d Resident files reviewed identified that the individual activity plan is not reviewed when at care plan review (one of eight files).

**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

One of eight residents' files sampled evidence that evaluations of care plans are not within stated timeframes. Evaluation are conducted by the RNs with input from the resident, family, care staff, activities coordinator and GPs. Family are notified of any changes in resident's condition, evidenced in all eight residents' files sampled.

Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. Residents' files evidence referral letters to specialists and other health professional. Multidisciplinary reviews are current. Short term care plans are recorded for short term problems.

D16.4a Care plans are not evaluated six monthly more frequently when clinically indicated (one of eight files).

There is one area requiring improvement that relates to care plan reviews to be conducted six monthly.

**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 not always conducted six monthly as per policy and ARC contract, D16.4a., sighted in one of eight files reviewed.

**Finding Statement**

Care plan evaluations are not always conducted six monthly as per policy and ARC contract, D16.4a., sighted in one of eight files reviewed.

**Corrective Action Required:**

Provide evidence care plan reviews are conducted six monthly.

**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

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

Residents’ files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services. Residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented.

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 registered nurses identified that the service has access to specialists when this is required.

**Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

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

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

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

**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

There are medication areas in the rest home and hospital. The medication areas evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Controlled drugs storage is secure and the controlled drug register is maintained and evidences weekly checks. Six monthly physical stock takes of controlled drugs by Pharmacist are noted on the register.

There is evidence staff are signing off, as the dose is administered. Residents' standing orders are current and authorised by GPs.

All staff authorised to administer medicines have current competencies, sighted in staff files sampled and on the staff competency register.

Twenty medicine charts (ten hospital and ten rest home) are sampled and demonstrate documentation is legible.

Medication audit conducted in January, February, March, April, May and June 2013 and corrective actions addressed, sighted

D16.5.e.i.2; 14 of 20 medication charts reviewed identify 3 monthly reviews have not been conducted and the medication chart is not signed

There are two areas requiring improvement that relate to providing evidence three monthly medication reviews are recorded on medicine charts, discontinued medications are dated and signed, PRN medicines record route of administration maximum doses and indications for use and administration of nutritional supplements is recorded and residents who self-administer medicines do so according to policy.

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

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

1) 14 of 20 medication charts evidence no three monthly medication reviews, as per ARC contract D16.5e3. Medication reviews are recorded on the medication progress notes in residents' clinical files.

2) Discontinued medications are not dated and or signed by the GPs in six of 20 medication charts reviewed.

3) PRN medicines do not always record route of administration, maximum doses and indications for use, sighted in six of 20 medicine charts.

4) Nutritional supplement is charted, however there is one record for May and one in July 2013 of administration.

**Finding Statement**

Medicine charts evidence three monthly reviews are not recorded on the medication charts, discontinued medicines are not dated and signed, PRN medicines do not always record route of administration, maximum doses and indications for use and administration of nutritional supplements are not recorded.

**Corrective Action Required:**

Provide evidence three monthly medication reviews are recorded on medicine charts, discontinued medications are dated and signed, PRN medicines record route of administration maximum doses and indications for use and administration of nutritional supplements is recorded..

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

The medication management policy was updated on 24th July 2013 with addition to the self-administration of medicines policy, including self-medication authorisation form and self-medication weekly review form. The clinical manager (RN) states residents' competency assessments have not been conducted, as yet.

There are three residents who self-administer medicines at the facility.

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

Discussion were held with management in respect of the above findings and all three residents were consulted by management and self-administration of medicines discontinued on second day of audit.

**Finding Statement**

There are three residents who self-administer medicines. Residents' clinical and medication charts evidence there are no residents' competency assessment, omission of administration on signing sheets and medicines are not safely stored in three of three residents' files.

**Corrective Action Required:**

Provide evidence residents who self-administer medicines do so according to policy.

**Timeframe:**

3 months

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

A tour of the kitchen shows the environment is clean and well organised. Staff hold food handling certificates or are studying towards them at the local EIT. The kitchen monitors hygiene, has a cleaning schedule and also monitors temperatures of foods being received and meals delivered to the residents. Meals are served in the dining room and delivered to the hospital wing in a bain marie. Staff in the hospital wing plate the meals for residents. The menu is assessed by a dietitian, who records the menu is suitable for the residents in the home. Special needs and preferences are catered for within the menu, the kitchen has a list of resident preferences and dietary requirements, that are determined on admission and whenever the resident needs change. One example of this was sighted during this assessment. Interviews with residents and family show the meals are well received. The home has a cooked lunch and lighter evening meal. Morning and afternoon tea snacks are also provided to residents. Satisfaction of the food services is measured through resident’s surveys and at residents meetings.

Weight is recorded on admission and three monthly thereafter, unless requested more often. (link 1.3.3.3)

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:** PA Moderate

Documented processes for the management of waste and hazardous substances are in place. Hazard Register sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and chemical safety is provided at orientation, confirmed at staff interview.

A visual inspection of the facility evidences the provision and availability of protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled. For example: goggles/visors, gloves, aprons, footwear, and masks viewed in sluice rooms. Clothing is provided and used by service providers. Sluice facilities are available for the disposal of waste and hazardous substances.

Two suppliers provide chemicals for the facility. Ecolab provide chemicals for the laundry and have commenced supply when the new laundry commenced operation (approximately eight weeks ago). All containers of chemicals supplied by Ecolab are labelled and comply with labelling requirements in line with legislation, labels are clear and are free from damage. Material Safety Data Sheets for Ecolab chemicals are located in the laundry and product information guides are also available. Interview with the laundry staff member confirms chemical use education was provided by Ecolab staff.

The second supplier of chemicals provides chemicals for the cleaning services at the facility. Visual inspection of the facility provides evidence that hazardous substances used for cleaning are not correctly labelled. Material Safety Data Sheets (MSDS) are available for some, but not all cleaning chemicals and product user guides are not current. Wooden shelving in the two chemical storage rooms is observed to be damaged.

Certificate of registration for offensive trade for the purpose of refuse collection of medical waste, dated as expiring on 31 March 2014.

There is one area requiring improvement that relates to providing evidence the chemical containers comply with labelling requirements, Material Safety Data Sheets and product user guides are available for all chemicals used at the facility and storage areas are able to be cleaned.

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

1) All hand held chemical containers used by cleaning staff are labelled with stick on labels, made by staff at the facility, indicating the name of the chemical. There are four large containers for dispensing chemicals in the chemical dispensing room, that evidence defaced/damaged labels or labels printed by service providers stating the name of the chemical only. Cleaning staff interviews confirm old dispensing containers are "topped up" with new chemicals by staff. There were two containers containing liquids in the chemical dispensing room that are observed to have no labels. The chemical storage room was observed to have chemicals, that are no longer used in the facility, confirmed at cleaner interview. The product user guides located outside the chemical storage room are out of date and do not include current chemicals used at the facility.

2) There are no MSDS for the some cleaning chemicals used at the facility.

3) The wooden shelving in both the chemical dispensing room and the chemical storage room is damaged causing "swelling" of the wooden shelves.

**Finding Statement**

Visual inspection of the facility provides evidence that hazardous substances /containers do not comply with labelling requirements in line with legislation. Material Safety Data Sheets (MSDS) are available for some, but not all cleaning chemicals and product user guides are not current. The wooden shelving in both the chemical dispensing room and the chemical storage room is damaged.

**Corrective Action Required:**

Ensure chemical containers comply with labelling requirements in line with legislation, Material Safety Data Sheets and product user guides are available for all chemicals used at the facility and storage areas are able to be cleaned.

**Timeframe:**

3 months

**Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. Maintenance person interviewed and confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place, along with current calibration / performance verified stickers in place on medical equipment. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 1st November 2013, displayed at entrance to the facility.

Visual inspection of the facility provides evidence of safe storage of medical equipment; corridors are wide enough to allow residents to pass each other safely; safety rails are secure and appropriately located; minimal changes in floor surface and levels occur; equipment does not clutter passageways; floor surfaces/coverings are appropriate and maintained in good order (except carpet in corridors of old hospital and parts of the rest home). Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

The external areas are safely maintained and are appropriate to the resident group and setting. Residents are protected from risks associated with being outside, e.g. safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; safe area for evacuation purposes.

Staff receive education in the safe use of medical equipment and there is a system in place to review staff competency for specific equipment e.g. hoists. This is confirmed via interview of staff and review of staff education records. Care staff interviewed confirm that; they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

Gas fitting certificate of compliance dated 25 July 2013 was sighted for the hot water boiler.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, hoists, lifting aids.

There is one area requiring improvement that relates to providing evidence all surfaces that residents come in contact with are maintained to prevent the spread of infections and the fixtures are constructed from materials that can be easily cleaned and the stretched /taped carpet areas in the rest home minimise risk to mobilising residents, staff and visitors.

Annual environmental audit conducted in August 2012 and corrective actions have been addressed.

Maintenance systems audit was conducted in May 2013 with 100% compliance , sighted.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

There is a safe storage of medical equipment; corridors are wide enough to allow residents to pass each other safely; safety rails are secure and appropriately located; minimal changes in floor surface and levels occur; equipment does not clutter passageways; floor surfaces/coverings are appropriate and maintained in good order (except some corridor carpets ). Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

**Finding Statement**

(I) The rest home communal showers, have wooden seats of bare timber making the surface permeable to micro-organisms, posing a risk of infection to residents. (ii) Carpet in rest home hallways is stretched and taped at joints.

**Corrective Action Required:**

(i) Ensure all surfaces that residents come in contact with are maintained to prevent the spread of infections and the fixtures are constructed from materials that can be easily cleaned. (ii) Ensure stretched carpet and taped carpet areas minimise risk to mobilising residents, staff and visitors.

**Timeframe:**

6 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

There are 14 residents' rooms with full ensuites, eight rooms with shared full ensuites and rest of the residents' rooms have hand basins in rooms. All toilets have appropriate access for residents, based on their needs and abilities. There are clearly identified toilet/shower facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. There is an adequate number of communal toilet and shower facilities that have a system that indicates if it is engaged or vacant. There is also a safe locking system that provides for privacy, but allows service providers access in the case of emergency. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Hot water temperatures are monitored at monthly and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).

**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

Visual inspection evidences that adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. Rooms used for hospital residents have double leaf doors to allow for easy access for 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 adequate access provided to lounges, dining rooms and other communal areas and that residents are able to move freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

**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

Cleaning policy and procedures, and laundry policy and procedures are available. Product user charts, chemical safety data sheets for chemicals used in the laundry were sighted.

Visual inspection evidences the implementation of cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning are reviewed along with Ecolab monthly reports.

Visual inspection of the facility evidences: safe and secure storage areas are available for chemicals and service providers have appropriate and adequate access to these areas as required. Chemicals are not labelled correctly (refer to CAR 1.4.1.1). Chemical safety data sheets are not available for all chemicals used in the facility (refer to CAR 1.4.1.1). Appropriate facilities exist for the disposal of soiled water/waste - i.e. sluice room/facilities. Hand washing facilities are available. Residents interviewed state they are generally satisfied with the cleaning and laundry service.

There are four cleaning and two laundry staff. There is a new laundry complex that allows for in house laundering of all linen & personals.

Cleaning services audit was conducted in February 2013, sighted.

Laundry services audit conducted in July 2013, sighted.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Emergency training for staff is provided every six months. Training has been provided on 4 February 2013 and 17 July 2013. This is part of mandatory training module 2. Attendance records sighted for these events. The home has flip charts located throughout the facility to provide extra guidance to staff.

The evacuation plan has recently changed due to a building alteration. The new plan has been sent to the NZ Fire Service for approval, letter dated 28 May 2013 from the Station Officer sighted to show the approval process has been started. Full approval has not yet been signed off. The facility held a fire evacuation on 9 July 2013. Attendance records and results sighted.

(The building alterations concern a new laundry and lounge area. The plan has been written by a professional fire advisor).

All staff attend first aid training as part of the mandatory training in module three, this was delivered February 25th and May 8th 2013.

All rooms have call bells. Residents and family members interviewed were satisfied with response times.

Facilities are locked at the end of each day. A senior staff member said the doors are checked each evening to make sure the facility is secure.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. The facility maintains a supply of civil defence equipment that includes food, water, bedding and alternative cooking facilities. There are alternative energy sources for emergency lighting.

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

The evacuation plan has recently changed due to a building alteration. The new plan has been sent to the fire service for approval, letter dated 28 May 2013 from Bob Palmer Station Officer sighted. Full approval has not yet been given. The facility held a fire evacuation on 9 July 2013. Attendance records and results sighted.

**Finding Statement**

The fire evacuation scheme has not yet been approved.

**Corrective Action Required:**

Approval needs to be secured for the updated fire evacuation plan.

**Timeframe:**

1 month

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

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

ARC requirements are met.

**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

Documented systems are in place to ensure the use of restraint is actively minimized. The facility is utilising restraint and enabler use on audit days. There are nine residents requiring restraint and five residents requiring the use of enablers. Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques.

The service has an overarching risk and quality management system, that demonstrates compliance with the Standard. The definition of restraint and enabler is congruent with the definition in NZS 8134.0.The process of assessment and evaluation of enabler use is recorded.

Policies and staff training on restraints form part of the mandatory Health and Safety education. Mandatory challenging behaviour education was provided in April and June 2013.

Initial assessment for the need of a restraint is carried out and documented by a Registered Nurse in consultation with resident and family (where appropriate) and the General Practitioner.

The need for the use of restraint is reviewed by the Quality Team at monthly meetings and also at the six monthly review of the resident’s care plan.

Restraint audit was conducted in May 2013.

**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

The service has processes in place at both governance and facility level for determining restraint approval and processes. RMSP policy/procedures define approved restraints and alternatives to restraint. Policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement.

Staff interviewed and residents' files sampled evidence responsibilities are clearly identified and known. Residents' files sampled evidence residents/family input into the restraint approval processes. The role of the “Restraint Coordinator” is delegated to RN, who has been in this position for five weeks and states the facility manager and the clinical manager (RN) support is available. Interview with the Restraint Coordinator was conducted. Clinical staff interviewed are aware of the residents' that use restraint and enablers. The orientation/induction programme includes overview of RMSP policies/procedures.

**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

Systems are in place to ensure assessment of residents is undertaken prior to restraint usage being implemented. Residents' files sampled demonstrate restraint assessment and risk processes are being followed. Policies relate to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement.

Residents' files where restraint is utilised evidence restraint is documented and evaluated on a regular basis and include resident and/or family input. Restraint use is reviewed by the Quality Team at monthly meetings and also at the six monthly review of the resident’s care plan.

**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

Appropriate systems are in place to ensure the service is using restraint safely. Restraint policies and procedures identify risk processes to be followed when a resident is being restrained. The facility manager's monthly reports to the Governing Body includes a review of restraint usage. Residents' files sampled evidence evaluations / review of restraint goals / interventions.

Residents' files sampled demonstrate appropriate alternative interventions are implemented and de-escalation attempted prior to initiating restraint, this is completed by RNs. Completed restraint assessments identify alternative interventions are considered. Restraint consent by residents and/or family are current.

Service provider's documentation evidences a restraint register is established that records sufficient information to provide an auditable record of restraint use.

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

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

 (b) Following appropriate planning and preparation;

 (c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

 (d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

Restraint evaluation processes are documented in the restraint minimisation and safe practice policy. Residents' files evidence that each episode of restraint is being evaluated and based on the risk of the restraint being used. Policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement are documented. Service provider's documentation evidences the organisation's RMSP policy has specified the evaluation frequency of restraint use. Restraint use is evaluated by the Quality Team at monthly meetings, stated by the facility manager and the clinical manager.

**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

The restraint monitoring and quality review occurs on a regular basis and covers all the necessary components. Outcomes of these reviews are documented and reported on to the Governing Body/Trust as well as being discussed at facility meetings. The RMSP policies and procedures include monitoring and quality review processes. Policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement are documented and current. Facility manager’s reports to the Trust include restraint and this occurs monthly. Restraint audit conducted in May 2013 and corrective actions have been implemented.

**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 terms of reference for the infection control leader were sighted. These were issued 11.07.13. The infection control committee has a clearly defined terms of reference and standard agenda. Members of the infection control committee are appointed based on their roles in the organisation, e.g. cleaner, Maintenance and kitchen staff are on the committee. Meetings occur every month. Infections are reported to the nurses and followed up with the Doctor. A recent example where a person was admitted with Clostridium difficle demonstrates clear reporting and management structures are in place in the facility.

The infection control programme has been reviewed and a new policy manual from Bugs Control put in place in January 2013. Organisation procedures were issued in July 2012.

The infection control team membership was reviewed. It shows good input from staff in key roles in the organisation. Minutes of the infection control meetings are available for everyone to read on the staff room notice board.

Isolation procedures are in place. The recent experience with a resident admitted with Clostridium difficle demonstrated the use of isolation procedures. Families re reminded not to visit if they are unwell. Residents are routinely kept in their rooms if they are suffering from diarrhoea. A recent improvement to the infection control programme is the provision of an infection control trolley where all equipment needed to set up an isolation protocol is located in one place.

**Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control coordinator and committee have resources to call upon should there be queries. The facility has recently purchased Bug Control infection control manual to provide an in-depth resource to the team. The manual supports current policies and procedures already in place in the home. If more information or support is required the Coordinator can access the laboratory and the district health board infection control practitioner. The current coordinator is new to the role, she has training planned for later in the year. She has been allocated eight hours a month to spend on the infection control programme.

**Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

The organisation uses Bugs Control manual issued in January 2013 to provide clear policies and procedures to guide practice. The Bug Control manual supports the policies found in 'Infection control policy ndmtp45' All policies and procedures required by the standard are in place.

D 19.2a: Infection control policies include; standard precautions, hand hygiene, needle stick injuries, transmission based precautions. outbreak management, and pandemic planning.

**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

Infection control education is provided by the Nurse Educator. She is a registered nurse who has been providing this training for the last four years. The last infection control training was provided to staff on the 5th of June 2013. The infection control coordinator is newly appointed to the role and will be attending in detail training in September 2013. Training for residents occurs as necessary especially around the reasons for isolation/precautions when someone has diarrhoea.

**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

Surveillance programme is in place. Records showing trends for 2012-2013 were sighted. There are no trends that need to be addressed. Surveillance procedures are described in the infection control manual. Surveillance reporting is a standard part of the information considered at quality meetings. The board is kept informed if there are any issues and receive summary data monthly. The surveillance programme is suitable for an organisation of this type.

Data is collected throughout the month, this is presented to the Quality Review Committee who then evaluate and make decisions if any are required. Quality Review Committee minutes for July and June 2013 were sighted showing that information is presented and reviewed. Graphs are also prepared for trend analysis.

**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:**