

## Waikanae Country Lodge Limited

**CURRENT STATUS: 15-Aug-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

Waikanae Country Lodge is a purpose built facility constructed in 1993. The service can provide care for up to 79 with 59 beds used for either hospital and rest home level care and up to 20 rest home residents in the serviced apartments. The current occupancy is 58 residents, 13 rest home residents and 45 hospital residents. There are currently no rest home level residents in the serviced apartments.

The owner is the general manager. He has owned the facility for twenty years. He also owns another rest home /hospital facility in the North Island. The facility operations manager has just left her role and the facility is currently recruiting for this position. A management consultant contractor who is a registered nurse is currently supporting the general manager until an operations manager is recruited. The general manager is also supported by a clinical team leader and a stable workforce.

The general manager has a developed business plan that includes goals, quality improvement and risk management and the mechanism for monitoring progress. All residents and relatives interviewed were happy with the care and support provided by staff and management.

There are improvements required around complaints management, staff meeting minutes, incident monitoring documentation, staff file documentation, staff appraisals, training, medication management systems, pain assessments, service coordination and maintenance services.

### AUDIT SUMMARY AS AT 15-AUG-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

Indicator	Description	Definition
	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

Consumer Rights	Day of Audit 15-Aug-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.		<b>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk</b>

Organisational Management	Day of Audit 15-Aug-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.		<b>Some standards applicable to this service partially attained and of low risk</b>

Continuum of Service Delivery	Day of Audit 15-Aug-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.		<b>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk</b>

<b>Safe and Appropriate Environment</b>	Day of Audit 15-Aug-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.		<b>Some standards applicable to this service partially attained and of low risk</b>

<b>Restraint Minimisation and Safe Practice</b>	Day of Audit 15-Aug-13	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		<b>Standards applicable to this service fully attained</b>

<b>Infection Prevention and Control</b>	Day of Audit 15-Aug-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.		<b>Standards applicable to this service fully attained</b>

## **AUDIT RESULTS AS AT 15-AUG-13**

### **Consumer Rights**

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

### **Organisational Management**

Waikanae Country Lodge has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process

being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. A new quality process is currently being implemented by the management consultant contractor and the general manager.

There are monthly staff meetings. There is an improvement required around staff meeting minutes. Residents and relatives are provided the opportunity to feedback on service delivery issues at two monthly meetings and via annual satisfaction surveys. There is a reporting process to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. There is an improvement required around monitoring incidents documentation. There is a staff file documentation and staff appraisals process. There is an annual in-service programme that has been implemented for the year. There is an improvement required around training attendance. The service has a documented rationale for determining staffing and caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

### **Continuum of Service Delivery**

The clinical team leader and registered nurses are responsible for each stage of service provision which is provided within the identified time frames. Residents' needs and goals are identified and documented via the assessment process. Since the last audit, a new post fall observation and assessment form was introduced and there has been a reduction in the number of falls in the facility. Improvements are required around pain assessments and service coordination.

A physiotherapist is contracted to the service to offer advice and provide education. Multi-disciplinary involvements are evident in the residents files including a geriatrician, general practitioners, nurse practitioner, clinical team leader and Parkinson's field officer. A nurse practitioner employed by the local DHB provides staff training and supports staff in addressing complex medical issues. Waikanae Country Lodge also is supported by Mary Potter Hospice nurse educators and community liaison nurse for palliative care.

There are two diversional therapists that are responsible for the rest home and the hospital residents. The diversional therapy plan is developed on admission to the service which identifies resident's needs, their likes, dislikes and past hobbies. Consumer satisfaction survey results and resident family interviews show satisfaction with the program.

The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice. There is an improvement required around the implementation of medication management system. There are food policies and procedures for food services and menu planning appropriate to this type of service. Meals are cooked on site. Dietician input is obtained. Residents food preferences are identified and this includes consideration of any particular dietary preference or needs.

## **Safe and Appropriate Environment**

Waikanae Country Lodge has waste management policies and procedures for the safe disposal of waste and hazardous substances. The building holds a current warrant of fitness and a current approved evacuation scheme.

The physical environment is appropriate and safe. Rooms have either ensembles or sharing ensembles and there are adequate communal toilets and showers. There is adequate space for recreation and privacy if needed. General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. There are policies and procedures for effective management of laundry and cleaning practices. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. The service has implemented policies and procedures for civil defence and other emergencies. Audit identified an improvement required around maintenance services.

## **Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently seven residents requiring restraints and seven residents using enablers. Staff are trained in restraint minimisation and challenging behaviour.

## **Infection Prevention and Control**

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

# Waikanae Country Lodge

Waikanae Country Lodge Limited

Certification audit - Audit Report

Audit Date: 15-Aug-13



## Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RN, Dip HEd, BSc, Health Audit Cert	13.00	8.00	15-Aug-13 to 16-Aug-12
Auditor 1	XXXXXXXX	RN, Health Audit Cert	13.00	6.00	15-Aug-13 to 16-Aug-12
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX			1.50	

<b>Total Audit Hours on site</b>	26.00	<b>Total Audit Hours off site</b> <i>(system generated)</i>	15.50	<b>Total Audit Hours</b>	41.50
<b>Staff Records Reviewed</b>	8 of 63	<b>Client Records Reviewed</b> <i>(numeric)</i>	8 of 58	<b>Number of Client Records Reviewed using Tracer</b>	2 of 8

				<b>Methodology</b>	
<b>Staff Interviewed</b>	13 of 63	<b>Management Interviewed</b> <i>(numeric)</i>	2 of 2	<b>Relatives Interviewed</b> <i>(numeric)</i>	8
<b>Consumers Interviewed</b>	12 of 58	<b>Number of Medication Records Reviewed</b>	16 of 58	<b>GP's Interviewed (aged residential care and residential disability)</b> <i>(numeric)</i>	1

## Declaration

I, (full name of agent or employee of the company) XXXXXXXX (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 of Health 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 Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 6 day of September 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*):



# Executive Summary of Audit

## *General Overview*

Waikanae Country Lodge is a purpose built facility constructed in 1993. The service can provide care for up to 79 with 59 swing beds between hospital and rest home level care and up to 20 rest home residents in the certified serviced apartments. The current occupancy is 58 residents, 13 rest home residents and 45 hospital residents. There are currently no rest home level residents in the serviced apartments. Waikanae Country Lodge is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care.

The owner is the general manager. He has owned the facility for twenty years. He also owns another rest home /hospital facility in the North Island. The facility operations manager has just left her role and the facility is currently recruiting for this position. A management consultant contractor who is a registered nurse is currently supporting the general manager until an operations manager is recruited. The general manager is also supported by a clinical team leader and a stable workforce.

The general manager has a developed business plan that includes goals, quality improvement and risk management and the mechanism for monitoring progress. All residents and relatives interviewed were happy with the care and support provided by staff and management.

There are improvements required around complaints management, staff meeting minutes, incident monitoring documentation, staff file documentation, staff appraisals, training, medication management systems, pain assessments, service coordination and maintenance services.

### *1.1 Consumer Rights*

Waikanae Country Lodge provides care that is based on individual residents assessed needs. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ('the code') is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan to support practice and individual values are considered during care planning. There is a complaints register. There is an improvement required around complaints management. Residents and family members and staff interviewed verify ongoing involvement with community groups and confirm visiting can occur at any time.

### *1.2 Organisational Management*

Waikanae has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. A new quality process is currently being implemented by the management consultant contractor and the general manager.

There are monthly staff meetings. There is an improvement required around staff meeting minutes. Residents and relatives are provided the opportunity to feedback on service delivery issues at two monthly meetings and via annual satisfaction surveys. There is a reporting process to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. There is an improvement required around monitoring incidents documentation. There is a staff file documentation and staff appraisals process. There is an annual in-service programme that has been implemented for the year. There is an improvement required around training attendance. The service has a documented rationale for determining staffing and caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

### *1.3 Continuum of Service Delivery*

The clinical team leader and registered nurses are responsible for each stage of service provision which is provided within the identified time frames. Residents' needs and goals are identified and documented via the assessment process. Since the last audit, a new post fall observation and assessment form was introduced and there has been a reduction in the number of falls in the facility. Improvements are required around pain assessments and service coordination.

A physiotherapist is contracted to the service to offer advice and provide education. Multi-disciplinary involvements are evident in the residents files including a geriatrician, general practitioners, nurse practitioner, clinical team leader and Parkinson's field officer. A nurse practitioner employed by the local DHB provides staff training and supports staff in addressing complex medical issues. Waikanae Country Lodge also is supported by Mary Potter Hospice nurse educators and community liaison nurse for palliative care.

There are two diversional therapists that are responsible for the rest home and the hospital residents. The diversional therapy plan is developed on admission to the service which identifies resident's needs, their likes, dislikes and past hobbies. Consumer satisfaction survey results and resident family interviews show satisfaction with the program.

The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice. There is an improvement required around the implementation of medication management system. There are food policies and procedures for food services and menu planning appropriate to this type of service. Meals are cooked on site. Dietician input is obtained. Residents food preferences are identified and this includes consideration of any particular dietary preference or needs.

### *1.4 Safe and Appropriate Environment*

Waikanae Country Lodge has waste management policies and procedures for the safe disposal of waste and hazardous substances. The building holds a current warrant of fitness and a current approved evacuation scheme.

The physical environment is appropriate and safe. Rooms have either ensembles or sharing ensembles and there are adequate communal toilets and showers. There is adequate space for recreation and privacy if needed. General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. There are policies and procedures for effective management of laundry and cleaning practices. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. The service has implemented policies and procedures for civil defence and other emergencies. Audit identified an improvement required around maintenance services.

## *2 Restraint Minimisation and Safe Practice*

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently seven residents requiring restraints and seven residents using enablers. Staff are trained in restraint minimisation and challenging behaviour.

### 3. *Infection Prevention and Control*

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

## Summary of Attainment

### 1.1 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 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	FA	0	1	0	0	0	2
Standard 1.1.7	Discrimination	FA	0	1	0	0	0	5
Standard 1.1.8	Good practice	FA	0	1	0	0	0	1
Standard 1.1.9	Communication	FA	0	2	0	0	0	4
Standard 1.1.10	Informed consent	FA	0	3	0	0	0	9
Standard 1.1.11	Advocacy and support	FA	0	1	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	FA	0	2	0	0	0	2
Standard 1.1.13	Complaints management	PA Moderate	0	1	1	0	0	3

Consumer Rights Standards (of 12):	N/A:0	CI:0	FA: 11	PA Neg: 0	PA Low: 0	PA Mod: 1	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Criteria (of 48):	CI:0	FA:22	PA:1	UA:0	NA: 0			

## 1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	FA	0	2	0	0	0	3
Standard 1.2.2	Service Management	FA	0	1	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems	PA Low	0	7	1	0	0	9
Standard 1.2.4	Adverse event reporting	PA Low	0	1	1	0	0	4
Standard 1.2.7	Human resource management	PA Low	0	2	2	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

Organisational Management Standards (of 7):	N/A:0	CI:0	FA: 4	PA Neg: 0	PA Low: 3	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 34):	CI:0	FA:18	PA:4	UA:0	NA: 0		

### 1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	FA	0	1	0	0	0	5
Standard 1.3.2	Declining referral/entry to services	FA	0	1	0	0	0	2
Standard 1.3.3	Service provision requirements	PA Low	0	2	1	0	0	6
Standard 1.3.4	Assessment	PA Low	0	0	1	0	0	5
Standard 1.3.5	Planning	FA	0	2	0	0	0	5
Standard 1.3.6	Service delivery / interventions	FA	0	1	0	0	0	5
Standard 1.3.7	Planned activities	FA	0	1	0	0	0	3
Standard 1.3.8	Evaluation	FA	0	2	0	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	FA	0	1	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	FA	0	1	0	0	0	2
Standard 1.3.12	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

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 9	PA Neg: 0	PA Low: 2	PA Mod: 1	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:17	PA:4	UA:0	NA: 0		

#### 1.4 Safe and Appropriate Environment

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

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

## 2 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

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

### 3 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

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

Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0

**Total Standards (of 50)** N/A: 0 CI: 0 FA: 42 PA Neg: 0 PA Low: 6 PA Mod: 2 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: 91 PA: 10 UA: 0 N/A: 0

## Corrective Action Requests (CAR) Report

Provider Name: Waikanae Country Lodge Limited  
 Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:15-Aug-13 End Date: 16-Aug-13  
 DAA: Health and Disability Auditing New Zealand Limited  
 Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.1.13	1.1.13.1	PA Moderate	<p><b>Finding:</b></p> <p>In six of nine complaints for 2013 viewed there was no written acknowledgement to complainants as per Right 10. In four complaints viewed there was no documentation of the complainant being given investigation results of the complaint and no documentation that the complainant was satisfied with the resolution of the complaint or that they were given information on the right to appeal the facilities decision. In one complaint viewed there was no progress letter within the 10 or 20 day time lines determined in Right 10. A letter from the facility was sent to the complainant over one month after the original complaint was made. The letter gave the facilities decision to the complainant. The letter did not include the investigation process or the right to appeal. The operations manager (RN) who has now left the facility wrote a report about the investigation that was not included in the returned information to the complainant but was retained in the complaints folder. There is no documentation that the GP was consulted regarding the medical opinion noted in the investigation report.</p> <p><b>Action:</b></p> <p>Ensure the complaints procedure is carried out that aligns with the facilities complaints policy and Right 10.</p>	1 month

1.2.3	1.2.3.6	PA Low	<p><b>Finding:</b> Monthly staff and the managers meeting minutes do not reflect the issues identified in the safety section in the environmental audit conducted in July 2013 regarding answering time for call bells, cleaning issues, lighting and equipment issues. Staff meeting minutes viewed for 2013 do not reflect that rest home caregivers have been attending staff meetings. Staff meeting minutes do not document responsibilities, timelines, outcomes, review or if issues are completed and date closed . Meeting minutes do not document audit results. Restraint is not a standing agenda item in staff meeting minutes.</p> <p><b>Action:</b> Ensure all staff meeting minutes reflect all results from the quality programme. Ensure all meeting minutes include responsibilities, timelines, outcomes, review or if issues are completed and date closed.</p>	3 months
1.2.4	1.2.4.3	PA Low	<p><b>Finding:</b> Two of six incident forms viewed had potential head injuries reported. Neuro obs were not documented as carried out per the facilities protocol for neuro-obs.</p> <p><b>Action:</b> Ensure neuro-obs are documented as being carried out as per the facilities protocol.</p>	3 months
1.2.7	1.2.7.3	PA Low	<p><b>Finding:</b> Six of eight staff files do not have a signed job description in their files. On interview the human resources assistant stated that staff are given their job descriptions to take home. Five of eight staff files reviewed do not have a current annual appraisal.</p> <p><b>Action:</b> Ensure staff annual performance appraisals are current.</p>	3 months
1.2.7	1.2.7.5	PA Low	<p><b>Finding:</b> The staff roster evidence that there are five caregivers who work night shift and who are rostered permanent night duty. In the five caregivers staff files and training records there is no evidence that any of these five caregivers have attended the following training in over two years: restraint, continence, challenging behaviour, code of rights and infection control.</p> <p><b>Action:</b> Ensure night staff attend inservice training.</p>	3 months

1.3.3	1.3.3.4	PA Low	<p><b>Finding:</b></p> <p>One resident's nutritional profiles is not implemented in delivery of food services. It was the resident's choice to have a jam sandwich at supper however the clinical staff were not aware that this occurs. The kitchen staff failed to record the resident as an insulin dependent diabetic when the nutritional profile clearly included all this information. The clinical staff interviewed also were not aware why the decision around monitoring of the resident's blood sugar level had changed in April, this had not been reviewed since then.</p> <p><b>Action:</b></p> <p>Ensure that communication with the kitchen occurs and nutritional profiles are taken into account in delivery of the food services. Ensure that blood sugar level monitoring occurs.</p>	6 months
1.3.4	1.3.4.2	PA Low	<p><b>Finding:</b></p> <p>1) There is a new pain assessment tool and pain aid scale for residents with dementia but these are not always utilised. Residents who receive control drugs and regular pain relieving medicines do not have completed pain assessments in both the rest home and the hospital. 2 ) One of the files reviewed showed that a resident was most recently transferred from rest home to hospital level care and re assessments were not completed.</p> <p><b>Action:</b></p> <p>Ensure that pain assessments are completed for the residents who require pain medication, controlled drug or express pain or discomfort. Ensure that assessments are completed when residents level of care changes from rest home to hospital level care.</p>	6 months
1.3.12	1.3.12.1	PA Moderate	<p><b>Finding:</b></p> <p>1) Six monthly physical stock take of controlled drugs by the pharmacist do not occur. 2) One medication was expired on the first day of the audit but it was administered on the second day of the audit. 3) monitoring of fridge which the drugs are stored does not occur. 4) monitoring of the blood sugar level of a resident who has insulin dependent diabetes mellitus, has not occurred since April 2013. 5) insulin administration is not double checked by staff.</p> <p><b>Action:</b></p> <p>Ensure that six monthly physical stock take from a pharmacist occurs. Expired date of medications are checked and expired medicines are returned to the pharmacy. Ensure fridge temperature is monitored. Insulin administration checked by two staff members who are medicine competent and blood sugar monitoring occurs.</p>	1 month

1.3.12	1.3.12.3	PA Moderate	<p><b>Finding:</b> Staff medicine administration competencies are not current and the June quality report identified this but a follow up was not completed. On the first day of the audit, an enrolled nurse who administered medication did not have a current completed medication competency.</p> <p><b>Action:</b> Ensure that all staff who administer medication complete a medication competency.</p>	1 month
1.4.2	1.4.2.1	PA Low	<p><b>Finding:</b> There are regular checks of the building and equipment documented and carried out by the maintenance person but following are noted as requiring repair. 1) in two bathrooms, wall vinyl's were not intact. 2) hospital dining room door had deep scratches, 3) skirting board painting between rest home to service apartments has not been completed yet and 4) electrical equipment checks are not completed. Some equipment has not been checked and tagged and some equipment last checked in 2010 and stated a re-check in 2011 but this was not completed.</p> <p><b>Action:</b> Ensure that electrical equipment checks are completed. Ensure that bathroom vinyl and walls are intact and doors are repaired.</p>	6 months

## Continuous Improvement (CI) Report

Provider Name: Waikanae Country Lodge Limited  
Type of Audit: Certification audit  
Date(s) of Audit Report: Start Date:15-Aug-13 End Date: 16-Aug-13  
DAA: Health and Disability Auditing New Zealand Limited  
Lead Auditor: XXXXXXXX

# 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  Mal  V  CQ  SQ  STQ  Ma  L

#### How is achievement of this standard met or not met?

**Attainment: FA**

There is a code of rights policy. On interview all five caregivers (two who work in the rest home wing and three hospital), three registered nurses (RN's) and one clinical team leader), were aware of consumers rights and were able to describe how they incorporated consumer rights within their service delivery. Code of Rights is discussed at two monthly resident and staff meetings. Twelve of 12 residents (six rest home and six hospital) and eight of eight family members (two rest home and six hospital), interviewed spoke highly of the staffs respect of all aspects of the Code of Rights. Code of rights training including: advocacy, informed consent and privacy was last carried out in Nov 2011.

#### 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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

There are posters of the code of rights on display throughout the facility and leaflets in the foyer of the facility. On entry to the service residents receive an information pack that includes a code of rights information and a service agreement. Large format and Maori information is also available. On interview all nine care staff (five caregivers, three RN's and one clinical team leader), stated that they take time to explain the rights to residents and their family members. Twelve residents (six rest home and six hospital) and eight family members (two rest home and six hospital) confirmed that they had received information about their rights on entry to the service.

The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service the clinical team leader or an RN discusses the information pack with the resident and the family/whānau. This includes the Code of Rights, complaints and advocacy. On interview 12 of 12 residents and eight of eight family members were able to state their understanding of the code of rights.

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

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

**Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All 12 residents and eight family members interviewed indicated staff were highly respectful and maintained resident's privacy especially when discussing personal issues and that personal belongings are not used as communal property. Privacy training as part of code of rights training occurred in November 2011.

The resident's initial assessments and care plans comprehensively detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. All 12 residents interviewed stated their needs were met. All eight resident files viewed (four rest home and four hospital) have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this.

There is a policy that describes residents spiritually care. There are various churches locally and residents are encouraged to attend these. Multidenominational services are conducted in the facility at least once a week. All residents and family members interviewed indicated that resident's spiritual needs are being met when required. On interview all 12 residents (six rest home and six hospital) stated staff respect their rights. There are currently no married couples resident in the facility. The service includes emotional wellbeing in the care planning process.

Resident preferences are identified during the admission and care planning processes and family involvement is documented. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered. On interview all 12 residents stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview all five caregivers could described how they encouraged residents to engage in activities in the facility and to link with community activities including school, church groups and the RSA.

There is a policy that describes abuse and neglect and the topic is covered at orientation, inservice training has been addressed at staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Abuse and neglect training last occurred July 2012. Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. Twelve residents and eight family members were complementary of the care provided and stated staff were very approachable and friendly

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

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

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

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

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

Staff training includes cultural safety at orientation. There is one resident who identifies as Maori in the facility. They have their cultural needs and preferences reflected in their care plan. Waikanae identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health policies.

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

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

D20.1i: The service has developed a link with local iwi to obtain Maori advisory services and advocacy should this be required.

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

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

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

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

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

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The facility has a policy that determines staff principles around code of conduct which states that discrimination is not tolerated. The abuse and neglect processes and policies covers harassment and exploitation. All residents interviewed reported that the staff respected them. Abuse and neglect prevention training occurs at orientation and as part of code of rights training and includes professionalism and standards of conduct. The RN's supervises staff to ensure professional practice is maintained in the service. The orientation and employee agreement provided to staff on induction includes standards of conduct.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
<p>The service has policies to guide practice that align with the health and disability services standards. There is a quality framework that is being implemented that supports an internal audit programme. The caregivers are encouraged to complete ACE NZQA level training and an internal in-service training programme is implemented. The manager and clinical team leader attend external training sessions appropriate for their positions.</p> <p>A2.2: Services are provided at Waikanae that adhere to the health &amp; disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.</p> <p>D1.3: All approved service standards are adhered to.</p> <p>D17.7c: There are implemented competencies for the registered nurses, (link CAR 1.3.12.3 regarding medication competencies).</p>	

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
 <b>Finding Statement</b>  <b>Corrective Action Required:</b>  <b>Timeframe:</b>		

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Accident/incidents, complaints procedure and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. A sample of six incidents/accidents forms were viewed from June to August 2013. The forms includes a section to record family notification. All six forms indicated family were informed or if family did not wish to be informed. On interview 12 residents (six rest home and six hospital), eight family members (two rest home and six hospital) and five caregivers all stated that family are informed following changes in the residents' health status. The three registered nurses interviewed stated that they record contact with family/whanau in resident's files. Contact records were documented in all files reviewed.

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

A residents/relatives meeting occurs two monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan.

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

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

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

D16.4b:Eight of eight family members stated that they are always informed when their family members health status changes.

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

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
<p>Policies and training support staff in providing care and support to enable residents to make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with five caregivers identify that consents are sought in the delivery of personal cares. Written consent includes the signed admission agreements and consent for transporting, photographs and provision of care. All 12 residents (six rest home and six hospital) reviewed has signed consent forms signed by the family/whanau/EPOA. Advanced directives / resuscitation policy is implemented in all eight resident files reviewed. All advance directives are completed by the GP and discussion with family members is documented.</p> <p>D13.1: There were eight admission agreements sighted and eight had been signed on the day of admission</p> <p>D3.1.d: Discussion with eight family members (two rest home and six hospital) identified that the service actively involves them in decisions that affect their relative's lives.</p>	

**Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### STANDARD 1.1.11 Advocacy And Support

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

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

#### How is achievement of this standard met or not met?

**Attainment: FA**

There is an advocacy policy. Staff receive training on advocacy services. Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service, provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with five caregivers, 12 residents and eight family members informed they are aware of advocacy and how to access an advocate.

D4.1d; Discussion with eight family members (two rest home and six hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions.

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

#### Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

##### Audit Evidence

**Attainment: FA**

**Risk level for PA/UA:**

##### Finding Statement

##### Corrective Action Required:

##### Timeframe:

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

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

Residents are encouraged to be involved in community activities and maintain family and friends networks. All care staff interviewed (five caregivers, three RN's and one clinical team leader), stated that residents are encouraged to build and maintain relationships. On interview all residents and family members confirmed this.

D3.1h; Discussion with eight family members (two rest home and six hospital) stated that they are encouraged to be involved with the service and care.

D3.1.e: Discussion with care staff (five caregivers, three RN's, one clinical team leader), and eight family members (two rest home and six hospital), confirm that residents are supported and encouraged to remain involved in the community and external groups such as schools church and RSA visits.

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment:** PA Moderate

The service has a complaints policy that describes the management of the complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with 12 residents (six rest home and six hospital) and eight family members (two rest home and six hospital), inform an understanding of the complaints process and they felt any issues are addressed and they feel comfortable to bring up any concerns. All staff interviewed were able to describe the process around reporting complaints. There is a complaints register. Complaints for 2013 were reviewed. Verbal and written complaints are documented. Nine complaints recorded on the register for 2013 were reviewed. There is an improvement required around complaint management. Discussions with five caregivers stated that concerns/complaints were discussed at monthly staff meetings (link CAR 1.2.3.6.)

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

**Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.**

**Audit Evidence**

**Attainment:** PA

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

The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with 12 residents (six rest home and six hospital) and eight family members (two rest home and six hospital), inform an understanding of the complaints process and they felt any issues are addressed and they feel comfortable to bring up any concerns. All staff interviewed were able to describe the process around reporting complaints. Complaints for 2013 were reviewed. Verbal and written complaints are documented. Nine complaints recorded on the register for 2013 were reviewed.

**Finding Statement**

In six of nine complaints for 2013 viewed there was no written acknowledgement to complainants as per Right 10. In four complaints viewed there was no documentation of the complainant being given investigation results of the complaint and no documentation that the complainant was satisfied with the resolution of the complaint or that they were given information on the right to appeal the facilities decision. In one complaint viewed there was no progress letter within the 10 or 20 day time lines determined in Right 10. A letter from the facility was sent to the complainant over one month after the original complaint was made. The letter gave the facilities decision to the complainant. The letter did not include the investigation process or the right to appeal. The operations manager (RN) who has now left the facility wrote a report about the investigation that was not included in the returned information to the complainant but was retained in the complaints folder. There is no documentation that the GP was consulted regarding the medical opinion noted in the investigation report.

**Corrective Action Required:**

Ensure the complaints procedure is carried out that aligns with the facilities complaints policy and Right 10.

**Timeframe:**

1 month

**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**

Waikanae Country lodge is a purpose built facility constructed in 1993. The service can provide care for up to 79 with 59 swing beds between hospital and rest home level care and up to 20 rest home residents in the certified serviced apartments. The current occupancy is 58 residents, 13 rest home residents and 45 hospital residents. There are currently no rest home level residents in the serviced apartments. Waikanae Country Lodge is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care.

The owner is the general manager. He has owned the facility for twenty years. He also owns another rest home /hospital facility in the North Island. The facility operations manager (RN), has just left her role and the facility is currently recruiting for the post. A management consultant contractor who is a registered nurse is currently supporting the general manager until an operations manager is recruited. The general manager is also supported by a clinical team leader and a stable workforce.

Waikanae has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The current business plan service goals for 2011-2016 are a) market definition and analysis, b) company development, c) sales and marketing, d) contracts, e) staff development around care. The quality programme being implemented includes regularly review of policies, an internal audit programme and a health and safety programme that includes hazard management. Goals and objectives are included in the programme and mechanisms for monitoring progress are

outlined. The service has policies and procedures and associated implementation systems to provide assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. There are monthly staff meetings (Link CAR 1.2.3.6 regarding meeting minutes). There is an internal audit schedule that is implemented and a corrective action plan used to manage shortfalls. Currently the general manager and the management consultant contractor are working together to implement new policies and a new quality programme that links to the policies that has been developed by the contractor. She has experience in management in the aged care sector and is a registered nurse. The policies and quality programme have already been implemented in the general manager/owners other aged care facility.

The general manager and the clinical team leader share on-call. (Link CAR 1.2.7.3) regarding job descriptions for the clinical team leader that outline their authority, accountability and responsibility. The clinical team leader and the general manager have completed ongoing training appropriate to their positions. There is RN cover in the facility 24/7.

ARC,D17.3di (rest home), D17.4b (hospital): The managers have maintained at least either hours annually of professional development activities related to managing a hospital and rest home.

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

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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.**

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		

Timeframe:

**STANDARD 1.2.2 Service Management**

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

In the absence of the general manager the clinical team leader currently oversees the management of Waikanae.

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

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: PA Low**

Waikanae has a quality framework that is being implemented. The general manager is directly involved in operations at the facility and the clinical team leader and currently the aged care management consultant contractor (RN) supports him in this role. There is a current business plan that includes objectives/goals and a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff determined that they could describe the quality activities undertaken at Waikanae

Resident meetings occur two monthly (minutes viewed). Twelve of 12 residents interviewed are aware meetings are held. Annual surveys are conducted of residents and relatives. All residents and relatives interviewed stated they are asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service.

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

- 1) Continance policy. Continance assessments were evident in resident files.
- 2) Management of challenging behaviour policy. There is a challenging behaviour assessment and management plan.
- 3) Pain management policy and procedure. There is an assessment tool being utilised for residents with pain/on controlled drugs.
- 4) Personal grooming and hygiene process and policy
- 5) Skin management policy.
- 6) Wound management policy. There was a wound care assessment and management plan in place for residents with wounds.
- 7) Transportation of subsidised resident's procedure includes costs, resident, and staff safety.

D10.1: Care of the deceased resident process and policy that outlines immediate action to be taken upon a residents death and that all necessary certifications and documentation is completed in a timely manner.

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

D19.2g: Falls prevention strategies such as physiotherapy reviews and instruction around prevention in care plans.

Policies and procedures are in place with evidence of review. The general manager and currently the management consultant contractor (RN) and the clinical team leader manage quality systems. There is a quality team which includes staff. The quality programme is reviewed annually. There are monthly staff meetings.

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

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. Waikanae has seven residents with restraints and seven residents with enablers.

There is a 2013 internal audit programme which includes (but not limited to); education (July), fire evacuation (June) and environmental and cleaning (July). All issues found in the 2013 audits have identified corrective action plans and resolutions.

There is an improvement required around documentation of monitoring data reported through to quality / staff meetings. Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. All staff interviewed could describe the quality programme corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme. Waikanae has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be well utilised. Five caregivers interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

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

There is a quality team which includes staff. The quality programme is reviewed annually. There are monthly staff meetings. There is a 2013 internal audit programme which includes (but not limited to); education (July), fire evacuation (June) and environmental and cleaning (July) All issues found in the 2013 audits have identified corrective action plans and resolutions.

Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. All staff interviewed could describe the quality programme corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme. Residents two monthly meeting minutes reflect any issues identified through quality monitoring.

**Finding Statement**

Monthly staff and the managers meeting minutes do not reflect the issues identified in the safety section in the environmental audit conducted in July 2013 regarding answering time for call bells, cleaning issues, lighting and equipment issues. Staff meeting minutes viewed for 2013 do not reflect that rest home caregivers have been attending staff meetings. Staff meeting minutes do not document responsibilities, timelines, outcomes, review or if issues are completed and date closed . Meeting minutes do not document audit results. Restraint is not a standing agenda item in staff meeting minutes.

**Corrective Action Required:**

Ensure all staff meeting minutes reflect all results from the quality programme. Ensure all meeting minutes include responsibilities, timelines, outcomes, review or if issues are completed and date closed.

**Timeframe:**

3 months

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.****Audit Evidence****Attainment: FA****Risk level for PA/UA:****Finding Statement****Corrective Action Required:****Timeframe:****Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.****Audit Evidence****Attainment: FA****Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: PA Low**

There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the general manager and the clinical team leader who monitor issues. If risks are identified these are also processed as hazards. (Link 1.2.3.6) regarding incident trending reported to monthly staff meetings. There has been three incidents reported to the police. All three incidents were notified to DHB (emails viewed). The serious harm notification process was carried out.

Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. A sample of six incidents/accidents for March to August 2013 were viewed. Incidents are collated monthly onto a reporting sheet to monitor issues and trends. Preventative and corrective actions are documented as required. Actions are reflected in residents long term care plans (LTCP). If risks are identified these are also processed as hazards. There is an improvement required around the documentation of neuro-obs.

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: PA**

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

There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. A sample of six incidents/accidents for March to August 2013 were viewed. Incidents are collated monthly onto a reporting sheet to monitor issues and trends. Preventative and corrective actions are documented as required. Actions are reflected in residents long term care plans (LTCP). If risks are identified these are also processed as hazards.

**Finding Statement**

Two of six incident forms viewed had potential head injuries reported. Neuro obs were not documented as carried out per the facilities protocol for neuro-obs.

**Corrective Action Required:**

Ensure neuro-obs are documented as being carried out as per the facilities protocol.

**Timeframe:**

3 months

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Eight staff files were reviewed. All staff have employment contracts. The practising certificate of RN's and EN's are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist and physiotherapist. Appointment documentation is seen on file including signed contracts, orientation, reference checks and training. There is an annual appraisal process in place. There is an improvement required around annual appraisals.

There is a training/induction process that describes staff orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with five caregivers described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. This was verified by the general manager. The service has a training policy and two year training schedule for in-service education. The in service schedule is implemented. There is an improvement required around staff attendance at training.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication (link CAR 1.3.12.3) re staff medication competencies.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.****Audit Evidence****Attainment:** FA**Risk level for PA/UA:****Finding Statement****Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: PA**

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

Eight staff files were reviewed. Appointment documentation is seen on file including signed contracts, orientation, training and reference checking. The infection control coordinator has an infection control job description as this is part of her portfolio. There is an annual appraisal process in place.

**Finding Statement**

Six of eight staff files do not have a signed job description in their files. On interview the human resources assistant stated that staff are given their job descriptions to take home. Five of eight staff files reviewed do not have a current annual appraisal.

**Corrective Action Required:**

Ensure staff annual performance appraisals are current.

**Timeframe:**

3 months

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: PA**

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

The service has a training policy and two year training schedule for staff in-service education. The in-service schedule is implemented.as per the documented schedule.

### Finding Statement

The staff roster evidence that there are five caregivers who work night shift and who are rostered permanent night duty. In the five caregivers staff files and training records there is no evidence that any of these five caregivers have attended the following training in over two years: restraint, continence, challenging behaviour, code of rights and infection control.

#### Corrective Action Required:

Ensure night staff attend inservice training.

#### Timeframe:

3 months

### 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  Ma  V  CQ  SQ  STQ  Ma  L

#### How is achievement of this standard met or not met?

**Attainment: FA**

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

The daily roster states that there are the following staff on each day:

am – one clinical lead (Mon-Fri), two RN's, rest home - two caregivers and hospital - eight caregivers,

pm – two RN's, rest home - two caregivers and hospital – five caregivers ,

nights - one RN and three caregivers.

A contractor physio attends the facility for two hours a week.

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

#### Audit Evidence

**Attainment: FA**

**Risk level for PA/UA:**

## Finding Statement

Corrective Action Required:

Timeframe:

### STANDARD 1.2.9 Consumer Information Management Systems

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

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

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

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

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

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

Care plans and progress notes are legible, signed and dated by the RN's, EN's and caregivers. Medical notes and allied health input are signed and dated appropriately.

D7.1: Entries are legible, dated and signed by an 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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
Corrective Action Required:		
Timeframe:		

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Residents have a needs assessment completed prior to entry to ensure eligibility. The service has admission and decline to entry policies. These are clearly documented and explained to the prospective resident and family. Prospective residents and families are informed of the services the facility provides and are provided with a comprehensive information pack.

12 residents interviewed (six rest home and six hospital), all confirmed 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.

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment:</b> FA
Waikanae Country Lodge has an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member is informed of the reason for declining entry. This is confirmed on an interview with the clinical team leader.	

**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.

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		

Timeframe:

### STANDARD 1.3.3 Service Provision Requirements

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

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

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

#### How is achievement of this standard met or not met?

Attainment: PA Low

Each stage of the service provision is undertaken by the clinical team leader or RNs. The clinical team leader has a post graduate degree in primary care and she is supported by a senior RN who has many years of experience in elderly care in Australia and NZ. The clinical team is also supported by the nurse practitioner who is employed by the local DHB.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. There are written and verbal hand-overs between shifts and staff interviews confirm handover between shifts occur. The handover from am to pm shift was attended by the auditor. This process includes written documents from caregiver handover notes, RN handover and clinical team leader handover notes which includes GP and medical update. Eight resident's files reviewed showed that the care plans demonstrate team approach into evaluations. Multidisciplinary reviews evidence team/multidisciplinary approach to reviews. Five caregivers (three hospital and two rest home) and three RNs interviewed confirm continuity of service delivery is maintained.

The telephone interview with the GP confirms the staff inform the GP of any medical issues and concern in a timely manner. The GP prescribed treatments are followed by staff and any change in residents' condition is reported to the GP. There are mainly two GPs that provide services on site three times a week. D16.2, 3, 4: The eight files reviewed (four from each areas ), identified that in all eight files an assessment was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. All eight care plans evidenced evaluations completed at least six monthly.

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

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) nutrition, b) mobility, c) falls risk, d) skin integrity, e) continence and f) mood/ behaviour assessments. Wound assessments completed as required. There is also new pain assessment tool and pain aid scale for resident with dementia but these are not always utilised. See CAR.1.3.4.2.

Tracer Methodology: Hospital

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

Tracer Methodology: Rest home

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

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment:** PA

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

Seven out of eight files reviewed showed that the service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. This is also confirmed on interview with the GP who provides weekly services to Waikanae Country Lodge.

**Finding Statement**

One resident's nutritional profiles is not implemented in delivery of food services. It was the resident's choice to have a jam sandwich at supper however the clinical staff were not aware that this occurs. The kitchen staff failed to record the resident as an insulin dependent diabetic when the nutritional profile clearly included all this information. The clinical staff interviewed also were not aware why the decision around monitoring of the resident's blood sugar level had changed in April, this had not been reviewed since then.

**Corrective Action Required:**

Ensure that communication with the kitchen occurs and nutritional profiles are taken into account in delivery of the food services. Ensure that blood sugar level monitoring occurs.

**Timeframe:**

6 months

**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

A range of assessment tools are completed in resident files on admission, three week post admission and at least six monthly thereafter with the exception of pain assessments.

A new post fall observation and assessment form was introduced, the interview with the clinical team leader and a review of the documents showed that there has been a reduction in the number of falls in the facility.

Notes by the GP and allied health professionals are evident in eight of eight residents' files sampled. Families interviewed (six hospital and two rest home) are complimentary of the clinical and medical care provided and confirm they are kept informed of any significant events, changes in health status and are involved in the care planning.

Following the post fall assessments, physiotherapy and /or GP input is obtained.

Two staff ( one had resigned) completed InterRAI training. The clinical team leader stated that 10 residents have InterRAI long term care plans completed but these were not in use on the day of the audit.

**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

A range of assessment tools were completed on admission and again three weeks later and at least six monthly thereafter.

### **Finding Statement**

1) There is a new pain assessment tool and pain aid scale for residents with dementia but these are not always utilised. Residents who receive control drugs and regular pain relieving medicines do not have completed pain assessments in both the rest home and the hospital. 2 ) One of the files reviewed showed that a resident was most recently transferred from rest home to hospital level care and re assessments were not completed.

### **Corrective Action Required:**

Ensure that pain assessments are completed for the residents who require pain medication, controlled drug or express pain or discomfort. Ensure that assessments are completed when residents level of care changes from rest home to hospital level care.

### **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  Mal  V  CQ  SQ  STQ  Ma  L

### **How is achievement of this standard met or not met?**

**Attainment: FA**

All eight residents' files reviewed showed that the clinical care or interventions are clearly documented and based on the assessed needs of the residents. Appropriate interventions are recorded on the care plans and the medical treatment plans as a result of risk assessment findings ( with the exception of one file which is identified in CAR 1.3.4.2.) All eight of eight care plans viewed evidenced resident or family/whanau involvement in the care planning process and reviews six monthly where appropriate.

All eight files reviewed showed that a multidisciplinary team involvement There is a contracted physiotherapist who visits regularly. A geriatrician, GPs, nurse practitioner and the clinical team leader complete resident reviews case by case. The clinical team leader stated that this process also provides opportunity for support and professional advice to the clinical team.

A nurse practitioner employed by the local DHB provides staff training and supports staff in addressing complex medical issues and this is evidenced in the sample files. Mary Potter Hospice nurse educators and the community liaison nurse provides staff education and this is also documented in the training records.

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

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

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

Eight out of eight residents' files sampled showed that the care plans document appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required clinical care/treatment is recorded. Staff utilise written progress notes to record any current issues. The GP documentation and records are current.

Eight out of eight residents interviewed confirm that current care and treatments they are receiving, meets their needs.

A physiotherapist is contracted to the service to provide assessments, advice and education.

Geriatrician, GP, nurse practitioner, clinical team leader, complete resident reviews.  
 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. September 2011 and October 2012 respectively.  
 Wound assessment and wound management plans are in place for 13 residents (one rest home and 12 hospital) which include 11 minor skin tears, one pressure sore (on admission) and one surgical wounds.  
 Three RNs 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.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
There are two diversional therapists that are responsible for the rest home and the hospital residents. The diversional therapy plan is developed on admission to the service identifying special needs, their likes, dislikes and past hobbies.	

The diversional therapists discuss preferred activities with the residents and or their families such as types of activities that they enjoyed in the past and what their interests are and activities offered commensurate with their needs and functional capabilities. People living in apartments may attend activities as they wish. There is a van available for outings.

All 12 residents ( six from each areas) interviewed confirmed satisfaction with the program. Activities programmes are openly displayed and made available to all residents and relatives. Visitors from the community attend to provide entertainment (e.g., a piano player, and school children). Different church denominations visit the home.

16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment:** FA

Care plan evaluations are completed at least six monthly or more often when required. Evaluations are resident focused and indicates degree of achievement against the identified goals and interventions.

Progress notes include notes around start and completion date of short term care plans or interventions. The handover process includes written information from the RN and the clinical nurse leader and contains new interventions and outcomes of multidisciplinary reviews. Resident files reviewed included examples where a resident was transferred to the public hospital following a stroke, three files had geriatrician input and one file had a nurse practitioner input. Physiotherapy review is recorded in all files reviewed.

Progress reports are completed in each shift and includes changes in resident' condition and these are followed up by the clinical nurse leader.

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

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

Appropriate referrals to other health and disability services occur. Resident files reviewed included an evidence of referrals to a geriatrician, nurse practitioner, dietician, podiatrist and specialists from the local DHB.

Resident and family interview confirms access to specialist services and other health providers.

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 a physiotherapist, geriatrician, podiatrist, GP, nurse practitioner, Parkinson's field officer, Mary Potter Hospice nurse educators, and community liaison nurse.

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Family communication sheets record consultation. Progress notes and medical notes include information about communication with other providers. Discussions with the clinical team leader confirm that a transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, some communication with the family is made.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### **STANDARD 1.3.12 Medicine Management**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: PA Moderate**

Waikanae Country Lodge uses Douglas Medico medication management system, which are delivered in a four week supply. Staff check the delivery regularly and the supplying pharmacy is notified of any medication errors. Medication audits are completed and show full compliance. Medications are prescribed by the residents GP, and printed on a pharmacy-generated medication administration sheet. Signing sheets are most recently updated and comply with current legislative requirements. RNs and EN's administer the medication in the hospital and in the rest home. Controlled Drugs are stored in a locked safe in a locked room. All controlled drugs are managed from one central location for all residents and the control drug register is checked and found to be correct.

A resident who uses alternative medicines which were noted in their file and includes GP input. Medication errors are included in incident reporting. Identification of allergies occurs and this is documented on the drug charts. Appropriate systems are in place for residents who are self-medicating, but there are currently no residents self-administering medications. Sampled medication charts included one resident who receives insulin and one warfarin treatment. A recording of these found to be correct.

Medication reconciliations are conducted and recorded. Medication rounds at lunch times and evenings are observed on the first day of the audit and staff are compliant with the current legislative requirements and medicine management guidelines.

There are improvements required around implementation of medicine management system.

D16.5.e.i.2; 16 medication charts (eight from each areas) reviewed identified that the GP had seen the resident and reviewed the resident three monthly and the medication chart was signed.

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

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

Waikanae Country Lodge medication policies and procedures cover medication prescribing, dispensing, administration, review, storage, disposal and medication reconciliation, and follow recognised standards and guidelines for safe medicine management practice.

**Finding Statement**

1) Six monthly physical stock take of controlled drugs by the pharmacist do not occur. 2) One medication was expired on the first day of the audit (omeprazole in liquid form) but it was administered on the second day of the audit. 3) monitoring of fridge which the drugs are stored does not occur. 4) monitoring of the blood sugar level of a resident who has insulin dependent diabetes mellitus, has not occurred since April 2013. 5) insulin administration is not double checked by staff.

**Corrective Action Required:**

Ensure that six monthly physical stock take from a pharmacist occurs. Expired date of medications are checked and expired medicines are returned to the pharmacy. Ensure fridge temperature is monitored. Insulin administration checked by two staff members who are medicine competent and blood sugar monitoring occurs.

**Timeframe:**

1 month

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

Staff (eight ) received medication training in May 2013.

**Finding Statement**

Staff medicine administration competencies are not current and the June quality report identified this but a follow up was not completed. On the first day of the audit, an enrolled nurse who administered medication did not have a current completed medication competency.

**Corrective Action Required:**

Ensure that all staff who administer medication complete a medication competency.

**Timeframe:**

1 month

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.****Audit Evidence****Attainment:** FA**Risk level for PA/UA:****Finding Statement****Corrective Action Required:**

Timeframe:

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

An inspection of the kitchen and food areas showed compliance with all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal.

There is a four weekly rotating summer and winter menu that is approved by a registered dietician. There is one chef who was recently appointed to this position and there are three kitchen assistants. There are also two staff that assist with the evening meals.

The kitchen has a folder that contains residents' most up to date nutritional profiles and the information displayed on the wall that contains resident's individual preferences and special diets. One rest home file showed that the information in these two places does not match. Please see CAR 1.3.3.4. Specific foods are available such as diabetic or modified foods, developed with dietician input if required. There is a comprehensive cleaning schedule and regular food and cleaning audits are completed.

Food is directly served from the kitchen to the main dining room and transported to the resident's room and the second dining area in hot boxes.

Since the previous audit, the kitchen has been repainted and some fixtures have been renewed. The bench top was altered; new equipment has been purchased for food delivery.

Nutritional assessments are completed by the clinical team leader or the RN on admission and three week post admission and at least six monthly and these includes medical, nutritional and eating abilities, likes, dislikes and abilities, special cutlery or plates and interventions that the resident may require (link CAR 1.3.3.4).

There is a resident nutrition risks & MUST Nutritional assessment. These are new forms to the facility and residents weights are recorded and if their weight loss was more than three kilogram they are reported to the GP for medical review.

Resident's food and or fluid intake is monitored and documented by caregivers. This form is usually completed over a three day period and the RN completes an assessment and then it is forwarded to the GP for medical review. This form is also completed in order to assist the Diabetes Nurse, Dietician or speech language therapist in their review of residents who have been referred requiring their specialist input.

Residents ( six from each area) and family members (two rest home and six hospital) interviewed were satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided. A hospital family member and one hospital resident interviewed stated that they had made a complaint about food services in the past and the management had responded quickly and since then food services have been improved.

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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

There are policies and procedures on the management of waste and hazardous substances. Any incidents are reported on in a timely manner. Staff have received training and education to ensure safe and appropriate handling. Gloves, aprons, foot wear, antibacterial gels and wipes and goggles are available for staff. Chemicals are labelled

and stored safely. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols.

**Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### **STANDARD 1.4.2 Facility Specifications**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment:** PA Low

The building has a current WOF due for expiry 30 Nov 2013 an approved NZFS evacuation scheme in 13 May 2004. There is sufficient space so that residents are able to move around the facility freely. The hallways are wide enough with handrails appropriately placed.

External areas and gardens surrounding are well maintained. Ramps to the outside areas provide safe access for residents and visitors. Pathways are maintained.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, seven hoists, heel protectors, lifting aids walk in scale. Interviews with 12 residents confirmed that if any repairs/maintenance are required and that requests are appropriately actioned and stated that they can easily access the outside areas and garden areas is always well maintained.

Audit identified an improvement required around maintenance services.

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

**Audit Evidence**

**Attainment:** PA

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

Maintenance services are provided by the maintenance person.

**Finding Statement**

There are regular checks of the building and equipment documented and carried out by the maintenance person but following are noted as requiring repair.1) in two bathrooms, wall vinyl's were not intact. 2) hospital dining room door had deep scratches, 3) skirting board painting between rest home to service apartments has not been completed yet and 4) electrical equipment checks are not completed. Some equipment has not been checked and tagged and some equipment last checked in 2010 and stated a re-check in 2011 but this was not completed.

**Corrective Action Required:**

Ensure that electrical equipment checks are completed. Ensure that bathroom vinyl and walls are intact and doors are repaired.

**Timeframe:**

6 months

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

Timeframe:

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

There are 59 rooms. Eight of those rooms have shared bathrooms, 12 rooms have shared toilet facilities, 24 rooms are unsuited. There are adequate communal toilets that are easily accessible.

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Residents rooms are large . There is ample room for mobility with or without aids. On interview, the owner stated that they replaced single opening doors, now all residents who receive hospital level care have double opening doors.

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

There are several lounge areas for activities and relaxation. These are all bright and airy and allow freedom of movement for all residents including those with aids. There are two dining rooms . One is next to the kitchen and second one is a smaller dining room where residents who require more assistance from the staff dine there. Staff and residents stated that the residents can dine in their room if they would like to do so.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

There are designated areas for storage of cleaning/laundry chemicals. There are automatic chemical dispensers in the laundry and chemicals are stored outside the building in a locked cabinet. Chemicals for cleaning is kept in the locked room and all chemicals are labelled with manufacturer's labels. MSDS are available. Chemicals are monitored by Johnson Diversy and cleaning staff interviewed (two) confirmed that they completed chemical training. Laundry services and cleaning audits are completed in 2013 and consumer satisfaction survey also includes monitoring of these services.

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

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

The staffing level provided adequate numbers of staff to facilitate safe care to rest home and hospital level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme on 13 May 2004.

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

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

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

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

Waikanae Country Lodge uses a mix of panel heaters on the walls and ceiling and heat pumps for heating. Discussions with 12 residents stated the home is well heated and ventilated. All residents' rooms and living areas have at least one window.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

## OUTCOME 2.1 RESTRAINT MINIMISATION

### STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

#### How is achievement of this standard met or not met?

**Attainment: FA**

There is a Restraint Minimisation Manual applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and the use of enablers. The Restraint Minimisation Manual includes that enablers are voluntary and the least restrictive option. There are seven residents with enablers (one lazy boy (feet up), one chest harness and five bed rails) and seven residents requiring restraint (two fall out chairs, one fall out chair and bed rails and four harnesses), in the hospital. Seven enabler files were reviewed and included consents and assessments.

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The restraint coordinator is an RN. The coordinator has been in the role for one month. The clinical team leader is working currently with the restraint coordinator in the capacity to mentor and review restraint in the facility. Assessment and approval process for a restraint intervention includes the RN, resident/or representative and medical practitioner. There is a restraint meeting (link CAR 1.2.3.6).

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

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

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

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

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

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

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;

- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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.

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

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

Restraint practices are reviewed on a formal basis every monthly by the facility restraint co-ordinator and through restraint committee meetings. A restraint evaluation is completed for each individual month. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the resident, family, restraint co-ordinator and GP.

**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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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  Mal  V  CQ  SQ  STQ  Ma  L

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
Approved restraint process for individuals is to be reviewed at least three monthly by the restraint approval group and as part of the annual multidisciplinary review with family/whanau involvement.	
Restraint usage across the facility is monitored monthly . There is a monthly restraint meeting (link CAR 1.2.3.6) re restraint information in staff meeting minutes.	

**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.

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

### 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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment:</b> FA
<p>The infection control (IC) coordinator is an RN and has been in the post for two years. The IC coordinator can access external specialist advice from GP's, laboratories and DHB IC specialists when required. The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the coordinator and external expertise when required. IC is a standing agenda item at the monthly staff/quality meetings and monthly RN meetings (minutes viewed). Staff are informed about IC practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC coordinator and entered into the infection register.</p> <p>There is a job description for the IC coordinator including the role and responsibilities of the infection control coordinator. IC is part of the audit schedule and is undertaken monthly. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine.</p>	

**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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
Corrective Action Required:		

Timeframe:

### STANDARD 3.2 Implementing the infection control programme

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

ARC D5.4e ARHSS D5.4e

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

#### How is achievement of this standard met or not met?

**Attainment: FA**

The IC coordinator is a registered nurse. IC matters are taken to all staff meetings (minutes reviewed). The IC coordinators can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. They are responsible for reviewing the IC programme annually. The coordinator complies with the objectives of the infection control policy and work with all staff to facilitate the programme. The coordinator has attended DHB specialist groups and training. Staff complete annual infection control education. Access to specialists from the DHB, laboratories and GP's is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### STANDARD 3.3 Policies and procedures

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

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

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

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

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

**Criterion 3.3.1 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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

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

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.4.5** Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5** Surveillance

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

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

**How is achievement of this standard met or not met?**

**Attainment:** FA

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Waikanae are appropriate to the acuity, risk and needs of the residents. The IC coordinator enter information on infections on to the infection register and carry out a monthly analysis of the data. The analysis is reported

to the monthly staff meetings (minutes viewed). The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility.

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

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

