**Clair House Limited**

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

Claire House provides care for up to 54 rest home residents. The current occupancy is 52 rest home residents. The service also provides physical disability services and seven of the 52 residents are under 65 years old.

Claire House Limited is a family organisation with three managers now designated as having leadership roles (manager, assistant manager and administrator). The owner is the manager at Claire House. She has owned the facility for 28 years. She is supported in the manager’s role by the other two managers, the two registered nurses and a stable workforce.

The manager has developed a current business plan that includes goals, quality improvement and risk management and the mechanism for monitoring progress. The plan is being implemented. All residents and relatives interviewed spoke highly about the care and support provided by staff and management.

There is an improvement required around medication management. Two continued improvement ratings have been awarded for quality and risk management systems and good practice.

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

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  26-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. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Organisational Management** | Day of Audit  26-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. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Continuum of Service Delivery** | Day of Audit  26-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit  26-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. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  26-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. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  26-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. |  | **Standards applicable to this service fully attained** |

**Audit Results AS AT** **26-Aug-13**

**Consumer Rights**

Claire House strives to ensure that care is provided in a way that focuses on the individual and maintains their privacy and choices. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code is available and services are easily accessible to residents and families. Policies are implemented to support residents' rights, privacy and respect for stakeholders. Annual staff training that includes rights, advocacy services and open disclosure reinforces a sound understanding for staff of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and record cultural and spiritual needs and wishes within a holistic assessment and plan. Complaints processes are implemented and complaints and concerns are actively managed and well documented. Informed consent forms and advance directives are signed by the resident on the admission and all sign an agreement that includes payment for services if this is required.

**Organisational Management**

Claire House has a quality and risk management system in place that is well implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of restraint use and risk management. All staff, residents and family are involved in discussions around quality improvement and meetings minutes are documented and held monthly (quality, health and safety and staff meetings). The service is active in analysing data with evidence of resolution of any issues identified. Family satisfaction surveys are completed annually and resident surveys are completed two monthly with a focus on different aspects of the service. Health and safety policies, systems and processes are implemented to manage risk. Benchmarking with other organisations through an external consultant and analysis of trends leads to improvements.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents and family state that there is sufficient staff on duty at all times. There is a comprehensive orientation programme that provides new staff with relevant information and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

A rating of continuous improvement has been awarded for the quality and risk management programme.

**Continuum of Service Delivery**

The service has an admission process and policies. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. The registered nurses are responsible for each stage of service provision.

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

Medicines are managed and policies reflect legislative requirements. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around medication documentation.

The activities programme is facilitated by an activities officer. The activities programme provides varied options and activities are enjoyed by the residents. Each resident has an individualised plan and there are suitable activities for those under 65 years old. Community activities are encouraged.

All food is cooked on site by a cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented, homely and the menu plans have been reviewed by a dietician.

**Safe and Appropriate Environment**

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

The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. The buildings, plant and equipment comply with legislation, with documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

Documented systems are in place for essential, emergency and security services. Staff interviews and files evidence current training in relevant areas. Alternative energy and utility sources are available if required. An appropriate call bell system is available and security systems are in place.

**Restraint Minimisation and Safe Practice**

The restraint management policy states that enablers are voluntary. Restraint is not used in the service. There are no residents that require enablers as confirmed on the day of the audit by the manager and registered nurses interviewed and through observation. Behavioural management plans are sighted in files reviewed when challenging behaviour is identified and staff attended training last in July 2012. Health care assistants interviewed describe individualised strategies as per the resident plans to manage any challenging behaviour.

**Infection Prevention and Control**

The infection control coordinator role is shared by both registered nurses. 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.

Claire House Aged Care Facility

Clair House Limited

Certification audit - Audit Report

Audit Date: 26-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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| **Provider Name** | Clair House Limited |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Claire House Aged Care Facility | 91 Prospect Terrace | Mt Eden | Auckland |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 26-Aug-13 **End Date:** 27-Aug-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

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| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RN, Dip HEd, BSc, Health Auditor | 12.00 | 8.00 | 26-Aug-13 to 27-Aug-13 |
| Auditor 1 | XXXXXXX | RGON, MBA, MN, Lead Auditor | 12.00 | 6.00 | 26-Aug-13 to 27-Aug-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXX | RCompN, Health audit cert |  | 2.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 24.00 | **Total Audit Hours off site** *(system generated)* | 16.00 | **Total Audit Hours** | 40.00 |
| **Staff Records Reviewed** | 7 of 42 | **Client Records Reviewed** *(numeric)* | 8 of 52 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 8 |
| **Staff Interviewed** | 12 of 42 | **Management Interviewed** *(numeric)* | 1 of 3 | **Relatives Interviewed** *(numeric)* | 5 |
| **Consumers Interviewed** | 9 of 52 | **Number of Medication Records Reviewed** | 26 of 52 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 9 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*): 🗷

# Services and Capacity

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|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Claire House Aged Care Facility | 54 | 52 |  | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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There is an improvement required around medication management. Two continued improvement ratings have been awarded for quality and risk management systems and good practice.

1.1 Consumer Rights

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2 Restraint Minimisation and Safe Practice

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3. Infection Prevention and Control

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Summary of Attainment

* 1. Consumer Rights

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

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

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | CI | 1 | 7 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:1 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 34): CI:1 FA:21 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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

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

* 1. Safe and Appropriate Environment

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

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 8 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:17 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 1 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 1 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 3 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 2 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 1 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 5 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:0 FA:1 PA:0 UA:0 NA: 8 |

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 5 **CI:** 2 **FA:** 42 **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  **Total Criteria (of 219) CI:** 2 **FA:** 90 **PA:** 1 **UA:** 0 **N/A:** 8 |

# Corrective Action Requests (CAR) Report

Provider Name: Clair House Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:26-Aug-13 End Date: 27-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.12 | 1.3.12.6 | PA  Low | **Finding:**  Of 26 medication charts viewed: one residents medication chart had two separate gaps of signatures for night time medications for August 2013. Analgesia and antihistamines were prescribed for the resident at night time. One of 26 medication charts had the date and number of tablets written in the signature box but had no signature for the medication prescribed. The sample of charts was extended to 26 and no further problems identified. On day one of the audit, following the identification of the error all caregivers on morning and afternoon shift in the wing where the omissions had occurred were provided with a medication education session and their competencies are being reviewed.  **Action:**  Ensure medication prescribed is administered and signed for. | 1 month. |

# Continuous Improvement (CI) Report

Provider Name: Clair House Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:26-Aug-13 End Date: 27-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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| --- | --- | --- |
| **Std** | **Criteria** | **Evidence** |
| 1.1.8 | 1.1.8.1 | **Finding:**  Claire House has undertaken a number of initiatives and programmes to provide an environment that thrives on best practice. A new form has been developed for accident/incident analysis to better identify trends and reduce the falls rate. As part of the programme to reduce falls one high risk faller has been identified and a version of the DHB ‘hourly rounding’ initiative implemented where the staff ask the resident at least hourly ‘is there anything I can help you with?’. This initiative was commenced in 2013 and has resulted in falls reduction for this resident. There is evidence in the April 2013 staff meeting minutes of discussion and training around this and all are familiar with the project. Claire House has also been part of the DHB first do no harm project. This project is initiated by the DHB and is to reduce falls. Staff have attended the training and since the project commenced quality data shows falls have reduced. It was identified that some of the Claire House internal audits were not especially relevant to the service. The internal workbook has been updated along with a new corrective action plan/quality improvement plan template. This has resulted in Claire House better being able to identify and rectify service shortfalls. There has been a significant increase in corrective action plans and quality improvement plans since the new internal auditing process was implemented. Claire House has a number of residents who present behaviours that challenge and as a result of incident analysis and staff feedback the service introduced new challenging behaviour plans in March 2013. Since this time there has been a reduction in challenging behaviour incidents. Staff undertook training in behaviour management in May 2013 and staff spoken to have been very positive about the new challenging behaviour plans. Also as a result of the review of challenging behaviour management two residents have Wandertrack GPS trackers. Claire House provides very thorough staff meeting minutes for all staff to read. An average monthly meeting minutes is six pages long and contains details about residents, projects, quality indicator data and analysis and areas for improvement. All staff read and sign the minutes as they sometimes contain more detail than the actual meeting. Claire House runs a primary nurse system with a one to eight ratio. One health care assistant is responsible for eight residents for an eight week period before rotation occurs. This means they are responsible for all cares and medications for the eight residents under their care. The service has developed a treatment and needs plan which includes a high level of detail about resident likes and dislikes. This is to a greater level of detail than can be included in the care plan. Examples include the order a resident might take their pills in or the material and colour of pillow case a resident prefers. All staff interviewed report these treatment and needs plans are very useful and they support continuity of care for residents. These documents are primarily completed by the health care assistant and when a need is identified for a change in the care plan the RN is informed and the care plan is changed by the RN. Clair House also has a resident of the week where for each area of eight residents the health care assistant completes a resident of the week form that includes specific details about the residents care and any changes or challenges with the resident This data is used to provide continuity of care and allow constant care plan updates. |
| 1.2.3 | 1.2.3.1 | **Finding:**  The quality and risk management programme is fully integrated with cross referencing in all documents. Any complaints arising from the resident meetings for example are logged onto the complaints register with documentation indicating that they are followed up. There is also documentation in the staff, quality and health and safety meetings showing evidence that complaints are discussed and learnings taken from the discussion. The staff meeting minutes are comprehensively documented with full discussion reported. This enables any staff member who is unable to attend to follow by reading the minutes and have input into the discussions. Discussion and analysis of trends is documented with evidence of improvements in service delivery. All documentation is fully completed as per policy and this includes completion of satisfaction surveys and internal audits. The service has an external consultant who benchmarks data for the rest home against other services with a similar profile. The manager and staff analyse the data and again use the information to improve service delivery. The six caregivers state that they are fully informed and involved in the quality programme and the use of clip board in the office (locked when not in use) enables a quick reference for resident and other concerns, key appointments for residents and key quality improvements. Health care assistants and other staff state that the quality programme is also linked to the annual training plan with extra and impromptu training offered as issues are identified. The service takes every opportunity to be involved with initiatives led by Auckland DHB and has implemented the 'do no harm' project to reduce falls with evidence of monitoring of outcomes. They are currently involved in the 'Stop and Watch' early warning tool that provides guidelines around assessment of a resident with changes in state/behaviour. The service is to be commended for the depth of discussion documented in minutes, the knowledge of staff interviewed including the six health care assistants who are fully informed and feel very involved and for the improvements made to service delivery as a result of the information gathered and analysed. |

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, code of rights information, advocacy and information around the Health and Disability Commission.

The code of health and disability rights is incorporated into care. Staff training around the code of rights including open disclosure and complaints was last provided in January 2013 facilitated by the Health and Disability advocate. Discussions with six of six health care assistants (two on the afternoon shift and four on the morning shift), the two registered nurses and the manager identified their familiarity with the code of rights.

A review of eight of eight care plans including two under 65 years residents, monthly quality meetings, monthly health and safety meetings and monthly staff meetings confirm that the service functions in a way that complies with the code of rights.

Observation during the audit confirmed this in practice.

Nine of nine residents interviewed including two under 65 years residents confirm that they receive services consistent with legislation.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, information on the code of rights, advocacy and Health and Disability Commission. Code of rights leaflets are available in the service.

Resident's right to access advocacy services is identified for residents and advocacy service leaflets are available. If necessary, staff will read and explain information to residents. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.

Discussions with six of six health care assistants (HCA's) identified they are aware of the right for advocacy and how to access and provide advocacy information to residents if needed. They also state that they can give residents information around advocacy services at any time. This is reinforced by the manager and two registered nurses who also state that they can provide residents with information around advocacy services.

On entry to the service, the manager or a registered nurse discusses the information pack with the resident and their family/whanau. This includes the code of rights, complaints and advocacy information.

The service provides an open-door policy for concerns or complaints and five of five family members confirmed this. Each resident has a laminated copy of the Code of Health and Disability Services Consumers' Rights behind the door in the bedroom.

Nine of nine residents interviewed confirm that they are familiar with their rights.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

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. The mission statement is 'leading in the provision of premium quality, client focused residential care'.

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 if the resident or family identifies that they want this.

D4.1a Resident files reviewed (eight of eight including two identified as under 65 years), identified that cultural and /or spiritual values, individual preferences and values are identified. The cultural assessment page identifies specific values and beliefs, specific documentation around hapu/iwi/home marae/association with marae/next of kin and spokesperson, other cultural support, specific needs related to Maori, specific needs during palliative care or at a time of death related to religion or culture.

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Resident support needs are assessed using a holistic approach. Interventions to support these are identified and evaluated.

Residents are addressed by their preferred name and the preferred name is documented on the admission form.

A policy is available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality in an appropriate and discreet manner. There is one married couple who are supported to have time together and one of the partners states that they can have time together that is private.

There is a policy that covers abuse and neglect and staff have completed training last in June 2012 facilitated by Age Concern.

D5.4q There is a spiritual and counselling policy that includes availability of chaplaincy. Discussions with the registered nurses, six caregivers and nine residents confirm that residents are able to access spiritual support of their preference. During the resident admission, spirituality and religion are discussed and documented. There are visits by a Roman Catholic priest for holy communion and there is a monthly Anglican church service attended by any residents regardless of church affiliation.

Nine of nine residents and five of five family members interviewed were able to confirm that their privacy and dignity was respected and staff were observed to be respectful on the day of the audit.

Resident files are held in a locked office in Claremont and in locked cupboards in the Claire Villa and in Fleurmont wing.

**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

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e) and this has last been reviewed in March 2010 and again as part of the policy review in January 2013.

The services' policies and procedures provide evidence that the service is able to access appropriate Maori cultural advice to support the delivery of care to Maori residents. The policy manual includes information about the cornerstones of health, death of a Maori resident and other information relevant to the staff.

There is a culture policy and procedures that include accessing interpreter services if required.

D20.1i There is an external consultant /cultural advisor with linkage to Maori stakeholders and community groups.

There are no Maori residents currently. In the past the manager states that Maori residents have been asked by the external consultant if they want to have any specific cultural needs met and the answer has been no.

Discussions with the six health care assistants indicate that they have an awareness of the need to respond appropriately to the cultural values and beliefs of Māori.

Individual cultural values are identified and documented through the assessment and admission processes and staff make every effort to assist residents to practice their cultural values. There is a specific cultural assessment completed for all residents and this includes documentation of hapu, iwi, cultural support people, specific needs related to Maori culture and specific needs e.g. in palliative care.

Family/whanau involvement is actively encouraged through all stages of service delivery. Family/whanau are invited to attend resident clinical reviews. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

D3.1g The service provides a culturally appropriate service by asking residents and family members what their cultural needs are at each assessment, plan and review and through strong links with the community.

D4.1c Eight of eight care plans reviewed include the residents social, spiritual, cultural and recreational needs. During the admission process, a registered nurse and the manager along with the resident and family/whanau complete the documentation.

Regular reviews are evident and the involvement of family/whanau is recorded in the resident care plan.

Family members interviewed (five of five) state that they are involved in decision making around the care of the resident.

There are no residents who identify as requiring an interpreter however the manager is able to describe how an interpreter would be accessed. The manager and registered nurses describe a current resident who is lapsing into Japanese language because of her dementia but all state that she still understands and speaks English.

Claire House philosophy focuses on providing holistic care flows through into each resident care plan and this can be described by six health care assistants and the two registered nurses interviewed.

The service establishes links with family/whanau or other appropriate representatives as required.

There is an open door policy for family and the manager is on site. This allows family to keep in touch with the manager at any time.

Five family members and nine residents confirm that they are able to meet with management if they have concerns or questions about care.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. Staff can describe how professional boundaries are maintained. Discussion with the manager and a review of the complaints register identify that there have been no complaints regarding alleged harassment, coercion, discrimination or abuse of any kind.

There is an abuse and neglect policy. Education regarding the code of rights and abuse and neglect is provided during the orientation of new staff and annually as part of the in-service training programme. Attendance is documented and was last completed in January 2013 (2011, 2012, 2013 records sighted) around rights and advocacy services and in June 2012 around abuse and neglect.

Residents interviewed all state that there is no evidence of discrimination, coercion, harassment or other exploitation.

Staff were observed to have professional boundaries around the way they work with residents and all health care assistants state that there is definitely no evidence of abuse or neglect.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

A2.2 Services are provided at Claire House that adhere to the health and disability services standards. There is an implemented quality improvement programmes that includes performance monitoring, benchmarking against other organisations of similar size and mix of residents.

D1.3 All approved service standards are adhered to noting that there are some standards identified as partially achieved.

D17.7c There are implemented competencies for health care assistants and registered nurses (two) around medicines. There are clear ethical and professional standards and boundaries within job descriptions.

Nine of nine residents and five of five family members interviewed spoke very positively about the 'excellent' care provided with the environment.

The service links into the CANZ (Care Association NZ) as a member and for training with the manager attending two monthly meetings. The service is introducing the CANZ policies which will continue to be implemented.

A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery.

There is an internal audit schedule. It includes hazardous substances; documentation; medications; staff levels, skill mix and rosters; care plans; infection control; cleaning; food service; safe environment; emergency medical equipment; laundry; restraint; health and safety.

Nine residents and five family members interviewed spoke very positively about the ‘excellent' care provided using terms such as good communication, approachable staff, homely, good environment etc.

The manager is a member of the NZ Aged Care Association.

The service has linked into Auckland DHB initiatives including being part of the 'do no harm' project around reduction of falls with strategies implemented and they are now part of the working group around the development and implement of early warning tools that involve a tiered assessment process (HCA and registered nurse) to prevent residents being admitted into hospital.

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

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

The service links into the CANZ (Care Association NZ) as a member and for training with the manager attending two monthly meetings. The service is introducing the CANZ policies which will continue to be implemented.

A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery.

**Finding Statement**

Claire House has undertaken a number of initiatives and programmes to provide an environment that thrives on best practice. A new form has been developed for accident/incident analysis to better identify trends and reduce the falls rate. As part of the programme to reduce falls one high risk faller has been identified and a version of the DHB ‘hourly rounding’ initiative implemented where the staff ask the resident at least hourly ‘is there anything I can help you with?’. This initiative was commenced in 2013 and has resulted in falls reduction for this resident. There is evidence in the April 2013 staff meeting minutes of discussion and training around this and all are familiar with the project. Claire House has also been part of the DHB first do no harm project. This project is initiated by the DHB and is to reduce falls. Staff have attended the training and since the project commenced quality data shows falls have reduced. It was identified that some of the Claire House internal audits were not especially relevant to the service. The internal workbook has been updated along with a new corrective action plan/quality improvement plan template. This has resulted in Claire House better being able to identify and rectify service shortfalls. There has been a significant increase in corrective action plans and quality improvement plans since the new internal auditing process was implemented. Claire House has a number of residents who present behaviours that challenge and as a result of incident analysis and staff feedback the service introduced new challenging behaviour plans in March 2013. Since this time there has been a reduction in challenging behaviour incidents. Staff undertook training in behaviour management in May 2013 and staff spoken to have been very positive about the new challenging behaviour plans. Also as a result of the review of challenging behaviour management two residents have Wandertrack GPS trackers. Claire House provides very thorough staff meeting minutes for all staff to read. An average monthly meeting minutes is six pages long and contains details about residents, projects, quality indicator data and analysis and areas for improvement. All staff read and sign the minutes as they sometimes contain more detail than the actual meeting. Claire House runs a primary nurse system with a one to eight ratio. One health care assistant is responsible for eight residents for an eight week period before rotation occurs. This means they are responsible for all cares and medications for the eight residents under their care. The service has developed a treatment and needs plan which includes a high level of detail about resident likes and dislikes. This is to a greater level of detail than can be included in the care plan. Examples include the order a resident might take their pills in or the material and colour of pillow case a resident prefers. All staff interviewed report these treatment and needs plans are very useful and they support continuity of care for residents. These documents are primarily completed by the health care assistant and when a need is identified for a change in the care plan the RN is informed and the care plan is changed by the RN. Clair House also has a resident of the week where for each area of eight residents the health care assistant completes a resident of the week form that includes specific details about the residents care and any changes or challenges with the resident This data is used to provide continuity of care and allow constant care plan updates.

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

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 folder includes pamphlets and booklets including Seniorline, Long Term Residential Care for Older People , Residential Care Loan, ADHB Moving into Residential Care, ADHB list of residential services. There is also a fact sheet around subsidies.

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 as confirmed by residents and family interviewed.

D16.4b Five of five relatives state that they are always informed when their family members health status changes.

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

There are no residents using sign language, braille or other communication aids.

There are no residents requiring the use of an interpreter noting that the information pack for new residents describes access to interpreters if required.

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service continually and as required. Family are involved in the initial care planning and receive and provide ongoing feedback. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs.

Five of five family members interviewed report that they are always informed promptly about incidents or a change in health status.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

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

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

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

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure. Interviews with six HCA's 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 eight resident files reviewed including two under 65 years residents have 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.

D13.1: There were eight admission agreements sighted and eight had been signed on the day of admission

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

D4.1d; Discussion with five family identifies 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/whanau and chosen social networks.

Client right to access advocacy services is identified for residents and is available in the service. The information identifies who the resident can contact to access advocacy services. Information provided to residents prior to entry to the service provides them and family/whānau with advocacy information. Staff are aware of the right for advocacy and how to access and provide advocacy information to residents if needed and training has been provided last in January 2013 (2011 and 2012 training also sighted).

D4.1d; Discussion with nine residents and five family members identifies that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.

**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

D3.1.e Discussion with the six of six health care assistants, the two registered nurses, the manager and five relatives confirms that they are supported and encouraged to remain involved in the community and external groups such as church, two dollar shopping, Laura Fergusson for physiotherapist, movies, restaurants, library. Residents were sighted being involved in the community on the day of the audit including taking buses and walking.

The service has open visiting and relatives were sighted coming and going on the day of the audit.

D3.1h Discussion with five family members identified that they are encouraged to be involved with the service and care and state that they can come to the facility at any time.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

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

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

There is a complaints policy that complies with Right 10 of the Code. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaints forms are available in the building and there is . Staff is aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau.

Residents and family/whanau confirm they are aware of the complaints process and they would make a complaint to the manager if necessary. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack.

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

A complaints folder is maintained with all documentation including acknowledgement letters, investigation reports and follow up letters. These demonstrate that complaints are actively managed in accordance with the policy. The register records monthly summaries of complaints and there have been 11 in 2013. 10 of the 11 are very low level complaints captured through verbal feedback from residents and from the monthly resident meetings e.g. white fluff on blue shorts, soup not hot, chips not cooked enough. One of the complaints is around care (staff member squeezed the resident hand while giving cares) and this has been investigated extensively with the resident, staff involved and the family member who is very happy with the outcome of the review.

There have been no complaints in the last 12 months with the Health and Disability Commissioner - one complaint from a member of the public (24 April 2012) since the last surveillance audit, signed off 15th October 2012 with no further follow up required.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

**STANDARD 1.2.1 Governance**

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

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

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

Claire House Limited is a family organisation with three managers now designated as having leadership roles (manager, assistant manager and administrator). A mission statement (leading in the provision of premium quality, client focused residential care) and values are documented. The philosophy of care is to 'provide for our residents the highest standard of care'.

The organisation offers rest home level care with 52 residents currently occupying Claire House (54 beds total). The service provides physical disability services and seven of the 52 residents are under 65 years old.

A business plan is documented annually with evidence of monthly review. The key focus of the organisation for this year has been and continues to be to reduce falls.

Claire House has quality and risk management systems that are well implemented. The service has an experienced manager (director) who is supported by two registered nurses. The organisation also has an assistant manager.

ARC,D17.3di (rest home) The manager has maintained at least eight hours annually of professional development activities related to managing a rest home and workshops attended in 2013 include NZ Aged Care Association one day workshop, oral hygiene, cultural safety, pain management, employment law, rights/advocacy/open disclosure, outbreak planning and management, management of diabetes. She is a member of CANZ and the NZ Aged Care Association. A review of the 2012 training completed by the manager indicates that she has exceeded eight hours of training. She has also completed annual medication competencies. She has been the director and manager of the service since 1985 when it was purchased.

The manager lives in an adjourning property and is available 24 hours a day/seven days a week if necessary.

The general practitioner interviewed states that there is confidence in the manager and registered nurses who provide care.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

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

The assistant manager provides operational management in the absence of the manager. She is a trainee registered nurse and has been orientated by the manager to the role. The manager has confidence in her ability to provide leadership and is continuing to mentor her. She is fully supported by the managers with the registered nurses continuing to provide support and clinical oversight in the absence of the manager.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The service has a business plan and quality and risk management programme that is implemented. The service has in place a range of policies and procedures to support service delivery and these are reviewed regularly by an external consultant along with the manager and registered nurses. The registered nurse interviewed states that at times policies are adjusted to also meet the needs of residents with mental health needs.

Quality data is collected and evaluated and used for quality improvement. Key components of the quality system link to service delivery. Corrective actions are established when issues are identified from these processes.

D5.4 The service has the following policies/ procedures to support service delivery: continence, challenging behaviour with management plans documented for residents requiring this, pain management, personal grooming and hygiene policy, skin management, wound care, transportation of residents, death and policies to guide staff in managing clinical and non-clinical emergencies.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There is evidence on the register that hazards are addressed in a prompt manner.

D19.2g Falls prevention strategies such as providing extra supervision of residents and hourly rounding have been put in place. The service has been part of the 'do no harm' project instigated by ADHB and the goal of the service for the year has been to focus on reducing falls.

There are meetings to ensure that all aspects of the quality and risk management programme are discussed. These include monthly quality and risk meetings, monthly health and safety meetings and monthly full staff meetings.

There is an implemented audit schedule with 2012 and 2013 with all audits reviewed. These evidence corrective actions and resolution against any actions identified.

Resident meetings are provided monthly at the service and this enables residents to have input into the service. The activities coordinator facilitates the meetings and any corrective actions are also recorded in the complaints register to ensure that trends can be reviewed. Nine of nine residents and five of five family members state that they are asked for their opinion and feel that suggestions are valued.

Meeting minutes are documented and evidence of follow up documented in the next meeting minutes and/or on complaints forms/register.

Satisfaction surveys are completed during the year and include an overall satisfaction survey (February and August), the complaints system (March and August), food satisfaction (April and October), family satisfaction (May), activities (July). This includes actions with recommendations implemented if these are identified.

Family interviewed (five) state that they attend planning meetings and are able to give suggestions through informal 'chats' with manager, registered nurses and staff. They also state that they are informed of the resident meetings and can attend if they choose.

Residents interviewed (nine) state that they are encouraged to 'have a say' at the resident meetings and inform managers if they have any issues.

The service has an external consultant who supports policy development and enables benchmarking against other rest homes of a similar profile. Trends are analysed with evidence of improvements in service delivery.

The service links with ADHB initiatives and has implemented the 'do no harm ' project. The manager is represented on the project team for ADHB around 'Stop and Watch' early warning tool.

D5.4 The service has policies and procedures that align with the resident care plans.

A rating of continuous improvement has been given for the quality improvement and risk management programme implemented.

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

There is a comprehensive process implemented to ensure that all service providers are involved in the quality and risk management programme.

**Finding Statement**

The quality and risk management programme is fully integrated with cross referencing in all documents. Any complaints arising from the resident meetings for example are logged onto the complaints register with documentation indicating that they are followed up. There is also documentation in the staff, quality and health and safety meetings showing evidence that complaints are discussed and learnings taken from the discussion. The staff meeting minutes are comprehensively documented with full discussion reported. This enables any staff member who is unable to attend to follow by reading the minutes and have input into the discussions. Discussion and analysis of trends is documented with evidence of improvements in service delivery. All documentation is fully completed as per policy and this includes completion of satisfaction surveys and internal audits. The service has an external consultant who benchmarks data for the rest home against other services with a similar profile. The manager and staff analyse the data and again use the information to improve service delivery. The six caregivers state that they are fully informed and involved in the quality programme and the use of clip board in the office (locked when not in use) enables a quick reference for resident and other concerns, key appointments for residents and key quality improvements. Health care assistants and other staff state that the quality programme is also linked to the annual training plan with extra and impromptu training offered as issues are identified. The service takes every opportunity to be involved with initiatives led by Auckland DHB and has implemented the 'do no harm' project to reduce falls with evidence of monitoring of outcomes. They are currently involved in the 'Stop and Watch' early warning tool that provides guidelines around assessment of a resident with changes in state/behaviour. The service is to be commended for the depth of discussion documented in minutes, the knowledge of staff interviewed including the six health care assistants who are fully informed and feel very involved and for the improvements made to service delivery as a result of the information gathered and analysed.

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

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

Incidents/accidents and near misses are investigated and analysis of incidents trends occurs monthly. There is discussion of incidents/accidents at the monthly quality meetings, health and safety and staff meetings. These include actions to minimise recurrence.

Discussions with the manager and registered nurses confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

There is an open disclosure policy and family members interviewed stated they are informed of changes in health status. Staff have had training around open disclosure in January 2013 facilitated by the health and disability advocate. Incident/accident forms document whether or not family have been informed and 15 of 15 incident forms indicate that family have been informed and if not, why not.

D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents. One resident has a tracking device that the police are able to trace. When the resident wanders, then the police are notified and can track at any time. The DHB are not notified of every incident as this is an arrangement between the service and the police for extra support. The service has had the resident reassessed for dementia care and are waiting for the transfer to occur. The ADHB are ringing one to two weekly to see that the service can still manage while waiting for the bed.

Graphs are documented monthly of all incidents and accidents and there is a resident monthly summary in each resident file that is used to ensure that information is reviewed as part of the care planning process. The registered nurses and six health care assistants state that these are useful to see trends and discuss any on-going issues.

One resident had three falls in July 2013, one of which resulted in a bruise to the head. Neuro obs in the form of pupil reactions were taken but only once. Following this, in the week before the audit a memo was sent to all staff (posted on a clip board in the staff room) outlining the appropriate process for neuro observations. The memo is in the staff memos folder. During the audit the manager and RN finished developing a policy and procedure around head injuries and neuro obs to further clarify the procedure. All staff received training around neuro obs as part of the July 2013 staff meeting (minutes sighted) and further training around neuro obs is planned for September 2013 (training schedule available).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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:** FA

There are a total of 42 staff with job descriptions in place for all positions. Human resources policies are implemented. Human resource policies establish the requirements for vetting of qualifications and the maintenance of practising certificates for registered nursing staff and for other health professionals involved in the service. Relevant checks are completed to validate individual qualifications and experience. A record of practising certificates is maintained including a copy for the registered nurse, doctors involved dietician and podiatrist.

A comprehensive orientation programme is in place that includes the assessment of initial medication competencies if relevant for the staff member. Completed orientation programmes are evident in all staff files reviewed and health care assistants can describe the orientation training.

A comprehensive annual in-service education programme is in place. There is an education plan for 2012 and 2013 sighted. The annual training plan covers a wide range of subjects and exceeds the required eight hours annually. Discussions with the manager, the registered nurses and health care assistants and a review of documentation demonstrates a commitment to the education of staff that is implemented into practice.

D17.7d: There are implemented competencies for registered nurses related to medication with all relevant health care assistants and the registered nurses having a current competency completed.

Nine of nine residents interviewed and five family members interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent and friendly.

The service has a staffing policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. Police checks are documented in recent years noting that these are not completed for family members who are also staff.

Seven of seven staff files confirms that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements.

The registered nurses and manager (staff files reviewed) attend external training including sessions provided by the DHB with certificates on file to evidence this. This exceeds eight hours a year.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is an organisational staff numbers and skill mix policy that aligns with contractual requirements. The current breakdown of staffing hours specifically documented for Claire House has been adjusted to accommodate the new 16 bed facility with the occupancy at 15 on the day of the audit. The service has had 21 admissions since 12 December when the new building was opened.

There are a total of 42 staff in the service including the manager, two registered nurses, an assistant manager, maintenance, two gardeners, 21 health care assistants, three cooks and two kitchen hands, two activities coordinators (six days a week), three cleaners (seven days a week), two laundry assistants, two administrators.

The following staff are rostered onto shifts (rosters sighted) with an occupancy of 52 of 54 residents:

Claire House (32 of 32 residents)

AM: 4 health care assistants (two short shifts)

PM: 2 health care assistants (plus laundry and short shift staff)

Night: 2 health care assistants (nine hours).

Fleurmont (15 of 16 residents)

AM: 2 health care assistants

PM: 1 health care assistants and 1 short shift

Night: 1 health care assistant (nine hours)

Claire Villa (4 of 5 residents)

7am-12pm 1 health care assistant and the afternoon staff from Claire House support residents. There is an on call health care assistant with residents able to call at any time. If there are any residents with identified needs e.g. a chest infection for one resident, then a health care assistant will complete rounds.

There is one resident in an attached flat with health care assistants providing oversight. There is a designated health care assistant who provides one to one support for showers, activities of daily living and support for access to the community. All meals and social activities are at one of the wings.

Nine of nine residents and five of five family members confirm that there are sufficient staff at all times.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

There are paper based files appropriate to the service type available. Information is entered into the resident files in an accurate and timely manner to provide a sufficient record of care.

This includes comprehensive information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service. There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.

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

Residents files are protected from unauthorised access by being locked away in an office and in locked cupboards in each wing. Informed consent is obtained from residents on admission to display photographs.

Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities officer. Medication charts are in a separate folder with medication and this is appropriate to the service.

**Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

**STANDARD 1.3.1 Entry To Services**

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

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

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

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. NASC assessments are required for entry to the service. The service communicates with the needs assessor and other appropriate agencies prior to the resident’s admission regarding the residents level of care requirements. There is a comprehensive information pack provided to all residents and their families for rest home level care. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the H&D Code of Rights,' complaints information, advocacy, and admission agreement. All nine residents (including two under 65 years old) and five family members (including three for residents under 65 years old) interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Eight resident files (including two under 65 years old) were reviewed and all had NASC approval and signed service agreements.

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

There is a declining entry section in the admission procedure. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.

**Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

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

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission.

Activity assessments and the activities care plans have been completed by the activities coordinator.

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment, c) continence assessment d) cultural assessment, e) skin assessment, f) nutritional assessment and g) pain assessment.

Care plans are used by nursing staff and HCA's to ensure care delivery is in line with the residents assessed needs. The care summary is reviewed as part of the regular resident review process (three to six monthly or sooner if needs change). Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

All eight files identified integration of allied health including the mental health team, physio, optician and podiatry. The GP interviewed spoke very positively about the service and describes effective communication processes.

D16.2, 3, 4: The eight resident files reviewed identified that in all eight files a nursing assessment was completed within 24 hours and all eight files identify that a 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. Seven of eight care plans reviewed evidenced evaluations completed at least six monthly. One resident was in the facility less than six months

D16.5e: The eight resident files (including two under 65 years olds), 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 3 monthly.

Tracer Methodology: Rest Home

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

Tracer Methodology: Under 65 years rest home resident

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

A comprehensive initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs outcomes and goals of residents are identified. A range of assessment tools are completed in resident files and reviewed at least six monthly including (but not limited to); falls, pressure areas and continence. Nutrition and pain are assessed on admission and as needed and weights and BP's are monitored on a monthly basis dependant on needs. Assessments are conducted in an appropriate and private manner. All nine residents interviewed are satisfied with the support provided.

Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Nine residents (including two under 65 years old) and five family members (including three under 65 years old) stated they were informed and involved in the assessment process.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

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

Care plans are individually developed with the resident and family/whānau involvement is included where appropriate. All eight resident files (including two under 65 years old), reviewed were evidenced to be up to date. Goals and outcomes are identified and agreed and how care is to be delivered is explained.

All residents have an individualised long term care plan that covers all areas of needs identified. Areas covered in the eight resident files sampled include (but are not limited to): behaviour, emotional needs, cultural needs, falls risk, ADL's, nutrition and social needs. Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health including MHSOP, physiotherapy and the podiatrist. There is evidence that residents are seen by their GP at least three monthly. The care plan format is comprehensive and goal oriented. Significant events and communication with families are documented.

D16.3k: Short term care plans are in use for changes in health status including infections, skin tears, sticky eyes and rashes.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

The service provides services for residents requiring rest home level care and physical disability care for residents under 65 years old. Care plans are completed comprehensively.

Eight resident care files were reviewed for this audit.

Challenging behaviour plans, prevention of wandering plans, catheter care, diabetes management and pain care plans evident. Care plans evidenced at least six monthly care plan reviews. The use of short term care plans is evident. The care being provided is consistent with the needs of residents, this is evidenced by discussions with six HCA’s, two RN's, one manager, nine residents and five family members. The GP interviewed stated the facility applied changes of care advice in a timely manner and was complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission.

There is evidence of referrals to specialist services such as the mental health team, dental and the podiatrist. There is also evidence of community contact.

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.

Currently there are no residents with wounds at Claire house. On interview the two RN's stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The activities coordinator has been employed in the role for 10 years. She works 27 hours a week over five days a week. There is an assistant activities coordinator who works four hours at weekends. All recreation/activities assessments and reviews are up to date. The activities coordinator writes in the progress notes once a week if residents generally attend activities or not. On interview the coordinator stated she remembered each week who had attended and generally attendance was very good. On the day of audit, residents were observed going out for coffee and going to the gym. Residents have an assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family.

There are seven under 65 years residents in the facility. There is a weekly activities plan for all residents. Residents have one on one activities in their activities care plan. Activities provided reflect ordinary patterns of life. Activities include quizzes, exercises, bingo, group walk to shops, art, music and entertainers.

The five family members (including three for residents under 65 years old) interviewed stated that activities are appropriate and varied enough for the residents. All nine residents (including two under 65 years old) interviewed stated they were happy with the activities available and are given a choice regarding attendance.

D16.5d: Eight of eight 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

All initial care plans were developed by an RN within three weeks of admission and evaluated three to six monthly or if there is a change in health status. There is a three monthly review by the GP. There was documented evidence that evaluations were up to date in all eight care plans reviewed. Overall changes in health status are documented and followed up. Care plan reviews are signed as completed by an RN. GP's review residents medication at least three monthly or when requested if issues arise or health status changes.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service facilitates access to other medical and non-medical services. Referral forms and documentation are maintained on resident files.

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

D16.4c: The service provided an archived example of when a resident’s condition had changed and the resident was reassessed for a higher level of care. Currently no residents are awaiting a NASC reassessment.

D 20.1: Discussions with the RN's identified that the facility has direct access to services including mental health services, podiatrist and physiotherapy services.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

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

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

There is a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy is kept on the resident’s file. This was sighted in one resident file where the resident had been transferred to another service level. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by an RN. Any mistakes by the pharmacy are regarded as an incident.

Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member.

Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All medication charts reviewed had allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms. There is an improvement required around medication signing. The sample of charts was therefore extended to 26 for review with no further signing omissions of signing identified. On day one of the audit, following the identification of the error all caregivers on morning and afternoon shift in the wing where the omissions had occurred were provided with a medication education session and their competencies are being reviewed.

There is a locked cupboard that is used for controlled drugs. Weekly controlled drug checks occur. There is a drug trolley for each wing that is kept in a locked cupboard when not in use. Medication round observed; all practice is appropriate.

A medication competency has been completed annually by the RN's and the HCA’s who administer medication.

There is a policy and process that describes self-administered medicines . There are currently five residents who self-administer medication and all have current competency checks.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All medication charts reviewed had allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms.

**Finding Statement**

Of 26 medication charts viewed: one resident’s medication chart had two separate gaps of signatures for night time medications for August 2013. Analgesia and antihistamines were prescribed for the resident at night time. One of 26 medication charts had the date and number of tablets written in the signature box but had no signature for the medication prescribed. The sample of charts was extended to 26 and no further problems identified. On day one of the audit, following the identification of the error all caregivers on morning and afternoon shift in the wing where the omissions had occurred were provided with a medication education session and their competencies are being reviewed.

**Corrective Action Required:**

Ensure medication prescribed is administered and signed for.

**Timeframe:**

1 month.

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

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

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

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

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

The service has a workable domestic kitchen. The kitchen and equipment are well maintained. The service employs three cooks and one kitchen hand to provide meal services over seven days a week. There is a rotating four weekly menu in place that was designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. The RN completes a nutritional profile with the aid of the resident and family. Special diets are catered for and documented in the kitchen. The facility has a coloured plating system to determine special diets.

Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.

The service encourages residents to express their likes and dislikes. The residents interviewed were very happy with the meals provided and they all stated that they are asked by staff about their food preferences. The residents satisfaction survey determined that residents were happy with the meals provided. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted.

The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. Fridge/freezer temperatures are checked daily. Food in the fridge and chiller were covered and dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away.

A food audit was last carried out in January 2013 and compliance was achieved.

D19.2: Staff have been trained in safe food handling.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

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

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

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

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

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

The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident / accident reports reviewed involving waste, infectious material, body substances or hazardous substances. There is an emergency manual available to staff which includes hazardous substances. Six HCA's, two RN's and the manager interviewed were able to describe hazard management.

There is an emergency plan to respond to significant waste or hazardous substance management. Waste management/chemical training has been carried out.

All chemicals sighted were appropriately stored in locked areas. Chemicals are appropriately labelled. Sufficient gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The building holds a current warrant of fitness which expires on 30 September 2013. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. The maintenance person is available on an on call basis. External contractors are engaged to complete work as required.

The facility's amenities, fixtures, equipment and furniture are appropriate for rest home level residents. There is sufficient space so that residents are able to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. There is one lounge area for every eight residents rooms. The lounges are designed so that space and seating arrangements provide for individual and group activities. Resident’s bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Pathways are clear and maintained.

D15.3;The following equipment is available, pressure relieving mattresses, shower chairs, heel protectors and lifting aids.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

There are sufficient shared ensuites and communal toilets provided for resident care. Visitor/staff toilets are well signed. All bathroom facilities have locks. A sample of hot water temperatures are taken monthly and these are maintained at (or just below) 45 degrees. Hand basins are located in all service areas. All toilets have access to hand basins and adequate hand drying facilities. Hand sanitizer gel is provided throughout the facility. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. The floor coverings are carpet and vinyl. The facility was clean and well presented on the day of audit.

**Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

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

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

There is adequate space in all bedrooms for residents and staff. Six HCA's were asked if there was sufficient room and they confirmed they were able to move freely to provide cares. Doorways into residents' rooms and communal areas are wide enough for wheelchair, and trolley access. All nine residents interviewed are happy with their rooms.

**Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

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

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

The service has a lounge and dining area for every eight resident bedrooms. Residents were seen to be moving freely throughout facility. Residents are able to move freely from their bedrooms to communal rooms and the outside. Pathways are maintained and there are ramps to give walkers and wheelchair access. Activities occur in the lounge areas and residents are able to access their rooms for privacy when required.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

There is a cleaning policy and a cleaning process. Cleaning audits occur as part of the audit schedule. Corrective actions required are followed through quality/risk management and staff meetings. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer’s labels. There is a sluice room for the disposal of soiled water or waste. This is locked when unattended.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence boxes are available (sighted). The 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 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 last approved the evacuation scheme on 12 December 2012.

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 an RN and the manager on call to all residents 24 hours per day, seven days per week.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

General living areas and resident rooms are appropriately heated and ventilated. The facility has central heating. All bedrooms and communal areas have at least one external window.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The restraint management policy states that enablers are voluntary. Restraint is not used in the service.

There are no residents that require enablers as confirmed on the day of the audit by the manager and registered nurses interviewed and through observation.

Behavioural management plans are sighted in files reviewed when challenging behaviour is identified and staff attended training last in July 2012. Health care assistants interviewed describe individualised strategies as per the resident plans to manage any challenging behaviour.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The role of the infection control (IC) coordinator is held by both the RN's. One has been in the post for nine years and one has been in the post for two years. The IC coordinators 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 coordinators and external expertise when required. IC is a standing agenda item at the monthly staff / quality meetings (minutes viewed). Staff are informed about IC practises and reporting. They can contact the IC coordinators 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 coordinators and entered into the infection register.

There is a job description for the IC coordinators including the role and responsibilities. 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.  The service has had no outbreaks since the previous audit.

An annual infection control review is also carried out.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The two RN's are the IC coordinators. 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 have the responsible for reviewing the IC programme annually. The coordinators comply with the objectives of the infection control policy and work with all staff to facilitate the programme. The coordinators have both attended Bug Control training. Staff complete annual infection control education. Access to specialists from Bug Control, laboratories and GP’s is available for additional training support if required. The coordinators have access to all relevant resident information to undertake surveillance, audits and investigations.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

Claire House has infection control policies and an infection control manual which reflect current practise. The IC programme defines roles and responsibilities of the IC coordinators. 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 coordinators and they can access external specialist advice to do this if required.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The IC coordinators are the two RN's. They have both attended IC external training. All new staff receive infection control education at orientation including hand washing and preventative measures. Staff annual infection control education occurs. The training folder records the staff education and attendance. External resources including Bug Control and GP's can ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. 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 coordinators. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Claire House are appropriate to the acuity, risk and needs of the residents.

The IC coordinators enter infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly staff/quality meetings (minutes viewed). The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. An annual infection control review is also carried out. The facility employs an external consultant to benchmark the facilities results against other New Zealand rest home facilities.

Internal audit of infection control is included in the annual programme. 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:**