Golden Age Rest Home Limited - Hoon Hay

CURRENT STATUS: 01-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

Hoon hay Dementia and Hoon hay Village is part of the Golden Healthcare Group of facilities. The service provides residential mental health care and dementia level care for up to 80 residents in two separate units. On the day of the audit there were 30 of 40 residents in the dementia unit, 39 of 40 residents in the residential mental health unit. The mental health unit is managed by a registered nurse/manager and the dementia unit is managed by a registered nurse.

This audit identified improvements are required around incident documentation, staffing, privacy of information, aspects of care planning and medication management.

AUDIT SUMMARY AS AT 01-AUG-13

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights	Day of Audit 01-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.		**Standards applicable to this service fully attained**

Organisational Management	Day of Audit 01-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.		**Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk**

Continuum of Service Delivery	Day of Audit 01-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 medium or high risk and/or unattained and of low risk**

Safe and Appropriate Environment	Day of Audit 01-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**

Restraint Minimisation and Safe Practice	Day of Audit 01-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**

Infection Prevention and Control	Day of Audit 01-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 01-AUG-13

Consumer Rights

Golden Health Care Hoon Hay Village staff endeavour to provide quality of life care where the individual is valued. Residents and relatives spoke positively about care provided in the mental health and dementia units. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. 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 of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

Organisational Management

Golden Healthcare group, which includes Hoon Hay Village mental health and dementia unit, has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality and risk meetings. An annual resident and family satisfaction survey is completed and there are regular resident and relatives meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Benchmarking groups across the organisation are established for facilities that provide similar service levels. Benchmarking and audit data demonstrate that they have achieved good standards of care and service. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that

provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support. The organisational staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around the documenting of incidents and accidents, staffing, and ensuring that resident information is filed in the correct resident file.

Continuum of Service Delivery

Residents in the Dementia unit have a needs assessment completed prior to entry to the service. Mental health residents are referred by the Canterbury DHB coordinators for mental health residential care. All residents' assessment, care planning and care evaluations are developed by the registered nurses in either units in partnership with the resident and/or their family, as appropriate. A review of all residents' clinical files validates the service delivery to the residents. Residents and families interviewed confirm satisfaction with the care delivery provided at both facilities. Sampling of residents' clinical files validates the service delivery to residents. Residents in the dementia unit have care plans that the reflect their care requirements. Residents in the mental health unit have risk assessments conducted, crisis prevention plans and individual development plans. Improvements are required in the dementia unit to ensure all interventions are current best practice. Evaluations of all care plans sampled are completed within stated timeframes and reviewed more frequently if a resident's condition changes and this is noted on a short term care plan for dementia residents. Planned activities are appropriate to the group setting. There are divisional therapy activities appropriate to the dementia unit setting. Mental health unit activities have a community involvement focus and are tailored to meet the individual resident's needs. Residents and family interviewed confirm satisfaction with the activities programmes. An appropriate medicine management system is in place for both units. Improvements are required in the mental health unit around 'as required' medication orders and documenting of allergies or adverse reactions. Policies and procedures record service provider responsibilities. Staff responsible for medicine management have attended in-service education on medication management and have completed medication competencies. A central kitchen and on site staff provide the food service for both units. Kitchen staff have completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis. The menu has been reviewed by a dietitian. There was positive feedback from residents about the food service.

Safe and Appropriate Environment

There are documented processes for waste management. The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemical safety training is provided to staff. There is a current building warrant of fitness. The maintenance role entails checks for safety of the facility and implementing requests from the maintenance book. General living areas and resident rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. There are outside paved areas with suitable furniture and natural shading. The dementia unit has a secure outside area for residents to safely wander. The service provides adequate space allowing residents to move safely around in their rooms and the facility. Residents are being provided with safe and hygienic cleaning and laundry services, which are appropriate to the setting. The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on

duty with a current first aid certificate. Residents are provided with adequate natural light, safe ventilation, and a safe environment with comfortable temperature.

Restraint Minimisation and Safe Practice

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has no residents requiring the use of a restraint or enabler. There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings.

Infection Prevention and Control

The infection control management systems are well documented and implemented to minimise the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality risk management system. There is a comprehensive orientation and education programme for all staff. Infection rates are monitored and compared with other services within the organisation. The results are used to identify any shortfalls.

Hoon Hay Village

Golden Age Rest Home Limited

Certification audit - Audit Report

Audit Date: 01-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Golden Age Rest Home Limited

Premise Name	**Street Address**	**Suburb**	**City**
Hoon Hay Village	16 Anvers Place	Hoon Hay	Christchurch

Proposed changes of current services (*e.g. reconfiguration*)**:**

Type of Audit	Certification audit and (*if applicable*)	
Date(s) of Audit	**Start Date:** 01-Aug-13	**End Date:** 02-Aug-13
Designated Auditing Agency	Health and Disability Auditing New Zealand Limited	

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXX	RN, Auditor certificate	16.00	8.00	01-Aug-13 to 02-Aug-13
Auditor 1	XXXXXX	RCpN, Health Auditor, AdDipBusMan, Cert QA	16.00	6.00	01-Aug-13 to 02-Aug-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor	XXXXXX		8.00	2.00	01-Aug-13
Peer Review Auditor	XXXXXX	RCompN, PGDipHSM, Auditor certificate		2.00	

Total Audit Hours on site	40.00	**Total Audit Hours off site** *(system generated)*	18.00	**Total Audit Hours**	58.00

Staff Records Reviewed	17 of 47	**Client Records Reviewed** *(numeric)*	10 of 69	**Number of Client Records Reviewed using Tracer Methodology**	2 of 10
Staff Interviewed	12 of 47	**Management Interviewed** *(numeric)*	4 of 4	**Relatives Interviewed** *(numeric)*	9
Consumers Interviewed	5 of 69	**Number of Medication Records Reviewed**	20 of 69	**GP's Interviewed (aged residential care and residential disability)** *(numeric)*	1

Declaration

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

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

Dated this 12 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

				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**	Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Hoon Hay Village	80	69		☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☒	☐

** For DHB audits: Day of audit is to be day one (1).

Executive Summary of Audit

General Overview

Hoon Hay Dementia and Hoon Hay Village is part of the Golden Healthcare Group of facilities. The service provides residential mental health care and dementia level care for up to 80 residents in two separate units. On the day of the audit there were 30 of 40 residents in the dementia unit, 39 of 40 residents in the residential mental health unit. The mental health unit is managed by a RN/manager and the dementia unit is managed by a RN.

This audit identified improvements are required around incident documentation, staffing, privacy of information, aspects of care planning and medication management.

1.1 Consumer Rights

Golden Health Care Hoon Hay Village staff endeavour to provide quality of life care where the individual is valued. Residents and relatives spoke positively about care provided in the mental health and dementia units. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. 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 of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

1.2 Organisational Management

Golden Healthcare group, which includes Hoon Hay Village mental health and dementia unit, has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality and risk meetings. An annual resident and family satisfaction survey is completed and there are regular resident and relatives meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team.

Benchmarking groups across the organisation are established for facilities that provide similar service levels. Benchmarking and audit data demonstrate that they have achieved good standards of care and service. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support. The organisational staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around the documenting of incidents and accidents, staffing, and ensuring that resident information is filed in the correct resident file.

1.3 Continuum of Service Delivery

Residents in the Dementia unit have a needs assessment completed prior to entry to the service. Mental health residents are referred by the Canterbury DHB coordinators for mental health residential care. All residents' assessment, care planning and care evaluations are developed by the registered nurses in either units in partnership with the resident and/or their family, as appropriate. A review of all residents' clinical files validates the service delivery to the residents. Residents and families interviewed confirm satisfaction with the care delivery provided at both facilities. Sampling of residents' clinical files validates the service delivery to residents. Residents in the dementia unit have care plans that the reflect their care requirements. Residents in the mental health unit have risk assessments conducted, crisis prevention plans and individual development plans. Improvements are required in the dementia unit to ensure all

interventions are current best practice. Evaluations of all care plans sampled are completed within stated timeframes and reviewed more frequently if a resident's condition changes and this is noted on a short term care plan for dementia residents. Planned activities are appropriate to the group setting. There are divisional therapy activities appropriate to the dementia unit setting. Mental health unit activities have a community involvement focus and are tailored to meet the individual resident's needs. Residents and family interviewed confirm satisfaction with the activities programmes. An appropriate medicine management system is in place for both units. Improvements are required in the mental health unit around 'as required' medication orders and documenting of allergies or adverse reactions. Policies and procedures record service provider responsibilities. Staff responsible for medicine management have attended in-service education on medication management and have completed medication competencies. A central kitchen and on site staff provide the food service for both units. Kitchen staff have completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis. The menu has been reviewed by a dietitian. There was positive feedback from residents about the food service.

1.4 Safe and Appropriate Environment

There are documented processes for waste management. The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemical safety training is provided to staff. There is a current building warrant of fitness. The maintenance role entails checks for safety of the facility and implementing requests from the maintenance book. General living areas and resident rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. There are outside paved areas with suitable furniture and natural shading. The dementia unit has a secure outside area for residents to safely wander. The service provides adequate space allowing residents to move safely around in their rooms and the facility. Residents are being provided with safe and hygienic cleaning and laundry services, which are appropriate to the setting. The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. Residents are provided with adequate natural light, safe ventilation, and a safe environment with comfortable temperature.

2 Restraint Minimisation and Safe Practice

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has no residents requiring the use of a restraint or enabler. There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings.

3. Infection Prevention and Control

The infection control management systems are well documented and implemented to minimise the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality risk management system. There is a comprehensive orientation and education programme for all staff. Infection rates are monitored and compared with other services within the organisation. The results are used to identify any shortfalls.

Summary of Attainment

1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	FA	0	1	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	FA	0	2	0	0	0	2
Standard 1.1.3	Independence, personal privacy, dignity and respect	FA	0	4	0	0	0	4
Standard 1.1.4	Recognition of Māori values and beliefs	FA	0	4	0	0	0	4
Standard 1.1.5	Recognition of Pacific values and beliefs	FA	0	2	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	1
Standard 1.1.7	Discrimination	FA	0	4	0	0	0	4
Standard 1.1.8	Good practice	FA	0	1	0	0	0	1
Standard 1.1.9	Communication	FA	0	2	0	0	0	2
Standard 1.1.10	Informed consent	FA	0	3	0	0	2	5
Standard 1.1.11	Advocacy and support	FA	0	1	0	0	0	1
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	2

Consumer Rights Standards (of 13):	N/A:0	CI:0	FA:13	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 31):	CI:0	FA:29	PA:0	UA:0	NA: 2

1.2 Organisational Management

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

Organisational Management Standards (of 9):			N/A:0 PA Crit:0	CI:0 UA Neg:0	FA:6 UA Low:0	PA Neg:0 UA Mod:0	PA Low:1 UA High:0	PA Mod:2 UA Crit: 0	PA High: 0
Criteria (of 30):	CI:0	FA:27	PA:3	UA:0	NA: 0				

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	FA	0	2	0	0	0	2
Standard 1.3.2	Declining referral/entry to services	FA	0	1	0	0	0	1
Standard 1.3.3	Service provision requirements	FA	0	5	0	0	0	5
Standard 1.3.4	Assessment	FA	0	2	0	0	0	2
Standard 1.3.5	Planning	FA	0	3	0	0	0	3
Standard 1.3.6	Service delivery / interventions	PA Low	0	2	1	0	0	3
Standard 1.3.7	Planned activities	FA	0	1	0	0	0	1
Standard 1.3.8	Evaluation	FA	0	3	0	0	0	3
Standard 1.3.9	Referral to other health and disability services (internal and external)	FA	0	1	0	0	0	1
Standard 1.3.10	Transition, exit, discharge, or transfer	FA	0	1	0	0	0	1
Standard 1.3.11	Use of electroconvulsive therapy (ECT)	Not Applicable	0	0	0	0	4	4
Standard 1.3.12	Medicine management	PA Moderate	0	4	1	0	0	5
Standard 1.3.13	Nutrition, safe food, and fluid management	FA	0	3	0	0	0	3

Continuum of Service Delivery Standards (of 13):	N/A:1	CI:0	FA: 10	PA Neg: 0	PA Low: 1	PA Mod: 1	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	

Criteria (of 34): CI:0 FA:28 PA:2 UA:0 NA: 4

1.4 Safe and Appropriate Environment

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

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 17):	CI:0	FA:17	PA:0	UA:0	NA: 0		

2 Restraint Minimisation and Safe Practice

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

Restraint Minimisation and Safe Practice Standards (of 8):	N/A: 7	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 18):	CI:0	FA:1	PA:0	UA:0	NA: 17			

3 Infection Prevention and Control

		Attainment	CI	FA	PA	UA	NA	of
Standard 3.1	Infection control management	FA	0	3	0	0	0	3
Standard 3.2	Implementing the infection control programme	FA	0	1	0	0	0	1
Standard 3.3	Policies and procedures	FA	0	1	0	0	0	1
Standard 3.4	Education	FA	0	2	0	0	0	2
Standard 3.5	Surveillance	FA	0	2	0	0	0	2
Standard 3.6	Antimicrobial usage	Not Applicable	0	0	0	0	2	2

Infection Prevention and Control Standards (of 6): N/A: 1 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 11): CI:0 FA:9 PA:0 UA:0 NA: 2

Total Standards (of 57) **N/A:**9 **CI:**0 **FA:**43 **PA Neg:**0 **PA Low:**2 **PA Mod:**3 **PA High:**0 **PA Crit:**0 **UA Neg:**0 **UA Low:**0 **UA Mod:**0 **UA High:**0 **UA Crit:** 0

Total Criteria (of 141) **CI:** 0 **FA:** 111 **PA:** 5 **UA:** 0 **N/A:** 25

Corrective Action Requests (CAR) Report

Provider Name: Golden Age Rest Home Limited
Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:01-Aug-13 End Date: 02-Aug-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.2.4	1.2.4.3	PA Moderate	**Finding:** Hoon Hay Dementia: Discussion with a family member in the dementia unit described observing a choking episode taking place with her family member when she was visiting. No incident accident form was evidenced completed for this incident. The choking episode was not documented in the residents progress notes. Caregivers and RN interviewed were able to describe the incident had occurred and how it has been managed. **Action:** Ensure all incidents and accidents are documented by use of an incident accident form and are also documented in progress notes.	1 month
1.2.8	1.2.8.1	PA Moderate	**Finding:** Hoon Hay Dementia: The roster sighted for 17 Jun 2013 evidenced that there was only one of two night staff members on duty in the dementia unit. **Action:** Ensure there are enough staff on duty to meets the needs of the residents.	1 month
1.2.9	1.2.9.7	PA Low	**Finding:** Hoon Hay Dementia & Hoon Hay Mental Health: Personal documents pertaining to other residents was found in two resident files reviewed (one mental health and one dementia). **Action:** Ensure that documents personal to residents are kept private and secure.	1 month

1.3.6	1.3.6.1	PA Low	**Finding:** Hoon Hay Dementia: Documented interventions for one resident with choking risk are no longer current best practice. **Action:** Ensure documented interventions for choking risk resident reflect current best practice.	3 months
1.3.12	1.3.12.1	PA Moderate	**Finding:** Hoon Hay Mental Health On review of 10 medication charts it was noted that a) Three of 10 PRN medication orders did not detail indications for use. b) Two of 10 charts did not record allergies or nil known allergies. **Action:** a) Ensure all PRN medication orders detail the indications for use . b) Ensure all medication charts record allergies/adverse reactions or nil known allergies.	1 month

Continuous Improvement (CI) Report

Provider Name:	Golden Age Rest Home Limited
Type of Audit:	Certification audit
Date(s) of Audit Report:	Start Date:01-Aug-13 End Date: 02-Aug-13
DAA:	Health and Disability Auditing New Zealand Limited
Lead Auditor:	XXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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 resident's rights policy. On interview all staff (three support workers (mental health) and three caregivers (dementia) one registered nurse, one enrolled nurse, RN/ manager (mental health) and facility manager dementia), were aware of consumers rights and were able to describe how they incorporated consumer rights within their service delivery. Five residents and nine family members interviewed (four mental health and five dementia) spoke highly of respect for all aspects of the service. 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).

Code of rights training is delivered either from an in-service education session or via a self-learning tool. The tool includes advocacy, informed consent, privacy, complaints, and advanced directives. Hoon Hay Village Mental Health staff completed an in-service session on code of consumer rights on 23 March 2013 with seven attendees. Education for dementia staff in Code of Rights training is scheduled for August 2013 on the education planner.

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.

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

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

There are posters of the code of rights on display in the reception area of each facility and leaflets are available. On entry to the service residents and family receive an information pack that includes a code of rights information, advocacy, information around dementia services and Golden Healthcare specific information. Large format and Maori information is also available. On interview all staff (three caregivers - dementia, three support workers (mental health) one registered nurse, one enrolled nurse and one registered nurse/manager (mental health) and manager (dementia)), stated that they take time to explain the rights to residents and their family members. Five mental health residents and four family members interviewed from the mental health unit confirmed that they had received information about the code of rights on entry to the service.

Five family members from the dementia unit confirmed that they received information about the service and code of rights prior to admission.

The service is able to provide information in different languages and/or in large print if requested. Information is given to next of kin or EPOA to read and discuss. On entry to the service the manager of the unit (mental health, dementia) and or registered nurse/enrolled nurse, discuss the information pack with the resident/family/whānau. This includes the Code of Rights, complaints and advocacy.

On interview residents and family members were able to state their understanding of the code of rights.

Health and disability advocacy service leaflets are on display in the reception areas of each facility. A brochure advertising the service is also included in the information pack provided to new residents. The service can access local Maori advisory services should this be requested.

The information pack provided to residents on entry includes how to make a complaint, Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) pamphlet, advocacy and H&D Commission information.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

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

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 dignity and privacy policy. Staff were observed respecting residents privacy and could describe how they manage maintaining privacy and respect of personal property.

Mental health : Five residents and four family members interviewed indicated staff were highly respectful and maintained residents privacy especially when discussing personal issues and that personal belongings are not used as communal property.
Dementia :Five relatives reported that staff respect residents privacy and dignity and that staff close resident's bedroom/bathroom doors when carrying out resident personal cares and always introduce themselves to residents before entering their room. Privacy training last occurred in June 2013 in the mental health unit. Privacy training is scheduled to be completed in the dementia unit on 21-Aug-13.

Mental health: Resident Privacy audit was completed 18-Jul-13 with no corrective actions required.

Dementia: Resident Privacy audit was conducted in June 2013. The corrective action required was around privacy training, this is scheduled to take place 21 August 2013.

The resident’s initial assessments and care plans comprehensively detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. There is a cultural safety policy. All 10 resident files reviewed have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All family members interviewed could confirm this.

There is a spiritually and counselling policy. There are various churches locally and residents are encouraged to attend these. Church services are held weekly at the dementia facility. Residents and family members interviewed indicated that resident’s spiritual needs are being met when required.

On interview residents and family members advised that staff respect resident's rights. Resident preferences are identified during the admission and care planning processes occur with resident/family involvement. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. On interview residents and family confirmed that residents are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview staff (three support workers (mental health), three caregivers (dementia) one registered and one enrolled nurse, OT and diversional therapist), described how they encouraged residents to engage in activities in the facility and to link with community activities including family outings, and church groups if appropriate. There is an abuse and neglect policy and the topic is covered at orientation, as part of the ACE education programme, and as a self-learning tool, and has been addressed at quality and risk, and staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Discrimination and abuse and neglect self-learning tool and competency is available as a training tool in lieu of face to face training. Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. Residents and family members were highly complementary of the care provided and stated staff were very approachable and friendly.

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.

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. Resident files (five mental health and five dementia) reviewed identified that cultural, spiritual values and individual preferences are identified.

E4.1a Five dementia resident relatives stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

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.

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

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

The service has established cultural policies to help meet the cultural needs of its residents including recognition of Maori values and beliefs, dementia perspective for Maori, Maori health plan, Tikanga policy, and Treaty of Waitangi policy. The rights of the resident to practise their own beliefs is acknowledged in the policies and procedures. The plans and policies have been developed by Golden Healthcare in consultation with Maori advisors.

The Maori Cultural Advisor provided training for all the RNs on 'Writing a Maori Health Plan' on 07 November 2012.

There is currently one resident who identifies as Maori in the mental health facility. The resident attends Te Awa O Te Ora (a Maori based support centre) twice a week. The resident's family have been involved in care planning. On interview the resident advised that her cultural needs are met and she appreciates the service providing her with opportunities to remain involved in Maori support group and drop in centre, and to attend church with her son.

The service has access to a comprehensive cultural assessment appropriate to Maori needs and details whānau input around the initial assessment and care plan development and reviews. The service identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors and local iwi advocacy services as identified in the Maori health policy and plan.

Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by the registered nurse with the inclusion of the family / whānau. The service identifies opportunities to involve family/whānau in all aspects of planning individuals service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with the staff three caregivers (dementia), three support workers (mental health) and one registered and enrolled nurse confirm that they are aware of the need to respond to cultural differences. On interview all staff were able to identify how to obtain support so that they could respond appropriately.

Cultural safety and Treaty of Waitangi training last provided for staff in July 2013 and as a self-learning tool in December 2012 .

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

The service has developed a link with local iwi for advisory and advocacy services.

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:

Criterion 1.1.4.7 The service provides education and support for tangata whaiora, whānau, hupu, and iwi to promote Māori mental well-being.

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.5 Recognition Of Pacific Values And Beliefs

Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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 Hoon Hay Mental Health specific policy: Consumer Rights – recognition of Pacific values and beliefs policy implementation.
The Pacific Trust organisation is consulted to seek advice and guidance for assessment/treatment and in OT plans for any Pacific consumers.
Pacific Trust provides links with aiga, fanau, magafaoa and community involvement.

Criterion 1.1.5.1 The service delivers and facilitates appropriate services for Pacific consumers and recognises the fundamental importance of the relationships between Pacific consumers, their families, and the community. This shall include, but is not limited to the service:

(a) Developing effective relationships with Pacific people to support active participation across all levels;

(b) Where appropriate, developing services that are based on Pacific frameworks/ models of health that promotes clinical and cultural competence;

(c) Ensuring access to services based on Pacific people's need and planning and delivering services accordingly;

(d) Developing a culturally enhanced workforce that will respond effectively to the needs of Pacific consumers. This may include actively recruiting and employing service providers with links to Pacific people and providing suitable education/training/mentoring of service providers to respond to specific cultural requirements and preferences.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.5.2 The service provides education, training, and support to Pacific people or other agencies to promote the well-being of Pacific people.

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.

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 cultural safety policy which describes the cultural needs of residents. There is a Maori health plan and associated Maori policies. Five mental health residents and nine family members interviewed (four mental health and five dementia) interviewed reported that they were satisfied that their residents cultural and individual values were being met. There is currently one resident who identifies as Maori. On review of the resident's file it was noted that this was documented. Care plans document detail care provisions specific to cultural and ethnic needs - such as privacy and dignity, communication, dressing and hygiene.

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

The service provides a culturally appropriate service by carrying out a cultural assessment on admission with family/whānau involvement when available

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

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

Each facility has a discrimination and harassment policy which states that residents of all Golden Healthcare Group facilities are free from any discrimination, coercion, harassment, sexual, financial or other exploitation. The abuse and neglect policy covers harassment and exploitation. Five mental health residents interviewed reported that the staff showed respect. Abuse and neglect and discrimination training is provided two yearly as either a self-learning tool or face to face training. Training also occurs at orientation, as part of ACE programme and includes professionalism and standards of conduct. The RN/manager (mental health), facility manager (dementia) and registered nurse supervise staff to ensure professional practice is maintained in the service.

Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.

Criterion 1.1.7.2 Service providers should have an understanding of discrimination. Service providers shall demonstrate knowledge of the barriers to recovery posed by discrimination, which translates into provider systems that promote recovery.

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

Finding Statement

Corrective Action Required:

Timeframe:

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:

Criterion 1.1.7.4 The service does not withdraw support or deny access to treatment and support programmes when or if the consumer refuses some aspects of treatment.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.7.5 The service actively works to identify and address prejudicial attitudes and discriminatory practices and behaviours within its own service and any other service it has links with.

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.

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 general manager described the provision of external meetings and training for all managers of Golden Healthcare which exceeds eight hours per year. Managers and registered nurses are able to attend external training including sessions provided by the local DHB. Conference/ study days - records included in individual service provider files. The managers' meetings take place once a month and provides a forum for learning and reflection. Discussions with five mental health residents and nine family members interviewed (four mental health and five dementia) were very positive about the care they receive.

The quality manager works across all Golden Healthcare services and provides input into opportunities for learning identified through audits, incidents/accidents and benchmarking. The organisation has reviewed and updated all policies and procedures within the last 18 months and currently reflect best practice. Staff interviewed are knowledgeable in regards to policies and procedures and are conversant with the quality improvement programme in place. A clinical coordinator is employed to oversee the clinical standards of all of the Golden Healthcare homes and provides one to one support for the registered nurses.

Use of specialist services such as IPC specialist nurse, older person's health assessment services, complex wound service, community mental health, psychiatric services for elderly and clinical nurse specialists can be accessed. Education sessions include input from external specialists. All policies and procedures including clinical have been reviewed and updated in 2012 to reflect good practice. All training sessions are evaluated. The service has policies to guide practice that align with the health and disability services standards. There is a quality and risk framework and programme that is being implemented that includes performance monitoring. The caregivers and support workers are encouraged to complete NZQA level training and a comprehensive internal in-service training programme is implemented. Across Golden Healthcare quality data benchmarking occurs across all seven facilities. Hoon hay dementia unit are currently benchmarked with other Golden Healthcare facilities around infection control, skin tears, falls and medication errors. The quality manager reviews all benchmarked data and supports each facility to develop corrective actions. The service collects and collates data internally against previous years for incidents/complaints and audit outcomes. Collated incident/accident reports are forwarded each month to the quality manager. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflective in comprehensive reports. Education programme includes orientation programme, self-learning tools, ACE programme, and two yearly education and training programme. Quality improvement projects identified from audit outcomes, complaints, feedback from staff and incidents and accidents are identified each year. Quality goals are reviewed at each bi monthly quality and risk management meeting and comparisons are made with the previous two months. Education sessions are provided after staff meetings and include self-learning tools with competencies. Care staff are encouraged and supported to attend external education for example: all staff are trained in first aid. Clinical

policies and procedures have been updated in 2012 to reflect good practice. The RN/manager (mental health) and the manager (dementia) along with registered and enrolled nurses attend external training sessions appropriate for their positions.

Services are provided at Hoon Hay Village mental health facility and dementia unit that adhere to the health & disability services standards. There is an implemented quality improvement programme that includes performance monitoring.

All approved service standards are adhered to.

There are implemented competencies for caregivers/support workers and nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

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 open disclosure policy which describes ways that information is provided to residents and families. There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the code of rights. This information is discussed at entry and staff are available whenever the family members wish to discuss any aspect of service delivery. Family(where appropriate) are involved in the initial care planning and receive and provide on-going feedback.

Regular contact is maintained with family including if an incident or care/ health issues arises. Family members interviewed stated they were well informed and involved when needed in residents care. Five mental health residents and nine family members interviewed (four mental health and five dementia) confirmed the admission process and agreements documentation were discussed with them. Family state the service provides an environment that encourages open communication.

The admission agreement covers all the areas for the services contractual requirements. All 10 resident files reviewed (five mental health and five dementia) included signed admission agreements on the date of admission.

Discussions with three support workers and three caregivers identified their knowledge around open disclosure and reporting to registered or enrolled nurse who in turn contacts family.

There are resident meetings held quarterly in Mental Health Facility, where any issues or concerns to residents are able to be discussed. A Consumer Advocate Consultant is present at these meetings. Minutes are maintained and show follow-up actions for resolution of matters raised.

Family meetings are held twice a year in the dementia units. Annual family surveys are also completed. Family respondents in the 2012 survey are more than satisfied with the service. There is a large communal lounge and dining area and smaller sitting areas in all three units where discussions can occur. Privacy and sufficient time for discussion can be obtained in residents rooms if needed. Staff wear name badges.

Interpreter policy available to guide staff in how to access interpreter services for residents and family (via DHB). This information is provided in resident information packs.

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

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

Nine family members stated that they are always informed when their family members health status changes.

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.

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

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

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Residents' rights training was last provided in March 2012. Self-learning tools around code of consumer rights were completed in July 2012. The self-directed learning tool is completed two yearly. Interviews with three support workers (mental health), three caregivers (dementia), one registered and enrolled nurse identify that consents are sought in the delivery of personal cares and this is confirmed by five mental health residents interviewed. Written consent includes the signed admission agreements, care plans, receiving and recording information, consent for outings and consent for photography. All 10 resident files (five mental health and five dementia) reviewed has signed consent forms. Advanced directives / resuscitation policy is implemented in all 10 resident files reviewed and resuscitation forms are reviewed annually. The resuscitation advance directive form includes " I have been provided with information about resuscitation". Medical care guidance plans were evidenced completed for those residents who are deemed by their GP to be not competent. The RN manager and registered nurse and enrolled nurse interviewed were able to discuss that residents unable to make a decision are to have resuscitation attempted and only a resident (deemed competent) could sign the advanced directive.

There were 10 admission agreements sighted and 10 had been signed on the day of admission.

Discussion with five family members (dementia) interviewed and four family (mental health) identified that the service actively involves them (where appropriate) in decisions that affect their relatives lives.

An in service education session on family Inclusiveness occurred 19 March 2013 in the mental health facility with 11 staff attending.

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.

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

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

There is an advocacy policy. Staff last received training on advocacy services in March 2012, and is to be completed in August 2013 as part of the Code of resident rights self-learning tool. Information about accessing advocacy services is available in the entrance foyers of both facilities. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information.

Dementia: There is a resident meeting facilitated by the dementia facility manager four times per year. Family meetings occur six monthly.

Mental Health: The consumer consultant attends the quarterly residents meetings in the mental health facility. Advocate support is available at any time on request.

The consumer consultant also attends quarterly meetings with the RN/ manager and GHG management team.

Interview with staff, residents and family members confirmed that they are aware of advocacy and how to access an advocate.

Discussion with nine family (four mental health and five dementia) identified that the service provides opportunities for the family/EPOA to be involved in decisions.

The resident files reviewed includes information on residents family/whānau and chosen social networks.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

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

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

Residents are encouraged to be involved in community activities as appropriate and maintain family and friends networks. On interview staff (three caregivers, three support workers, one RN, one EN, one OT and one diversional therapist) confirmed that residents are supported and encouraged to remain involved in the community and external

groups such as church, and community groups. Discussion with nine family members interviewed (four mental health and five dementia) stated that they are encouraged to be involved with the service and care.

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.

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 complaints procedure is provided to residents within the information pack at entry

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

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with five mental health residents and nine family members interviewed confirms an understanding of the complaints process. All staff interviewed (three caregivers, three support workers, one registered nurse, one enrolled nurse and two managers) were able to describe the process around reporting complaints.

There is a complaints register. The 2013 complaints were reviewed. Verbal and written complaints are documented.

In the mental health facility four complaints have been received. The complaints register evidences that complaints are documented, responses recorded and the complainant signs the register once they are satisfied that resolution has occurred. All complaints reviewed for 2013 have been signed off by the complainant. All four complaints have been managed and due process has been followed. Outcomes are documented and improvements made following complaints.

In the dementia facility there were three complaints in 2013. The complaints have been managed and due process has been followed. Outcomes are documented and improvements made following complaints. One complaint received in 2013 has been investigated by CDHB and no further action is required.

Staff meeting minutes confirm that the issues have been discussed and communicated to staff. Complaints process is displayed in the reception areas with complaint forms. Discussions with caregivers, support workers and registered and enrolled nurses confirmed that concerns/complaints were discussed at staff meetings.

The complaints have noted acknowledgement, investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants. Discussions with five mental health residents and nine family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns.

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.

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

Golden Healthcare (GHC) Hoon Hay village provides mental health and dementia level care.

There 40 beds in the mental health unit which has four "pods" each with ten single ensuite rooms a lounge and dining area. On the day of the audit there were 39 residents.

Mental health: There is an RN/ manager and an enrolled nurse.

There is a 40 bed dementia unit which is divided into two twenty bed units each with single rooms and a lounge and dining area. One the day of audit there were 30 dementia level care residents.

Dementia Unit: There is a facility manager (RN) who does not hold a current APC.

Golden Healthcare organisation has a general manager who reports to the owner of all seven GHC facilities. The organisation employs a quality manager and a clinical coordinator who work across all facilities and provide support to the manager and registered nurses at Hoon Hay mental health and dementia units.

The GHC group is managed by an executive team comprising the owner/managing director, a general manager, a business manager/human resources manager, an administration manager, a clinical coordinator, and a quality assurance manager. The mission statement for GHC includes: 'To provide quality

care for the resident catering for their physical, mental, social, emotional and cultural needs in a residence where they are cared for as unique individuals who merit the highest respect'. The performance of the organisation will be monitored through the: annual audit plan, policy and procedure review, family surveys, resident/family meetings, staff meetings, incident/accident review, complaints management, risk management surveying, the quality management programme, staff appraisals and orientation, and the quality and risk management plan.

Golden Healthcare group has comprehensive quality and risk management systems implemented across its facilities. There is an overall GHC group strategic plan for 2013 - 2018 which includes services, financial, occupancy, building repairs and maintenance, and staffing.

The quality and risk management plan for the mental health unit includes goals and objectives for: certification of the facility, health and safety, infection prevention and control, management of corrective actions, policy and procedure review, services to Maori, and family involvement. Annual reviews are conducted of the quality and risk programme - last conducted January 2013

In the dementia unit additional quality improvement projects have been developed including; that falls will be reduced by 10% in twelve months, increasing occupancy, reducing the number of incidents and accidents per 1000 occupied bed days to below 30, and reducing infections. Across GHC, benchmarking groups are established for facilities with similar service levels. Benchmarking of key clinical quality and incident data is conducted.

GHC provides a comprehensive orientation and training/support programme for their managers. The GHC group senior team managers meet two monthly. Alternate months the facility managers and registered nurses meet. Both managers are supported by the clinical coordinator, quality manager, HR manager and general manager. The organisation provides annual training for managers.

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

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.

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

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

During a temporary absence, a registered nurse, solely employed to provide RN and management cover across all facilities, provides cover for each unit manager with support from the other unit managers, clinical coordinator, general manager, quality manager and registered nurses.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

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

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

Policies and procedures align with the client care plans. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.

Falls prevention strategies such as use of sensor mats, falls risk assessments conducted, physiotherapy input, exercise programme, environment review including flooring, use of Vitamin D, low-low beds, medication reviews, resident education and staff training on manual handling.

Policies and procedures are in place with evidence of review. New or revised policies are available for care staff to read and sign that they have read and understand the changes. The quality manager and the unit managers all manage quality systems within the individual units. There is a quality committee in each unit which reviews all quality activities taking place in the unit. The quality programme is reviewed two monthly and annually and is being implemented. Information is reported through the two monthly quality and risk meeting and monthly staff meeting. The two monthly Q&R meeting discusses key components and standing agenda items and includes reports from each part of the service including kitchen cleaning, laundry, nursing/clinical, carers, infection control, management, activities, and quality programme. Progress of quality objectives are reviewed at the Q&R meeting. Monthly staff meetings take place in each unit with agenda items including discussion and reporting on quality and risk meeting minutes, resident care, incidents/accidents, infection control, audits, corrective actions, complaints, health and safety and education.

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

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. The hazard register is reviewed annually. Restraint and enabler usage is documented. Each month a monthly summary report is prepared by the managers and reported to the quality manager. Items include all complaints, hospital admissions, staff incidents/accidents, compliments, falls, skin tears, behaviours, medication errors, and infections. All quality data is collated and reported to the quality manager for analysis and review. Monthly and yearly statistical graphs are generated and comparisons made. Benchmarking occurs against other GHC facilities who provide similar service level care.

Internal audits are conducted in each unit. Audits conducted so far for 2013 in both the mental health and dementia units include: food services, housekeeping, infection prevention, incident and accidents, complaints, workplace hazards, resident file audit, first aid and civil defence kits, laundry, waste and hazardous substances, medications, complaints compliments, diversional therapy programme, staff files, staff training, wound management, hand hygiene, cleaning, continence management, restraint minimisation and resident admission. Corrective action format is used for all audits, meeting minutes and reports. Corrective actions list all activities relating to the issue identified including current and newly developed. There is evidence that all corrective actions are completed and signed off when implemented. The quality manager also reviews all corrective actions to ensure completion and provides follow up with any outstanding issues.

The service plans and operational structures combine to provide a comprehensive quality development and risk management structure. The scope of the quality improvement meeting is comprehensive. There is a culture of quality improvements and on-going annual reviews.

All staff interviewed could describe the corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme.

Resident meetings in both the mental health unit and dementia unit occur three monthly (minutes sighted for 8-Feb-2013). Nine family members interviewed are aware meetings are held. Family meetings are held six monthly in the dementia unit and mental health unit. All relatives interviewed stated they are regularly asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

3 months

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.4 Adverse Event Reporting

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

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

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

There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms by the registered nurses. The incidents forms are then reviewed and investigated by the RN/manager in the mental health unit and facility manager in the dementia unit who monitor issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to quality and risk committee, staff meetings and then onto organisational management meetings.

Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification.

A sample of incident/accident forms were reviewed for June 2013. The incident forms for mental health residents included one behavioural episode, one graze and one resident found on floor. There is evidence of the recording of the event, any action/treatment taken/provided and follow up by RN.

A sample of incident/accident forms were reviewed for June 2013 from the dementia unit and included 10 falls, one fall (head injury) with 2cm laceration, one medication error (resident given wrong medication), three skin tears and three residents found on the floor. There is evidence of assessment and first aid provided, development of short term care plans and wound care plans, review of risk assessments, review by GP and referral as appropriate. Entries in

progress notes evidence that the resident who sustained a potential head injury following a fall had neurological observations completed and that the resident was closely observed.

There is an improvement required around the documenting of incidents and accidents in the dementia unit.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The service captures adverse events by use of incident accident forms. These were observed to be completed.

Finding Statement

Hoon Hay Dementia: Discussion with a family member in the dementia unit described observing a choking episode taking place with her family member when she was visiting. No incident accident form was evidenced completed for this incident. The choking episode was not documented in the resident's progress notes. Caregivers and RN interviewed were able to describe the incident had occurred and how it has been managed.

Corrective Action Required:
Ensure all incidents and accidents are documented by use of an incident accident form and are also documented in progress notes.

Timeframe:
1 month

STANDARD 1.2.5 Consumer Participation

Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.

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 contract for the consumer consultant which details his responsibilities. He attends all management meetings. He is paid for his services. There is an agenda for the resident meetings and terms of reference for the meetings that includes the need for support and education for consumers participating in the meeting. All consumers interviewed report having input into the care and support they receive at an individual level.

Criterion 1.2.5.1 The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.5.2 Consumers and consumer groups involved in planning, implementation, and evaluation of services have clear terms of reference and position descriptions, and are appropriately reimbursed for expenses and/or paid for their time and expertise.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.5.3 The service assists with training and support for consumers and service providers to maximise consumer participation in the service.

This shall include:

(a) Education and/or training for service providers whose colleagues are consumers working in the service;

(b) Supervision, debriefing, and peer support.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.5.4 The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view.

This shall include, but is not limited to:

(a) Employing consumers where practicable;

(b) The service assisting with education, training, and support for consumers to maximise their participation in the service;

(c) Training for service providers in working with consumers as advisors;

(d) Advisors liaising with consumer groups or networks.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.5.5 The service implements processes that involve consumers at all levels of service delivery.

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.6 Family/Whānau Participation

Family/Whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

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

Family/whanau provide feedback to the service via satisfaction surveys, verbal feedback, and compliment/comment/complaint forms that are available. They also attend social gatherings from time to time in which informal feedback is gathered. AGHG communication feedback loop has been developed by the consumer consultant: Tri monthly cycle of Hoon Hay Village residents /consumers feedback meetings (residents – staff – GHG Executive Management (Executive members with Consumer Consultant, RN Manager) quarterly.

Family/whanau are now being directly involved with policy and service development advisory capacity at Hoon Hay Village mental health unit by having an experienced family support worker from Supporting Families in mental illness, Canterbury facilitating six monthly meetings for residents and families, providing training to staff on family inclusiveness and reviewing the Hoon Hay Village policy on family/whanau involvement policy.

Criterion 1.2.6.1 The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.6.2 Family/Whānau who participate in an advisory capacity have clear terms of reference.

This shall include, but is not limited to:

(a) Advice is sought from family/whānau advisory groups when developing terms of reference;

(b) Roles and responsibilities shall be clearly outlined and include accountabilities, confidentiality, and conflicts of interest.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.6.3 The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view.

This shall include, but is not limited to:

(a) Employing family/whānau where practicable;

(b) The service assisting with education, training, and support for families/whānau to maximise their participation in the service;

(c) Training for service providers in working with families/whānau as advisors;

(d) Advisors liaising with family/whānau groups or networks.

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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 job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of registered nurses are current. The service also maintains copies of other visiting practitioners certification including GP, pharmacist and physiotherapist. Staff files (17) were reviewed including three unit managers, three registered nurses (one rest home and two dementia), nine care givers (three rest home and six dementia), and two cooks. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, reference checks and training. There is an annual appraisal process in place and appraisals are current in 15 of 17 files reviewed - (two staff have commenced employment within the last 12 months and are therefore not yet due for annual appraisal).

There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. The registered nurses complete a specific orientation for registered nurses. Interview with 13 caregivers (three rest home and 10 dementia) described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. This was verified by the manager. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Each session includes an attendance sheet and training content. In-service education is conducted every second month following staff meetings with self-learning tools and competencies completed on alternate months. For those staff members who are unable to attend education, a competency is completed. Comprehensive records are kept. Interview with caregivers and four registered nurses advised that there is access to sufficient training. Medication competencies are completed for all nurses and caregivers who administer medication. These are checked by the registered nurses. Education conducted for 2013 includes wound care, challenging behaviours, falls prevention. In 2012 education provided included: hearing aids, medications, safe chemical handling, asthma and COPD, skin tears, manual handling, diabetes, fire training, wound care, health and safety and emergency preparedness, code of resident's rights, documentation, continence, hand hygiene, manual handling, restraint. Self-learning tools and competencies have been completed for dementia and challenging behaviours, documentation, abuse and neglect and discrimination, restraint, wound care, code of resident's rights, cultural safety and Treaty of Waitangi, infection control and restraint.

There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, restraint, and insulin administration.

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

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

E4.5f There are 17 caregivers who work in the dementia unit - eight have completed the required dementia standards, six caregivers are in the process of completing. The three caregivers who are yet to start have all commenced employment within the last six months.

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.

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

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

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery included in the rostering policy. Five caregivers interviewed reported that staffing levels and the skill mix was appropriate and safe. One staff member reported that there has been issues regarding night duty staffing in the dementia unit. Five mental health residents and nine family members interviewed advised that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that there is a registered nurse either on duty or on call at all times, and that at least one staff member on duty will hold a current first aid qualification. New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. The managers of both units stated that the roster is able to be changed in response to resident acuity. However there is an improvement required to ensure there are enough staff on duty in the dementia unit.

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

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery included in the rostering policy. One incident which was documented as occurring on 18 June 2013 involved a dementia resident being found on the ground outside in the garden by the morning staff was reviewed. The resident was assisted to stand by two staff members, and an ambulance was called following assessment of resident by RN to transfer the resident to hospital as staff were uncertain as to how long the resident had been outside and what caused the resident to be on the ground. The residents family member was informed of the incident and the residents admission to hospital. The resident was discharged from hospital with a diagnosis of myocardial Infarction. Resident showed signs of hypothermia on admission to hospital. An investigation of the incident was evidenced completed by the facility manager which evidenced discussion with the night staff member who was on duty and identified that the resident had been sighted by the night staff member on duty at 6.30am. Resident was found outside at 8am. Corrective actions were put in place immediately following the incident. Staff now sight allocated residents after hand over and door alarms are to be left on at all times, and during the winter months doors to the garden area are to be locked. On discussion with the facility manager one night staff member had phoned in sick at the last minute and was unable to be replaced by a permanent member of staff or agency caregiver. The manager was available on call.

Finding Statement

Hoon Hay Dementia: The roster sighted for 17 Jun 2013 evidenced that there was only one of two night staff members on duty in the dementia unit.

Corrective Action Required:
Ensure there are enough staff on duty to meets the needs of the residents.

Timeframe:
1 month

STANDARD 1.2.9 Consumer Information Management Systems

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

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

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

All resident files are hard copy. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Residents files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Both services keep a resident register.

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

Resident files are stored securely and protected from unauthorised access by being held at the nurses' station in a secured room. Old files are individually archived and locked in a secure area for 10 years.

There is an improvement required around the storing of residents personal information/documents.

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

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Eight of ten resident files reviewed contained only information relating to those residents.

Finding Statement

Hoon Hay Dementia & Hoon Hay Mental Health: Personal documents pertaining to other residents was found in two resident files reviewed (one mental health and one dementia).

Corrective Action Required:
Ensure that documents personal to residents are kept private and secure.

Timeframe:
1 month

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.

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

Golden Healthcare Group Hoon Hay has two units - Hoon Hay Village mental health unit and Hoon Hay dementia care unit.

Mental Health: This unit is managed by an experienced RN who is responsible for screening of admissions. The unit has contracts to provide level five mental health residential care. Each resident admitted has been assessed and coordination of admission is via one of two mental health referral agencies attached to the Canterbury DHB. All admissions are timely and in consultation with the transferring provider such as community support workers, GP, psychiatrist, acute mental health care, or social workers. On entry there is an admission process which includes collection of personal data and details as evidenced in five of five mental health residents files reviewed. An information pack includes provision of services for prospective residents. Policies and procedures are

implemented to ensure that entry to the service is coordinated and facilitated in a least disruptive manner. Entry criteria is based on management of waiting lists - which is clearly communicated to consumers, and includes risk assessment protocols, crisis intervention services, relapse prevention plans and advance directives.

Dementia Care: The dementia care unit has an experienced manager (previous RN) who is responsible for the screening of admissions in conjunction with the RN. There is evidence of needs assessor service coordination assessments prior to entry in five of five dementia care resident files reviewed. All admissions are timely and in consultation with the transferring provider such as other facility, community, social worker or Canterbury district health board. On entry there is an admission process which includes collection of personal data and details. An information pack includes provision of services for prospective residents and their families.

E4.1.b There is written information on the service philosophy and practices particular to the Hoon Hay dementia unit included in the information pack and complaints process, safe environment, staff skills which includes understanding behaviours and restraint minimisation and safe practice.

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

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

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

E3.1 Five of five dementia unit resident files were reviewed and all include a needs assessment as requiring specialist dementia care.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.1.5 To facilitate appropriate and timely entry to the service, a system is implemented to prioritise referrals and identify potential risks for each consumer, including considering previous risk management plans.

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.

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 records the reason for declining entry should this occur. There are documented and implemented policies and procedures for declining entry to GHC group facilities.

Mental health: The RN manager of the mental health unit holds weekly meetings with referral agencies to discuss potential residents, and to prioritise admissions. The referrer is informed of any potential decline to entry and this is communicated to the resident/family/whanau in a timely manner. The RN manager from the mental health unit and EN in the dementia unit interviewed where knowledgeable in the reporting and referral process for declining entry. Reasons for declining entry in the mental health unit would be if the person is assessed as not appropriate for the service, if the care requirements are outside the scope of the DHB contracts or no beds are available. The responsibility for finding alternative accommodation lies with the coordination service. Reasons for declining are documented for future reference.

Dementia unit: Reasons for declining entry in the dementia unit would be if the person does not have the appropriate assessment completed or there are no beds available.

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.

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

Mental Health: The RN manager completes a nursing comprehensive admission assessment and initial care plan within 24 hours of admission to the unit. Information is gathered from the resident, needs assessment, GP letters and medical history, discharge summaries and allied health professionals to form a basis and guide for the safe delivery of care. The resident and their family/whanau (if appropriate) are involved in the initial plan of care, in the development of the crisis prevention plan, and in the development of the IDP - individual development and treatment plan (long term care plan). Residents (five) and family (four) interviewed confirmed they were involved in crisis prevention plans, IDP care planning, and are informed of health changes and any medical or nursing interventions required to meet the residents health needs.

Five of five IDP's reviewed were developed and completed within three weeks of admission. The resident signs a summary of the IDP which outlines the various life domains of the IDP. There is documented evidence that the IDP care plans were reviewed by the RN manager and amended with current changes. All care plans evidenced evaluations completed at least six monthly.

The resident's GP conducts three monthly medical reviews and more frequently as required. There is also evidence of regular psychiatrist reviews if the resident is under the care of a psychiatrist. Both psychiatrist and GP interviewed confirm that communication channels facilitate a team approach to resident care. Medical notes are maintained. Residents may retain their own GP or register under the Home GP. On interview the GP advised that RN manager, enrolled nurse or senior support workers are prompt to notify him of any residents health changes. Allied health professionals involved in the care, intervention and management of residents record entries into the resident files. Progress notes are maintained and there is verbal handover at the beginning of each shift ensuring all staff involved in the delivery of care are kept informed of residents health status and any changes to care plans. The service aims to promote wellness and community integration. Where appropriate, plans are formulated to assist residents to supported independent living arrangements.

Five mental health resident files sampled.

Tracer methodology: Mental Health resident.

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

Dementia unit: The RN completes an initial assessment and an initial care plan within 24 hours of admission. Information is gathered from the family, needs assessment, GP letters and medical history, discharge summaries and allied health professionals to form a basis and guide for the safe delivery of care. The resident (if appropriate) and their family/whanau are involved in the initial plan of care. Five relatives interviewed confirmed they were involved in care planning, informed of health changes and any medical or nursing interventions required to meet the residents health needs.

The five files reviewed identified that in all five resident files, an initial assessment was completed within required timeframe of 24 hours. Five of five dementia care resident files identify that the long term care plan was completed within three weeks.

There is documented evidence that the care plans were reviewed by the RN and amended with current health changes. All care plans evidenced evaluations completed at least six monthly.

Five of five resident files reviewed identified that the GP had seen the resident within two working days. The GP conducts three monthly medical reviews and more frequently as required (confirmed on interview). Medical notes are maintained. Residents may retain their own GP or register under the Home GP. On interview the GP advised that RN and senior care staff are prompt to notify him of any resident's health changes. Allied Health professionals involved in the care, intervention and management of residents record entries into the resident files. Progress notes are maintained and there is verbal handover at the beginning of each shift ensuring all staff involved in the delivery of care are kept informed of residents health status and any changes to care plans.

Five resident files sampled.

Tracer methodology: Dementia care 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:

Criterion 1.3.3.5 The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.3.6 The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.

This shall include, but is not limited to:

(a) Consumer support group referrals;

(b) Education programmes;

(c) Consultation and liaison with community groups or relevant self-help groups.

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.

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

Mental Health: The RN manager develops an initial assessment within 24 hours of the resident's admission. All available information is gathered including care coordination needs assessments, social worker information, GP medical history and medications, allied health professional records/letters, discharge summaries, specialist letters and information. The resident and their next of kin (if appropriate) provide personal information, other details and provide input into the nursing comprehensive admission assessment, crisis prevention plans and individual development plans. The nursing comprehensive assessment covers communication, mobilising, nutrition, activities of daily living, behaviours, mental state, elimination, skin, pain, social needs, spiritual care, cultural and advanced directives. Further separate assessments used include skin assessment, Coombes falls risk assessment, pain, continence, food and nutrition, and risk assessment for suicide/self-harm. Occupational therapists also conduct assessments for the activities plan and completes a cognitive assessment for each resident. The use of assessment tools identify risk and interventions, equipment and resources required to ensure the safety of the resident. The range of assessment tools are completed on admission and reviewed at least six monthly. Assessments were completed in five of five resident files reviewed. One Maori resident has a comprehensive cultural assessment completed by a Maori provider at the local DHB and this has been utilised in the resident's long term care plan.

Dementia care: The RN develops an initial assessment within 24 hours of the resident's admission. All available information is gathered including needs assessments, social worker information, GP medical history and medications, allied health professional records/letters, discharge summaries, specialist letters and information. The resident and their next of kin (if appropriate) provide personal information, other details and provide input into the initial nursing admission assessment and initial care plan, and the long term care plan. Further assessments used include skin assessment, Coombes falls risk assessment, continence, food and nutrition, abbey pain scale, pressure area risk. Diversional therapist conducts a social profile on which to base the activity plan. The use

of assessment tools identify risk and interventions, equipment and resources required to ensure the safety of the resident. The range of assessment tools are completed on admission and reviewed at least six monthly. The RN has completed InterRai assessment training and has commenced using the tool. All information is used to form a basis for service delivery planning.

ARC E4.2; Five dementia resident files reviewed included an individual assessment that identified diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed for five of five dementia unit resident files reviewed.

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:

Criterion 1.3.4.5 Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.

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.

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

Mental Health: Individual development plans (IDP) are developed from assessment information, on-going collection of information, progress notes, monitoring and observations over a three week period following admission. This support plan includes seven headings covering daily living situation, financial, vocational/education, physical/emotional health, leisure/recreation, social supports, and spiritual/cultural. The long term care plan is resident focused and is developed with the resident with issues, diagnosis, individual goals and interventions to promote wellbeing and independence. Short term care plans are used to document any changes in health needs such as wound management, toileting regime, respiratory infections. These are kept alongside the long term care plan until resolved or included into the long term care plan as an on-going need. Care plans are kept in the resident file integrated with other records including the progress notes, medical notes, RN/family contact forms, allied health professional notes, risk assessment tools, incident and infection summary. Crisis prevention plans are developed with the resident as evidenced in five of five files reviewed. This plan identifies triggers, signs of unwellness, action to take, people to contact and has the resident's signature and a review date. Crisis prevention plans are reviewed six monthly. The occupational therapist develops an activities plan with the resident which includes goals, timetable, and attendance records. Five residents and four family members interviewed stated they were involved in all aspects of care planning. One RN manager and one enrolled nurse interviewed confirmed family were contacted in regards to any changes or resident needs and conversations were recorded in the RN notes or family contact sheet.

Dementia Care: Long term care plans are developed from assessment information, on-going collection of information, progress notes, monitoring and observations over a three week period following admission. The long term care plan is resident focused with a issues, diagnosis, individual goals and interventions to promote wellbeing and independence. Current individual physical and cognitive abilities are identified with achievable objectives and outcomes for the resident. The long term care plan includes: mental state/behaviours, cognitive function, mobility, hygiene/grooming, nutrition/hydration, elimination, sleep patterns, medications, respiratory, skin integrity, pain, social/cultural/spiritual, and activities plan. Short term care plans are used to document any changes in health needs such as pain, tooth extraction, weight loss, post-acute admission care, wounds, falls, and infections. These sit alongside the long term care plan until resolved or included into the long term care plan as an on-going need. Care plans are kept in the resident file integrated with other records including admission information, informed consent forms, progress notes, assessments, observations, multi-disciplinary team meeting records, family consult records, medical admission and medical progress notes, DT records, allied health professional notes, assessment tools, incident and infection summary.

Five family members interviewed stated they were involved in all aspects of care planning. One RN interviewed confirmed family were contacted in regards to any changes or resident needs and conversations were recorded in the RN notes or family contact sheet. Allied health professionals record visits in their progress notes in the integrated resident file.

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

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

D16.3f; Five dementia resident files reviewed identified that family were involved. There are RN and family contact sheets in use in each residents file.

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:

Criterion 1.3.5.4 The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.

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.

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

Mental health: The use of nursing comprehensive admission assessment tool and the individual development plan (IDP) identifies the need for interventions, care and support to meet the needs, goals and outcomes for the resident. On interview the GP and the psychiatrist confirmed that they are notified promptly when their patients' health status has changed and stated the clinical staff were experienced in assessing residents and reporting appropriately. A community mental health support worker was interviewed. She visits weekly and provides follow up and support to residents, staff and families on specific mental health issues, problems and management. The support worker initiates also facilitates referrals to the GP or acute psychiatric services team if required. Interventions in the IDP relate to seven aspects of care and support: daily living situation, financial, vocational/education, physical/emotional health, leisure/recreation, social supports, and spiritual/cultural. Five of five IDP's reviewed evidence individual and personalised care plans that are tailored to meet specific goals for each resident. A crisis intervention plan is developed with the resident and includes actions to take in the event of signs of unwellness being identified. The resident focused IDP care plans have a wellness focus and promote mental health and wellbeing. Residents have access to physiotherapist, podiatry and OT.

Dementia care: The nursing assessment completed on admission, along with the on-going assessments and six monthly review, form the basis of the long term care plan. Interventions relate directly to personalised goals and issues identified as evidence in five of five dementia resident's files reviewed. One resident has an identified issue with choking risk - the care plan interventions are detailed and relate to preventative measures as well as first aid measures should a choking incident occur. It was noted however, that the interventions for first aid in the event of choking are no longer considered best practice. Improvements are required whereby the documented interventions reflect current best practice.

Mobility aids required to meet the mobility needs and safety of residents assessed needs were available and referrals made to the physiotherapist as needed. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for five residents (three skin tears; one chronic lesion; and one graze) The RN interviewed described the referral process should they require assistance from a wound specialist or continence nurse. Additional resources and products were readily available on request.

D18.3 and 4 There are adequate dressing supplies and a range of products available.

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

Interventions relate directly to personalised goals and issues identified as evidence in five of five dementia resident's files reviewed. One resident has an identified issue with choking risk - the care plan interventions are detailed and relate to preventative measures as well as first aid measures should a choking incident occur. It was noted, however, that the interventions recorded for first aid in the event of choking are no longer considered best practice.

Finding Statement

Hoon Hay Dementia: Documented interventions for one resident with choking risk are no longer current best practice.

Corrective Action Required:
Ensure documented interventions for choking risk resident reflect current best practice.

Timeframe:
3 months

Criterion 1.3.6.3 The consumer receives the least restrictive and intrusive treatment and/or support possible.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.6.5 The consumer receives services which:

(a) Promote mental health and well-being;

(b) Limit as far as possible the onset of mental illness or mental health issues;

(c) Provide information about mental illness and mental health issues, including prevention of these;

(d) Promote acceptance and inclusion;

(e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

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.

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

Mental health: An occupation therapist is employed 16 hours per week. The current OT is covering for maternity leave. An activities coordinator is employed 30 hours per week and coordinates and facilitates the activities programme. She has completed the national certificate in mental health. The activities programme is appropriate to the setting of the service and meets the individual abilities. The OT and activities coordinator meet to organise the monthly programme which has a week by week plan. The OT provides a monthly report to the quality assurance meeting on the mental health unit's activities programme. The programme is displayed on the four notice boards with the unit. Residents meet regularly to discuss the programme and to make suggestions for outings and activities. The activities coordinator advised that she transports residents to numerous community groups and activities in the community including mental health support and drop in centres (three), the local library, church groups and services, swimming, shopping, visiting family. In the unit there are activities held in the purpose built OT room which has a kitchen and dining area and space for arts and crafts and games. Activities include a men's group, a women's group, baking, coffee group, word games, housie, and cooking. One to one cooking assessments are conducted for those residents who wish to be more independent. A six week healthy living course was recently held with 11 residents completing the course. Family parties and BBQ's are held and a large games room is used for playing pool. A TV room/movie room is also available for residents. The programme is flexible to meet the individual ability and resident choice. A small vegetable garden is cared for by the residents and provides the OT kitchen with herbs and vegetables. Special occasions and festivities are celebrated. Residents are encouraged to maintain community links. Resident activities were observed in the mental health unit .

Each resident has an OT assessment, cognitive assessment, personal profile, past and present activities and interests, a plan, timetable, attendance records, evaluation and progress notes. OT and activities coordinator are involved in the MDT meetings for residents. The resident and/or their family are involved in the activity care plan. Residents sign the care plan and attendance records. Residents and families interviewed confirm that are involved in the activity care plan and are able to provide feedback and suggestions on the programme.

There are monthly resident meetings held in the mental health unit with an opportunity to provide feedback and suggestions on the activity programme.

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

Dementia care: The diversional therapist (qualified July 2013) works 30 hours/week and has worked in the dementia unit for the past two years (as activities coordinator). The activities programme is appropriate to the setting of the service and meets the individual abilities. Activities are provided by care staff on duty in the weekends. Activities are person centred, flexible and timed to meet identified individual behaviours such one to one walks, reminiscing, photo books, activities boxes and tool boxes. Sing-alongs and entertainment are enjoyed. Van rides are provided for those residents who are able. The car givers and DT ensure activities are provided over a 24 hour period as required. An activities trolley is set up at all times for diversional activities which care givers can utilise for residents who are restless or wandering and include photo books, puzzles and things to look at and touch. Activities programme includes housie, exercises, news and views, arts and crafts, one to one time, walks, indoor games, entertainment twice a week, ladies and men's groups, word games, happy hour, garden walks, ball activity. Special occasions and festivities are celebrated with church services held weekly. Resident activities were observed in the dementia care unit - newspaper reading and discussion, a word finder quiz, visiting musical entertainment and happy hour.

Each resident has a personal profile, past and present activities and interests, a plan which includes behaviours, triggers, and activities for morning, afternoon and night time, a person centred summary, monthly progress review and evaluation and activities attendance records. The resident and/or their family are involved in the activity care plan. Families interviewed (five) confirm that are involved in the activity care plan and are able to provide feedback and suggestions on the programme. There are three monthly resident meetings with an opportunity to provide feedback and suggestions on the activity programme.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed at the time of 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.

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

Mental Health: Individual development plans (IDP) and crisis prevention plans are evaluated at least six monthly and when there is a change in the health status of the resident. Five of five residents' files sampled evidence that evaluations of IDP's are within stated timeframes and reviewed more frequently if a resident's condition changes. The GP reviews residents' medical condition and medication charts at least three monthly as evidenced on GP interview and files reviewed. Evaluations are conducted by the RN manager with input from the resident, family, enrolled nurse, support workers, and GP. Family are notified (where appropriate) of any changes in resident's condition, evidenced in residents' files sampled . Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. Each life domain aspect of the IDP is reviewed and updated to reflect current care requirements. Risk assessment tools are evaluated at the time of the care plans review or earlier if there is an increase in risks identified for the resident. Short term care plans are evaluated and signed off as resolved. The IDP summary is reviewed with the resident who signs if when review is undertaken. Multidisciplinary team meetings are held six monthly and involve the resident, RN, GP, OT, and care staff.

Dementia care: Long term care plans are evaluated at least six monthly and when there is a change in the health status of the resident. Five of five residents' files sampled evidence that evaluations of long term care plans are conducted within stated timeframes and reviewed more frequently if a resident's condition changes. The GP reviews residents' medical condition and medication charts three monthly or more frequently if required. Evaluations are conducted by the RN with input from the family, care givers, and GP. Family are notified of any changes in resident's condition, evidenced in residents' files sampled . Five family members interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. Risk assessment tools are evaluated at the time of care plan review or earlier if there is an increase in risks identified for the resident. Short term care plans are evaluated regularly with any on-going needs being included in the six monthly review.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.8.4 Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.

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.

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

Mental Health: Referrals are actioned by the RN manager as required with input from community support worker if appropriate. Referrals evidenced in five files reviewed include referral to dietitian, psychiatrist, GP, continence nurse, podiatry, acute medical and psychiatric care. Specific referral forms are used and sent via fax or mail. Records of the referrals are maintained in the residents files. Residents are consulted regarding referrals and are involved in the process of referrals.

Dementia care: The RN initiates referrals for any residents requiring specialist input. Referrals for allied health professionals are made to the DHB psychiatric services for elderly. There was evidence of referral letters noted on resident files including: needs assessment team, physiotherapist, dental, speech

language therapist, dietitian, district nursing service. The RN and family contact forms record families have been contacted regarding referrals and advised of options and choice of service.

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

D 20.1 Discussions with registered nurse identified that the service has access to a range of allied health 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.

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

Mental health: Advised by the RN manager that transfers are coordinated with residents ensuring a seamless transition of care. While discharge planning is available, advised that the majority of residents do not progress to more independent living arrangements. Transfers are made to acute care and necessary correspondence and documentation is provided.

Dementia Care: Transfers take place where needs have been assessed at a higher level of care or when the resident is admitted for acute care. This is coordinated between the RN and family ensuring a seamless transition of care. The RN ensures re-assessments were timely and staff and family are kept informed of progress.

Registered nurse interviewed was able to describe the process and documentation required for an external transfer to other provider or hospital. The DHB have a transfer checklist and form to be completed.

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.

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

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

Mental health: There are medicine management policies and procedures in place. A pharmacy contract is held with a local pharmacy for the supply of all pharmaceuticals to GHC Hoon Hay village - mental health unit. All medicines received are signed in and checked by the RN manager and recorded in a register for delivery. All medicines are stored safely in a locked treatment room. The medication trolley is locked and stored securely in the treatment room when not in use. Returns to the pharmacy are kept in the locked treatment room until collected by pharmacist. All eye drops and topical treatments were dated when opened. The medication fridge temperature is monitored and recorded weekly and has a thermometer in place for visual checks. One support worker in the mental health unit was observed during the lunch time medication round. Correct procedures were followed. Controlled drugs are stored in a locked safe in the treatment room. There is currently no residents on controlled drug medication. The controlled drug register was reviewed and evidenced correct completion for previous controlled drug administration, weekly stocktakes of controlled drugs and six monthly pharmacy audit as recorded in the CD Register. Ten medication charts were reviewed. Three monthly medication reviews by the GP are evidenced and confirmed on interview with the GP. Advised by the psychiatrist that any new medications or changes to medications are done in consultation with the resident with follow up and support from community support workers, GP and psychiatrist services. Regular medications are prescribed correctly, are legible and administration signing sheets are completed. It was noted on review of 10 medication charts that three of 10 PRN medication orders did not detail indications for use and two of 10 charts did not record allergies or nil known allergies. Improvements are required in this area. A PRN medication administration form is utilised to record the PRN medication given and effectiveness of the medication. All medicines competent persons attend annual medication training. Annual medication competency is completed for support workers, enrolled nurse and RN manager. The specimen signatures list was sighted. There are currently no residents self-medicating. Six monthly MDT reviews include medication discussion with the resident and family. Resident and families confirmed they were kept informed of medication use, changes and information.

Dementia Care: There are medicine management policies and procedures in place. A pharmacy contract is held for the supply of all pharmaceuticals to Hoon Hay dementia care unit. All medicines received are signed in and checked by the RN against the resident medication drug chart. All medicines are stored

safely in a locked treatment room in the nurses' station - which adjoins the two 20 bed resident areas. Two medication trolleys are locked and stored securely when not in use. Returns to the pharmacy are kept in a locked room until collected by pharmacist. All eye drops and topical treatments were dated when opened. The medication fridge is monitored and recorded weekly and the fridge has a thermometer in place for visual checks. One care giver in the dementia unit was observed during the lunch time medication round. Correct procedures were followed. Controlled drugs are stored in a locked safe. No residents are currently on controlled drugs. The controlled drug register was reviewed and evidenced correct completion, weekly stocktakes of controlled drugs and six monthly pharmacy audit as recorded in the CD Register for previous controlled drugs administered. Allergies or nil known allergies are recorded on the medication administration sheet as evident in 10 medication charts reviewed.

All medicines competent persons attend annual medication training. Annual medication competency is completed. The specimen signatures list was sighted for all staff. Six monthly MDT reviews include medication discussion with the family. Five families confirmed they were kept informed of medication use, changes and information.

D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed. The GP interviewed confirmed he reviewed the resident's medication three monthly or more frequently as required.

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

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

Mental health: Ten medication charts were reviewed. Three monthly medication reviews by the GP are evidenced and confirmed on interview with the GP. Regular medications are prescribed correctly, are legible and administration signing sheets are completed.

Finding Statement

Hoon Hay Mental Health On review of 10 medication charts it was noted that a) Three of 10 PRN medication orders did not detail indications for use. b) Two of 10 charts did not record allergies or nil known allergies.

Corrective Action Required:
a) Ensure all PRN medication orders detail the indications for use . b) Ensure all medication charts record allergies/adverse reactions or nil known allergies.

Timeframe:
1 month

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.12.7 Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

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 food for both mental health unit and dementia care unit are prepared in a centralised kitchen which is adjacent to one of the 20 bed areas of the dementia unit. Food is transported to the mental health unit and to the other 20 bed area of the dementia unit in hot boxes. The food is then served to residents from bain marie's. The cook is qualified in food safe handling and works full time. The cook orders in all food supplies and has a tracking system in place. A dietitian conducts menu reviews (April 2013) and all special/modified diets are met including: diabetic, pureed, soft, moist, and vegan. Resident likes and dislikes are known and alternative meals offered. Individual religious and cultural dietary needs are met. Food allergies are noted and catered for. The staff notify the kitchen with any resident changes in a timely manner. Feedback on the meals is provided via resident meetings in the mental health unit and from resident surveys. There are specialised crockery and utensils available to promote resident independence at meal times. Residents are offered fluids throughout the day. Residents' files sampled (five mental health and five dementia) demonstrate regular monthly monitoring of individual resident's weight. Five residents interviewed (mental health) and five relatives (dementia unit) were satisfied with the food service, report the individual preferences are met and adequate food and fluids are provided. A dietitian has input in to the summer and winter four week menu - reviewed two yearly. The dietician also provides input into the resident's weight management and special diets required to maintain weight such as dietary supplements and drinks. Hot food temperatures are monitored daily and fridge and freezer monitoring is done weekly. All perishable foods in fridges are dated and labelled. Food handling staff were observed wearing aprons, hats and gloves. Cleaning schedules are in place and implemented.

E3.3f, There is evidence that there is additional nutritious snacks available over 24 hours with food available in the dementia unit such as sandwiches, fruit, and other appetising "finger foods".

D19.2: All food handling 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.

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 waste management, hazardous substances and chemical safety policies and procedures. The maintenance person is responsible for waste management. Staff were observed using correct waste management receptacles for refuse. All general waste is emptied into skip bins collected by contracted service. Infectious waste is bagged and sharps containers are collected by an external contractor. There are blood and body fluid clean up equipment held in the sluice rooms. Chemicals are delivered and stored in a locked designated area. Protective wear is provided and includes gloves, aprons, face shields and masks for both the mental health unit and the dementia unit. The maintenance person is responsible for the storage and supply of chemicals to the kitchen, laundry, cleaning and sluice areas. All chemicals are in locked staff only areas. Ecolab visit regularly and provide training and education in chemical safety for kitchen, laundry and cleaning staff.

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.

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 displays a current building warrant of fitness which expires on 1 May 2014. The buildings are well maintained. The maintenance person carries out daily maintenance requests and planned maintenance as scheduled. Electrical checks are carried out and recorded.

Mental health unit: There are safe outdoor garden and seating areas with shaded areas. The interior is welcoming with décor, fixtures, furnishings and amenities selected to meet the consumer group needs and safety. The 40 bed unit is divided into four 10 bed modules with a dining room in each area. Access is to the mental health unit is through a separate entrance. Corridors in all areas are wide and spacious enough to allow residents the freedom to move around the facility with the use of mobility aids if required. There is adequate space for the use of wheelchairs. Safety handrails are in place along the corridors. There are adequate storage areas for equipment throughout the facilities. Visitors toilets are available. Staff amenities are available. Signage is clear. The carpets are well maintained and all wet floor surfaces are non-slip.

Dementia unit: There is sufficient space in the unit for access to mobility aids and wheelchairs as required or needs assessed. There are shower chairs, transferring aids and pressure area resources as required. There is a hoist and wheelchair scales available. Hoists were last serviced on 6 May2013. There are shower chairs, wheelchairs, mobility aids available. There are quiet areas provided to ensure residents privacy when required. The dementia care unit has three external entrances with walking paths and seating. Entry and exit are secure after hours. There are two internal doors in to the dementia unit with key pad locks.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities. Seating is appropriate and designed to meet the consumer group.

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

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

E3.4.c; There is a safe and secure outside area that is easy to access.

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.

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

Mental health: all rooms are single rooms with full ensuite facilities. Support workers were observed to knock on bedroom , toilet and bathroom doors before entering. Support workers interviewed confirmed residents privacy is respected when being supervised or allowing resident independence. Residents (five) and family (four) interviewed stated residents privacy is respected when staff are attending to personal hygiene requirements.

Dementia care unit: all single bedrooms with full ensuite facilities. There are pictures and signs on the toilet doors. All residents are assured privacy with doors being closed when they are being attended to in bathrooms or toilets. There are vacant/occupied signs on toilet doors. Staff were observed to knock on bedroom , toilet and bathroom doors before entering. Care staff interviewed confirmed residents privacy is respected when being supervised or allowing resident independence. Family interviewed (five) stated resident's privacy is respected when staff are attending to personal hygiene requirements.

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.

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

Mental health: the bedrooms in Hoon Hay village mental health unit are large and spacious enough for residents and staff to safely assist and manoeuvre residents if required. The bedrooms are personalised and residents are encourage to bring in their own personal items to furnish their bedrooms. The 40 bed unit has four modules of 10 bedrooms with a lounge and dining room in each module.

Dementia care: There are two 20 bed units both units have single bedrooms have personalised door names for easy recognition for the residents. The rooms are large enough for residents who mobilise with the assistance of mobility aids. Furnishings are personalised and the rooms are clutter free to help prevent risk of falls.

All residents (where appropriate) and families interviewed were happy with the bedroom space and layout of the room including being able to bring in personal belongings and adornments.

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.

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

Mental health: each of the four modules has a dining room and a lounge. There is also a large games room and a large TV room as well as a purpose built OT room with dining tables and a small kitchen. There is also an alcove area with a phone available for private telephone conversations and a portable phone for toll calls.

Dementia unit: the unit is divided by a door in to two areas of 20 beds - with dining and lounge areas in both areas. Both areas have spacious open plan dining and lounge area that meets the needs of the consumer and observational requirements for care staff. There is adequate space for activities persons to provide a group activity. The dementia care unit layout provides for freedom of movement within a safe and secure environment. There are external walking paths and internal space to allow wandering that is not obtrusive on other residents. There is sufficient space within the open plan dining and lounge areas to accommodate individual low stimulus activities and group activities. Resident dining can be easily observed and supervised. All communal areas can be observed from the nurses' station.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander

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.

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 cleaning and laundry policies and procedures in place. Laundry of towels and sheets is provided by an external commercial laundry service which collects and delivers linen daily for both dementia unit and mental health residents. The laundry person oversees the large laundry which has one large commercial washing machine and one large washing machine. Dementia unit residents personal items are laundered here. There are two dryers - one large and one smaller. There is sluice room in the dementia unit and a sluice area in the dirty area of the laundry. All laundry is sorted prior to washing. Ecolab chemicals are dispensed by oasis set system for cleaning and auto fed into washing machines for laundry processes. Soiled linen is managed according to procedure. Mental health unit residents are encouraged to do their own laundry with supervision from support workers. There are smaller domestic washing machines located in each unit where personal items are laundered. The main laundry, sluice and cleaning areas are locked and are staff only areas. There are good supplies of clean linen held in tidy linen storerooms in each area. Cleaning trolleys and equipment are stored securely when not in use. Wet floor signs are used. There is personal protective equipment available including heavy duty gloves, aprons, face shields and masks as appropriate. Cleaning schedules are in place and implemented. All other cleaning duties for sluice and laundry areas are on a yearly planner. The cleaners have a daily schedule with additional weekly duties. Ecolab carry out quality control checks and provide relevant training and education for staff. Internal cleaning and laundry audits are conducted regularly with the last audit conducted in 2013 with evidence of corrective actions taken.

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.

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

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

The service has an emergency manual and flip charts available in both the dementia unit and the mental health unit.

Mental health: there is currently a trained person with a first aid certificate on each shift. Hoon Hay village mental health unit has a NZFS approved fire evacuation scheme, dated 17 May 2012. A call bell light alerts staff to the area in which residents require assistance. The unit has one main entrance where residents, staff and visitors enter the facility. The mental health and dementia unit are connected via a service door and corridor which only staff can access. Staff room, laundry and kitchen are in this area. Fire drill last conducted 15 May 2013. Civil defence kits are stocked and available in the nurses' station and are checked three monthly. Call bell system evident and in use in the resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. Emergency manual includes fire and evacuation procedures, civil defence emergencies, a disaster plan including food and supplies, earthquake response, civil defence kits, resident and relative lists, and missing resident procedures. All staff have current first aid certificates.

Dementia unit: There is currently a trained person with a first aid certificate on each shift. Hoon Hay dementia unit has a NZFS approved fire evacuation scheme, dated 5 April 2011. A call bell light alerts staff to the area in which staff require assistance. The dementia unit has one main entrance where visitors

and contractors must sign in before entering the facility. The main entrance is where the dementia unit manager's office is as well as a meeting room. The dementia unit is accessible via two internal doors. Fire drill last conducted 15 May 2013. Civil defence kits are stocked and available in the nurses' station each unit and are checked three monthly.

Water is stored - sufficient for at least three days. Alternative heating and cooking facilities are available. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. Emergency manual and flip charts includes fire and evacuation procedures, civil defence emergencies, a disaster plan including food and supplies, earthquake response, civil defence kits, resident and relative lists, and missing resident procedures. The registered nurses and senior care givers have current first aid certificates.

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.

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 communal areas and all bedrooms have adequate natural light with large windows. There are a variety of heating methods used to maintain a warm environment within the communal areas and bedrooms including heat pumps and under floor heating. The temperature is thermostat controlled and can be individually adjusted in the resident bedrooms. Residents (five mental health) and families (four mental health and five dementia) interviewed advised that the bedrooms, lounges and other communal rooms are warm and comfortable.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

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 documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort.

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has no residents requiring the use of a restraint or enabler. There are clear guidelines in the policy to determine what is a restraint and what is an enabler.

There is a restraint approval group that is combined within the quality improvement group. It is responsible for prior approval of each individual resident's use of any form of restraint.

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

Education on the management of challenging behaviours occurred in August 2012.

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.

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

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

The service has an infection control programme with content and detail that is appropriate for the size, complexity, and degree of risk associated with the service.

The scope of the infection control programme policy and infection control programme description are available. The Infection control coordinator is the clinical coordinator for the group. There is an established and implemented infection control programme that is linked into the risk management system.

The two monthly Q&R meeting discusses key components and standing agenda items and includes reports from each part of the service including kitchen, cleaning, laundry, nursing/clinical, carers, infection control, management, activities, and quality programme. Progress of quality objectives are reviewed at the Q&R meeting. Monthly staff meetings take place in each unit with agenda items including discussion and reporting on quality and risk meeting minutes, resident care, uniforms, incidents/accidents, infection control, audits, corrective actions, complaints, health and safety and education. Minutes are available for staff.

Benchmarking occurs against other GHC facilities who provide similar service level care.

The facility has access to professional advice within the organisation and has developed links with the infection control nurse specialist CDHB, G.P's, the infection control and public health departments at the local DHB.

Information from these meetings is passed onto the management meeting, graphs and trend analysis is displayed in each of the notice boards.

The service has adequate signage at the entrance to each unit asking visitors not to enter if they have contracted or been in contact with infectious diseases. There is alcohol hand gel available at the entrance to each unit for visitor use.

Communal toilets/bathrooms have hand hygiene notices in large print.

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.

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 IPC Committee is made up of a cross section of staff from all areas of the service including; care giving, cleaning and laundry and professional nurses. The facility also has access to, infection control nurse specialist CDHB, G.P's and expertise within the organisation. The I.PC. coordinator, committee along with the governing body contribute to facilitation of the programme. There are internal and external seminars available for training as well as access to the IPC nurse Specialist, microbiologist, pharmacist and laboratory for additional education.

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.

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

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

The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes a job description, management of specific infections, specific polices for use of equipment, cleaning, responsibilities and oversight, the infection control team, quality improvement, training and education of staff.

Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual.

External expertise has been accessed by the infection control coordinator and quality consultant as required, to assist in the development of policies and procedures.

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.

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

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

The infection control coordinator is responsible for coordinating/providing education and training to staff. The infection control co-ordinator is the clinical coordinator who is an experienced registered nurse. There are internal and external seminars available for training as well as access to the infection control nurse specialist CDHB for additional education for both the coordinator and the staff. The infection control coordinator has completed education modules in infection control through CPIT. Orientation package includes specific training around hand washing and standard precautions. Training on Infection Prevention and Control was held in May 2012. Education records of attendance at infection control training are maintained on the staff personal file. The staff training folder includes the contents and objectives of the training session.

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 control data is collated monthly and reported at the Q&R meetings and staff meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the manager's report on quality indicators which is submitted to the quality assurance manager.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. The service has a proactive approach around follow up actions of infections and clinical indicators.

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: