

Lansdowne Park Village Limited

CURRENT STATUS: 04-Sep-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

Lansdowne Park is a purpose built facility which opened in October 2012 and provides rest home and hospital level care for up to 79 residents. Occupancy on the day of audit was 43 residents, 29 rest home including four residents in serviced apartments, and 14 hospital residents.

All residents and family interviewed praised the service for support and care provided within a comfortable and stimulating environment.

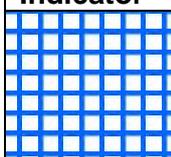
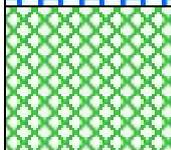
There is a quality and risk management programme that includes analysis of incidents, complaints and an implemented internal audit schedule. There is a schedule of meetings that provide an opportunity for all staff and residents to be engaged in analysis and discussion of issues. The facility manager (director) is supported by a clinical leader, and registered nursing and care staff.

There are improvements required around documentation of advance directives, aspects of care planning documentation, medication management and analysis of infection control data collected.

AUDIT SUMMARY AS AT 04-SEP-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

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights	Day of Audit 04-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk

Organisational Management	Day of Audit 04-Sep-13	Assessment
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained

Continuum of Service Delivery	Day of Audit 04-Sep-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 04-Sep-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 04-Sep-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 04-Sep-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.		Some standards applicable to this service partially attained and of low risk

AUDIT RESULTS AS AT 04-SEP-13

Consumer Rights

The service displays posters and pamphlets describing the Code of Health and Disability Services Consumers' Rights. Information about resident rights is also provided on admission to the facility. There is a complaints management process that meets the requirements of Right 10 of the Code. Staff and residents are aware of the complaints process and there is an up to date register documented. Resident values and beliefs are discussed in the initial assessment phase following admission and are documented in resident files. Staff are trained in resident rights and apply these in practice. Residents are encouraged to participate in community activities when possible and are supported to access activities that interest them. Residents have the opportunity to participate in a residents' meeting and there are annual satisfaction surveys for both residents and family. The service has in place a policy for informed consent. Required consent forms are evident in resident files reviewed. Residents and family interviewed praised the service for excellence of support provided.

An improvement is required in the signing of advance directives.

Organisational Management

The directors of the service live in the village and one is designated as the facility manager. Both have extensive experience in owning care services. They are currently recruiting for a facility manager noting that the service has only been opened for ten months. Policies and procedures have been purchased from an external consultant. There is a clinical leader who provides oversight of the service. Both the facility manager and clinical leader have extensive experience in aged care services and they are supported by caregivers who are skilled and experienced as stated by residents and family interviewed and through interviews. Documented procedures are followed for the recruitment, orientation and monitoring of staff performance. Staff training takes the form of on-going in-service monthly and participation of caregivers in the ACE/CareerForce programme. Regular in-service training for staff is well attended by caregivers.

The clinical leader and facility manager have at least eight hours training a year and there is a registered nurse available to relieve when the clinical leader is away.

There is an implemented quality and risk management programme that includes accident and incident reporting, infection control surveillance, internal audits, review of policies and procedures and hazard identification and management. Oversight and discussion occurs at the monthly staff meetings, weekly heads of department meetings. Corrective actions are issued as part of the audit process and resolution documented in the meeting minutes. Risks are identified and addressed.

Continuum of Service Delivery

Resident files reviewed include service coordination centre assessment forms. The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / Whanau or Enduring Power of Attorney. A registered nurse assessment, including a variety of risk assessments are completed on admission and reviewed three- six monthly following admission. The consumers' needs, and goals are clearly identified and interventions clearly guide staff. Residents and/or family have input into the development of care plans. Communication with family is well documented. Planned activities are appropriate to the various consumer groups. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly. An appropriate medicine management system is implemented. Policies and procedures detail service provider's responsibilities. Caregivers and registered nurses responsible for medicine management have attended in-service education for medication management and registered nurses and caregivers have current medication competencies. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are six residents who are self-medicating. An inspection of the medication systems evidenced compliance with respective legislation, regulations and guidelines. The service has transfer and discharge procedures. The staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital. A dietitian is available to provide dietetic assessment for residents and arrange special

authority's as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services. There are improvements required around aspects of care planning documentation, the evaluation of short term care plans and medication management.

Safe and Appropriate Environment

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. The building holds a Certificate for Public Use which expires in 2013. Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. All resident rooms have ensuite facilities. There are adequate toilets available close to lounge and communal areas. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The facility has under floor heating. The temperature of the facility is comfortable and constant and able to be adjusted in residents rooms to suit individual resident preference.

Restraint Minimisation and Safe Practice

Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate that residents are experiencing services that are the least restrictive. On the day of audit there is one resident assessed as requiring restraint use (bed rail) and one resident electing to use a bed rail as an enabler to help her get out of bed.

The service has processes in place for determining restraint approval and processes. Staff interviewed and files sampled evidence responsibilities are clearly identified and known. Resident files show that there is family input into the restraint approval processes. Restraint evaluation processes are documented in the restraint policy with monitoring of restraints when these are in place. Resident files evidence that each episode of restraint is being evaluated and based on the risk of the restraint being used. All staff receive on-going education on managing challenging behaviours and around restraint.

Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the facility and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the facility. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There is an improvement required whereby trending analysis of infections for the facility occurs .

Lansdowne Park Lifestyle Village

Lansdowne Park Village Limited

Certification audit - Audit Report

Audit Date: 04-Sep-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RN, Auditor certificate	12.00	8.00	04-Sep-13 to 05-Sep-13
Auditor 1	XXXXXXXX	RGON Lead auditor MBA MN B Ed Adv Dip Child and Family Dip Tchg	12.00	6.00	04-Sep-13 to 05-Sep-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX			2.00	

Total Audit Hours on site	24.00	Total Audit Hours off site <i>(system generated)</i>	16.00	Total Audit Hours	40.00
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Staff Records Reviewed	7 of 46	Client Records Reviewed <i>(numeric)</i>	8 of 43	Number of Client Records Reviewed using Tracer Methodology	2 of 8
Staff Interviewed	10 of 46	Management Interviewed <i>(numeric)</i>	4 of 4	Relatives Interviewed <i>(numeric)</i>	7
Consumers Interviewed	12 of 43	Number of Medication Records Reviewed	16 of 43	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	1

Declaration

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

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

Dated this 27 day of September 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit:

The audit summary has been developed in consultation with the provider:

Electronic Sign Off from a DAA delegated authority (*click here*):

Executive Summary of Audit

General Overview

Lansdowne Park is a purpose built facility which opened in October 2012 and provides rest home and hospital level care for up to 79 residents. Occupancy on the day of audit was with 43 residents, 29 rest home including four residents in serviced apartments, and 14 hospital.

All residents and family interviewed praised the service for support and care provided within a comfortable and stimulating environment.

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There are improvements required around documentation of advance directives, aspects of care planning documentation, medication management and analysis of infection control data collected.

1.1 Consumer Rights

The service displays posters and pamphlets describing the Code of Health and Disability Services Consumers' Rights. Information about resident rights is also provided on admission to the facility. There is a complaints management process that meets the requirements of Right 10 of the Code. Staff and residents are aware of the complaints process and there is an up to date register documented. Resident values and beliefs are discussed in the initial assessment phase following admission and are documented in resident files. Staff are trained in resident rights and apply these in practice. Residents are encouraged to participate in community activities when possible and are supported to access activities that interest them. Residents have the opportunity to participate in a residents' meeting and there are annual satisfaction surveys for both residents and family. The service has in place a policy for informed consent. Required consent forms are evident in resident files reviewed. Residents and family interviewed praised the service for excellence of support provided.

An improvement is required to advance directives.

1.2 Organisational Management

The directors of the service live in the village and one is designated as the facility manager. Both have extensive experience in owning care services. They are currently recruiting for a facility manager noting that the service has only been opened for ten months. Policies and procedures have been purchased from an external consultant. There is a clinical leader who provides oversight of the service. Both the facility manager and clinical leader have extensive experience in aged care services and they are supported by caregivers who are skilled and experienced as stated by residents and family interviewed and through interviews. Documented procedures are followed for the recruitment, orientation and monitoring of staff performance. Staff training takes the form of on-going in-service monthly and participation of caregivers in the ACE/CareerForce programme. Regular in-service training for staff is well attended by caregivers.

The clinical leader and facility manager have at least eight hours training a year and there is a registered nurse available to relieve when the clinical leader is away.

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1.3 Continuum of Service Delivery

Resident files reviewed include service coordination centre assessment forms. The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / Whanau or Enduring Power of Attorney. A registered nurse assessment, including a variety of risk assessments are completed on admission and reviewed three- six monthly following admission. The consumers' needs, and goals are clearly identified and interventions clearly guide staff. Residents and/or family have input into the development of care plans. Communication with family is well documented. Planned activities are appropriate to the various consumer groups. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly. An appropriate medicine management system is implemented. Policies and procedures detail service provider's responsibilities. Caregivers and registered nurses responsible for medicine management have attended in-service education for medication management and registered nurses and caregivers have current medication competencies. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are six residents who are self-medicating. An inspection of the medication systems evidenced compliance with respective legislation, regulations and guidelines. The service has transfer and discharge procedures. The staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital. A dietitian is available to provide dietetic assessment for residents and arrange special authority's as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services. There are improvements required around aspects of care planning documentation, the evaluation of short term care plans and medication management.

1.4 Safe and Appropriate Environment

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. The building holds a Certificate for Public Use which expires in 2013. Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. All resident rooms have ensuite facilities. There are adequate toilets available close to lounge and communal areas. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The facility has under floor heating. The temperature of the facility is comfortable and constant and able to be adjusted in residents rooms to suit individual resident preference.

2 *Restraint Minimisation and Safe Practice*

Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate that residents are experiencing services that are the least restrictive. On the day of audit there is one resident assessed as requiring restraint use (bed rail) and one resident electing to use a bed rail as an enabler to help her get out of bed.

The service has processes in place for determining restraint approval and processes. Staff interviewed and files sampled evidence responsibilities are clearly identified and known. Resident files show that there is family input into the restraint approval processes. Restraint evaluation processes are documented in the restraint policy with monitoring of restraints when these are in place. Resident files evidence that each episode of restraint is being evaluated and based on the risk of the restraint being used. All staff receive on-going education on managing challenging behaviours and around restraint.

3. *Infection Prevention and Control*

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the facility and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the facility. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There is an improvement required whereby trending analysis of infections for the facility occurs .

Summary of Attainment

1.1 Consumer Rights

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

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

1.2 Organisational Management

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

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

1.3 Continuum of Service Delivery

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

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 9	PA Neg: 0	PA Low: 2	PA Mod: 1	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:18	PA:3	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

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

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

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	FA	0	1	0	0	0	6
Standard 2.2.1	Restraint approval and processes	FA	0	1	0	0	0	3
Standard 2.2.2	Assessment	FA	0	1	0	0	0	2
Standard 2.2.3	Safe restraint use	FA	0	3	0	0	0	6
Standard 2.2.4	Evaluation	FA	0	2	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	FA	0	1	0	0	0	1

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

3 Infection Prevention and Control

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

Infection Prevention and Control Standards (of 5):									
N/A: 0	CI:0	FA: 4	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0			
PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0				
Criteria (of 29):	CI:0	FA:8	PA:1	UA:0	NA: 0				

Total Standards (of 50)	N/A: 0	CI: 0	FA: 45	PA Neg: 0	PA Low: 4	PA Mod: 1	PA High: 0	PA Crit: 0	UA
Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0					
Total Criteria (of 219)	CI: 0	FA: 96	PA: 5	UA: 0	N/A: 0				

Corrective Action Requests (CAR) Report

Provider Name: Lansdowne Park Village Limited
 Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:04-Sep-13 End Date: 05-Sep-13
 DAA: Health and Disability Auditing New Zealand Limited
 Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.1.10	1.1.10.7	PA Low	<p>Finding: Two of eight advance directives are signed by the family member/EPOA.</p> <p>Action: Ensure that advance directives are signed by the resident deemed competent by the general practitioner.</p>	6 months
1.3.5	1.3.5.2	PA Moderate	<p>Finding: (i) Files reviewed did not identify the need for intimacy and companionship or how staff were to support them to meet this need. (ii) Inconsistencies were observed in care plans where changes have been made to one area of the care plan and not documented in other areas of the care plan that the change in condition/care also affected. (iii) An agreed plan of care regarding pain management for one resident following a discussion with a family member which is documented was not evidenced transferred into the long term care plan or by use of a short term care plan.</p> <p>Action: (i) Ensure sexuality and intimacy needs are identified. (ii and iii) Ensure all areas of the care plan (where appropriate) and interventions are updated to reflect any changes to care/need.</p>	3 months
1.3.8	1.3.8.3	PA Low	<p>Finding: Four of six short term care plans reviewed had not been evaluated or signed off when the issue had been resolved or transferred into the long term care plan.</p> <p>Action: Ensure short term care plans are evaluated and signed off by a registered nurse when resolution has occurred or the condition and its management have been transferred in to the long term care plan.</p>	3 months

1.3.12	1.3.12.6	PA Low	<p>Finding: (i)Gaps were evidenced in two of sixteen medication signing charts reviewed. No rationale for medication not signed for/given was documented in progress notes or on the medication signing sheets.</p> <p>Action: Ensure medications are signed for at time of administration.</p>	immediate-1 month
3.5	3.5.7	PA Low	<p>Finding: While individual trending of infection for residents is occurring there is no overall analysis of trends documented for the facility by use of the 'Analysis Form' which forms part of the IC quality system/manual.</p> <p>Action: Ensure that trending and analysis of infections is fully completed.</p>	3 months

Continuous Improvement (CI) Report

Provider Name: Lansdowne Park Village Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:04-Sep-13 End Date: 05-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

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

How is achievement of this standard met or not met?

Attainment: FA

The code of health and disability rights is incorporated into care.

Discussions with five of five caregivers (AM/PM/night with staff working in the rest home/hospital/apartments), the facility manager, the director and clinical leader and the activities coordinator identified their familiarity with the code of rights.

A review of eight of eight care plans and monthly staff meetings confirm that the service functions in a way that complies with the code of rights.

Training around the code of rights and complaints was last provided in August 2013.

The auditors sighted respectful attitudes towards residents on the day of the audit and 12 of 12 residents (nine rest home including three in the serviced apartments and two using respite services and three in the hospital) confirm that they are treated with respect and dignity with staff 'going the extra mile', and also commenting on 'excellent staff who are respectful and understanding'.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.

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

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

How is achievement of this standard met or not met?	Attainment: FA
<p>There is a resident rights policy that includes roles and responsibilities.</p> <p>D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, advocacy services and the code of rights. The resident information booklet states where the code of rights pamphlet, advocacy pamphlet and information around the Health and Disability Advocacy service can be found in the service and the clinical leader states that this can be given when residents and family come to look at the service.</p> <p>Code of rights leaflets and advocacy pamphlets are available in the library by the main entrance.</p> <p>Code of rights posters are on the walls in the service.</p> <p>If necessary, staff will read and explain information to residents. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.</p> <p>12 of 12 residents (nine rest home including three in the serviced apartments and two using respite services and three in the hospital) and seven of seven family members (four rest home and three hospital) interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process.</p>	

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

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

D3.1b, d, f, i The service has a philosophy that is 'to provide excellence in care and to create an outstanding living environment and working environment for our residents and employees)'.
There are policies around independence, personal privacy, dignity and respect and these are referenced to the Privacy Act.

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement and there is a property list in all files reviewed (eight of eight files including four rest home and four hospital).

D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified in the assessment and care plan and activity planning process.

There is a weekly interdenominational service with two ministers from the village facilitating the services. One resident states that he loves the church services and values the service for being able to organise these.

12 of 12 residents (nine rest home including three in the serviced apartments and two using respite services and three in the hospital) and seven of seven family members (four rest home and three hospital) interviewed state that they receive respectful care and support. All state that staff knock before they enter the room and this was observed to occur on the day of the audit.

Residents and family members interviewed as well as five caregivers and the quality coordinator state that there is no evidence of abuse or neglect of residents and residents and family confirm this with all stating that there is excellent care provided.

The caregivers can describe the process of identifying and reporting any abuse or neglect.

The service has been opened for 10 months and training has been provided including training around managing challenging behaviour and resident rights. A training session was organised during the year around abuse and neglect however the trainer cancelled. Other sessions have included elements of training around abuse and neglect and the training has been re-confirmed for 25-Sept-13.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

A3.2 Policies documented include a Maori perspective of health with cultural policies in place and there is a Maori Health Plan.

D20.1i There is a Maori Health Plan and Ethnicity Awareness Policy/Procedure that is referenced to the Treaty of Waitangi and includes defined cultural practices for Maori.

The plan has further information on Maori health provision that may be obtained through Maori Disability and Resource centre - Maori Women's Welfare League, National Council of Maori Nurses, Maori Health Provider Collective, Professor Mason Durie - School of Maori Studies, Massey University, Maori Health Promotion and Nga Hau E Wha National Marae.

There are no Maori residents however there are Maori staff who are able to support Maori residents if required.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

D3.1g The service provides a culturally appropriate service by asking residents and family members what their cultural needs are at each assessment and review and any needs are included in the activities plan and review.

There are no residents with specific cultural needs in the files reviewed and as stated by the clinical leader.

D4.1c Eight of eight care plans and activity plans reviewed include the residents social, spiritual, cultural and recreational needs and this is consistently documented. During the admission process, the clinical leader along with the resident and family complete the documentation. Reviews are evident in the files reviewed.

There are no residents who identify as requiring an interpreter however the clinical leader is able to describe how an interpreter would be accessed through the DHB.

Staff were observed on the day of the audit to respect resident values by asking for their opinion and giving residents choice.

Seven of seven family members interviewed (four rest home and three hospital) felt that they were involved in decision making around the care of the resident and state that staff respect cultural beliefs and individual values. This was confirmed by the 12 residents interviewed.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

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

How is achievement of this standard met or not met?

Attainment: FA

Discrimination, harassment, professional boundaries and expectations are covered in the code of conduct that all staff are required to read and sign before commencing employment. Staff can describe how professional boundaries are maintained.

Discussions with the clinical leader and a review of the complaints register identify that there have been no complaints regarding alleged harassment, coercion, discrimination or abuse of any kind.

12 of 12 residents (nine rest home including three in the serviced apartments and two using respite services and three in the hospital) and seven of seven family members (four rest home and three hospital) state that there is no evidence of abuse or neglect.

The GP interviewed state that there is no evidence of abuse or neglect and praised the service for the continuing improvements as numbers of resident's increases.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

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

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

How is achievement of this standard met or not met?

Attainment: FA

2.2 Services are provided at Lansdowne Park that adhere to the health and disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 All approved service standards are adhered to noting that improvements are required as a result of this current audit for certification.

D17.7c There are implemented medication competencies for caregivers completed annually (link to 1.3.12).

Five of five caregivers interviewed describe the service as being an excellent place to work and they praise the management team for being approachable and hands on. They state that they have ample access to continence products and equipment (sighted with evidence of individualised continence products). They also described care for specific residents that are in line with the care plan documented and in line with good practice.

Five of five caregivers interviewed have a sound understanding of principles of aged care and state that they have been supported by the service for on-going education including training around the aging process.

12 of 12 residents (nine rest home including three in the serviced apartments and two using respite services and three in the hospital) and seven of seven family members (four rest home and three hospital) spoke very positively about the excellence of the care provided. Residents in the apartments state that the caregivers are very visible and provide support despite the fact that they are on a different level physically and their location is at varying intervals on the first floor. All state that if they ring, staff are prompt.

There are clear ethical and professional standards and boundaries within job descriptions.

All policies are updated by the external consultant in conjunction with the manager and director as required.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

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

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

How is achievement of this standard met or not met?	Attainment: FA
<p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b Seven of seven relatives state that they are always informed when their family members health status changes.</p> <p>Interpreters are available through the DHB if required. There have been no residents who have required or do require interpreting services.</p> <p>D11.3 The information pack is available in large print if required and advised that this can be read to residents.</p> <p>12 of 12 residents and seven of seven family members interviewed state that there is good communication with the staff and all 'know' the clinical leader, the manager and director. All family member's state that they are informed when there is an incident and the incident forms reviewed (15 of 15) reviewed reflects this).</p>	

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:
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Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.10 Informed Consent

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

Residents at Lansdowne Park are provided with information on choices to make an informed consent.

Lansdowne Park has well developed policies and procedures that support the provision of services and complies with the Code of Health and Disability Rights.

Information on informed consent is available in reception and is included in the information pack and discussed with residents and families at admission (confirmed by residents and family interviewed). There is a consent form, an advance directive and a process relating to advance directives when the resident cannot consent.

All files sampled (eight of eight) have appropriate consent forms .

An improvement is required to advance directives.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Six of eight advance directives are signed by the resident deemed competent by the general practitioner.

Finding Statement

Two of eight advance directives are signed by the family member/EPOA.

Corrective Action Required:

Ensure that advance directives are signed by the resident deemed competent by the general practitioner.

Timeframe:

6 months

STANDARD 1.1.11 Advocacy And Support

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

D4.1d; Discussion with seven family identified that the service provides opportunities for the family/EPOA to be involved in decisions.
 ARC D4.1e, The resident file includes information on residents family and chosen social networks.
 Resident right to access advocacy services is identified for residents as part of the resident information pack and pamphlets are available in the service. The information identifies who the resident can contact to access advocacy services with phone numbers provided.
 Staff are aware of the right for advocacy and how to access and provide advocacy information to residents if needed and training has been provided last in August 2013.
 Of the 12 residents interviewed, all are aware of rights and knew that there are pamphlets available in the facility.

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

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

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

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

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

How is achievement of this standard met or not met?	Attainment: FA
D3.1h; Discussion with seven of seven family indicate that they are encouraged to be involved with the service and care.	
D3.1.e Discussion with five caregivers, the clinical leader, the director, facility manager and seven of seven relatives confirms that the service supports and encourages residents to remain involved in the community and external groups. Examples of links into the community include shopping, visiting family and two who attend their own church services. There are progress notes and this records communication with family. There is also a family/whanau/resident representative contact sheet that includes a record of family visits/comments.	
Visitors were sighted coming and going on the days of the audit and were welcomed into the service.	

All family members interviewed state that they are always made to feel welcome and a part of the service and state that they can visit whenever they like.

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.13 Complaints Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The service has complaints management policies and procedures in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack.

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

D13.3g: The complaints procedure is provided to relatives on admission as confirmed by seven of seven family interviewed.

Staff including the five caregivers are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau.

Residents and family confirm they are aware of the complaints process and they would make a complaint to the manager if necessary.

There is a complaints register in place. Three complaints tracked indicate that the issues and responses are addressed as per timeframes in the policy. The manager states that there have been no complaints that have required authorities to be notified and none have been lodged with the HDC.

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

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

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

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

OUTCOME 1.2 ORGANISATIONAL MANAGEMENT

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

STANDARD 1.2.1 Governance

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The philosophy is documented and this is included in the welcome pack.

There are two directors with one identified as the facility manager. Both are based in the village and the facility manager provides operational management at all times. She has significant experience in management having owned/owns other continuing care services.

All staff have extensive experience in aged care.

Staff, residents and family interviewed state that the director and manager along with the clinical leader are the key to the service and state that they provide hands on and visible support for residents. The GP interviewed praised the service for continuing improvements in care as the occupancy has increased.

The service provides rest home and hospital level care for a potential 79 residents with 43 occupied on the day of the audit (25 rest home and 14 hospital). All are swing beds. Of the 29 apartments, all can be used as rest home beds and four are occupied by residents requiring rest home care (included in total numbers).

ARC,D17.3di (rest home, hospital), The clinical leader and facility manager have maintained more than eight hours annually of professional development activities related to managing the service.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

STANDARD 1.2.2 Service Management

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

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

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

How is achievement of this standard met or not met?	Attainment: FA
There are two directors who are able to provide cover in the event of one being away and if both are on leave, then the clinical leader would take overall responsibility for the service. The directors state that this has not been an issue to date as they live on site and the service has only been opened for 10 months. The clinical leader is a registered nurse who is able to provide clinical advice and hand on care if the facility manager is away.	

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

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

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that there are service operational management strategies and an implemented quality and risk programme which includes individually appropriate care.

The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning and these are reviewed annually to two yearly by the external consultant noting that these have been put in place with the opening of the service 10 months ago. All policies are current. There is a document control process in place for all policies.

D5.4 The service has the following policies/ procedures to support service delivery; continence, challenging behaviour, pain management policy and procedure, personal grooming and hygiene policy, skin, wound care policy and procedures. Transportation of subsidised residents policy and procedure includes costs, resident, and staff safety.

D10.1 There is a death policy and procedure that outlines immediate action to be taken upon a resident death and that all necessary certifications and documentation is completed in a timely manner.

D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

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

D19.2g Falls prevention strategies such as sensor mats and increased supervision are used in the service as described by the clinical leader and the registered nurse interviewed and the caregivers interviewed. Individual risks are identified in care plans.

The five caregivers interviewed state that any new caregiver receives an orientation that includes reading of the policies - orientation records signed off in all five staff files reviewed and confirmed by the five caregivers interviewed.

The service has an implemented internal audit programme and when issues are identified, there is evidence in the staff meeting minutes and registered nurse/quality meetings that these are followed up and issues resolved. Any issues are also reflected in the health and safety meeting as relevant.

There is a meeting structure that enables sound communication. This includes a monthly staff meeting, two monthly health and safety/infection control meeting, registered nurse/quality meeting two monthly, restraint approval meeting three monthly, resident meeting two monthly and a family meeting four monthly. The set agenda ensures that all aspects of the quality and risk programme are discussed i.e. infections and infection control, complaints, incidents and accidents, staff, resident issues. Minutes sighted indicate that meetings are held as per schedule with pre audit meetings held prior to the audit and weekly head of department meetings also held.

There is a preventative maintenance schedule completed annually and this includes documentation of maintenance completed in 2013.
There is a risk management register and hazards documented. A review of these indicate that these are signed off when resolved. A list of current hazards is kept with actions implemented to proactively prevent accidents.
Residents and family complete an annual satisfaction survey that is being sent out currently.

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:
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Finding Statement

Corrective Action Required:

Timeframe:

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

This shall include, but is not limited to:

- (a) Event reporting;
- (b) Complaints management;
- (c) Infection control;
- (d) Health and safety;
- (e) Restraint minimisation.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

STANDARD 1.2.4 Adverse Event Reporting

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

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

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

How is achievement of this standard met or not met?	Attainment: FA
<p>D19.3b; There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p> <p>Incidents/accidents are investigated and analysis of incidents trends with graphs documented occurs monthly. There is a discussion of incidents/accidents in monthly staff meetings and registered nurse/quality meetings.</p> <p>Discussions with the clinical leader and the facility manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service informed the DHB of an outbreak of vomiting and diarrhoea which occurred in June 2013.</p> <p>There is an open disclosure policy and seven of seven family members interviewed stated they are informed of changes in health status.</p>	

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

D17.7d: There are implemented competencies for all registered nurses around medication and evidence in a registered nurse file that these have been completed.

Current practicing certificates are sighted for the clinical leader (registered nurse), registered nurses, doctors and podiatrist.

Seven of seven staff files include a signed contract, application form, evidence of training and job description.

Seven of seven staff files reviewed indicate that staff have completed an orientation programme that is relevant to support for people using rest home level and hospital level care - confirmed by the caregivers all of whom are new to the service given that the service has only been open for 10 months. Caregivers have completed ACE, CareerForce or national certificate for aged care training. Staff who have not completed formal aged care qualifications are enrolled in the ACE programme.

The clinical leader and facility manager confirm that they have completed at least eight hours training a year (training records sighted).

12 of 12 residents (nine rest home and three in the hospital) and seven of seven family members (four rest home and three hospital) interviewed state that staff are competent, caring and knowledgeable. They also state that the clinical leader and the facility manager are very visible (as is the director) and state that this provides leadership for the service and provides a point of contact for them.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There are policies, systems and a roster in place that meets the requirements of the contract and supports safe staffing levels for service delivery. There are HR policies in place that outlines staffing responsibilities, staff levels and skill mix of the rest home, 24 hour on call management availability.

There are 47 staff including the clinical leader, facility manager, 28 caregivers, maintenance/groundsmen, activities coordinator, seven registered nurses , five kitchen cooks and kitchen assistants, one sales, six cleaners, two laundry.

There is a roster in place that meets the contract requirements - sighted with evidence that staff are replaced if off sick.

The care centre is split into three wings (rest home, hospital and mixed with four apartment rest home residents). There are four caregivers full shift and one short shift in the AM as well as one caregiver in the apartments (full shift). In the PM, there are three caregivers full shift and two from 5pm-9pm as well as a caregiver in the apartments from 5pm-8pm. At night there is a registered nurse and caregiver.

There is a registered nurse on each shift 24 hours a day.

Staff interviewed confirm that the roster provides adequate cover.

Both residents, family and staff interviewed confirm there are sufficient staffing levels to meet resident's needs.

The registered nurses are aware of when to call emergency services.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The service retains relevant and appropriate information to identify residents and track records. This includes information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service.

There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.

D7.1 Entries are legible, include dates and are signed by the relevant caregiver, registered nurse, manager including designation.

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.1 Entry To Services

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The service has a well-developed assessment process and resident's needs are assessed prior to entry. The facility manager and clinical leader are responsible for the screening of residents to ensure entry has been approved. The service has an admission policy, admission agreement and a resident

information booklet and pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. The information booklet answers a number of questions around admission and entry processes. The information booklet also includes an overview of the costs which will be met by the service and those which are the responsibility of the resident. Information gathered at admission is retained in resident's records. Seven rest home, three hospital and two residents from serviced apartments (assessed as rest home level care) interviewed confirmed they received information prior to admission and discussed the admission process with the manager.

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

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

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

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

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

STANDARD 1.3.2 Declining Referral/Entry To Services

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

ARHSS D4.2

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

How is achievement of this standard met or not met?	Attainment: FA
There is an Acceptance and Decline Entry to Service policy that describes the declined entry to services process. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the Needs Assessors (FOCUS) or referring agency for appropriate placement and advice.	

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.3 Service Provision Requirements

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hrs. of admission. The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy.

The clinical leader described that the facility uses a Primary Nursing Model and that registered nurses are allocated residents for whom they are responsible for care planning and act as a family liaison/contact person.

The service receives InterRAI assessments from Focus care coordination when residents are admitted and information from these InterRAI assessments form part of the initial nursing assessment/plan.

A wound care folder was evidenced in the treatment room and assessments are signed by a registered nurse. Activity assessments and activities care plans have been completed by the activity coordinator.

Timeframes are identified for assessment, initial care plan, long term care plan and evaluations. Staff were familiar with the timeframes and files reviewed were overall kept up to date.

D16.2, 3, 4; The initial admission assessments and plans and long term care plan were completed by the registered nurses within a three week timeframe in all eight resident files reviewed which included four rest home (which included two serviced apartments) and four hospital). The care plan is reviewed by the registered nurses and amended when current health changes. Evaluation is completed three monthly for hospital residents and six monthly for rest home residents. Five of eight resident files evidence six month evaluations (three files were newer admissions).

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment (Coombes) b) pressure area risk assessment (Braden), c) continence assessment (and diary), d) skin assessment and pain assessment.

A nutritional assessment was evidenced completed for a resident requiring dietary supplements prescribed by GP, following a dietitian review.

D16.5e; Medical assessments were documented in all eight resident files within 48 hours of admission. One- three monthly medical reviews were documented in the eight resident files by general practitioners. More frequent medical assessment/ review noted occurring in residents with acute conditions.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. There is a Handover document which is completed for each shift. There is a house GP involved with the service that visits weekly or more frequently if needed. The quality coordinator who is and enrolled nurse is responsible for residents in the services apartments with clinical oversight provided by the clinical leader (RN). Progress notes are maintained. Progress notes are written by staff for each resident on each shift. Eight files reviewed evidence this is occurring. A weekly management meeting provides an opportunity to discuss any clinical issues, infection control, wounds and restraint are also included as agenda items for discussion.

Physiotherapy is available and can be accessed by a community referral or through a private physiotherapist.

One GP interviewed stated that coordination of care is good and there is good overall clinical leadership.

Tracer Methodology:

Hospital resident:

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

Rest Home:

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

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

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.4 Assessment

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The following personal needs information is gathered during admission (but not limited to): personal and identification and Next of Kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whanau support, activities preferences, food and nutrition information and mental function.

Risk assessment tools and monitoring forms are available and implemented to assess level of risk and required support for residents including (but not limited to); Braden pressure area risk assessment, Coombes falls assessment, pain assessment, continence assessment, skin integrity, cultural assessment and nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

A designated area at the front of the care plan identifies involvement of resident/family/whanau in the assessment and care planning process. (these were evidence on all files reviewed).

An initial assessment/ plan is completed within 24 hours. The nursing assessment links to the care plan and this was evident in the eight long term care plans reviewed. The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.5 Planning

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Moderate

Eight resident files were reviewed.

Hospital- one resident with challenging behaviour, one resident with a wound, one resident who was a recent admission, one resident with noted weight loss.

Rest home- one resident from serviced apartments requiring the use of oxygen, one resident with a recent UTI, one resident who is self- administering medications, one resident who is a high falls risk.

Each area of the care plan includes: problems/needs, objectives and interventions. Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. Six monthly resident MDT meetings include input from GP, clinical leader, physiotherapist and any other allied health professionals involved in the resident's care/treatment. There is input from other allied health such as speech language therapist, physiotherapist, podiatrist and dietitians. Resident medications and medical status are reviewed one-three monthly by the General Practitioners. Activity therapists maintain activity assessment/care plans and evaluation in residents file. There are specific physiotherapy progress notes.

D16.3k Short term care plans are in use for changes in health status. (link to 1.3.8.3)

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Each area of the care plan includes: problems/needs, objectives and interventions. Six of eight care plans reviewed described the required support to achieve the desired goal/outcome.

Finding Statement

(i) Files reviewed did not identify the need for intimacy and companionship or how staff were to support them to meet this need. (ii) Inconsistencies were observed in care plans where changes have been made to one area of the care plan and not documented in other areas of the care plan that the change in condition/care also affected. (iii) An agreed plan of care regarding pain management for one resident following a discussion with a family member which is documented was not evidenced transferred into the long term care plan or by use of a short term care plan.

Corrective Action Required:

(i) Ensure sexuality and intimacy needs are identified. (ii and iii) Ensure all areas of the care plan (where appropriate) and interventions are updated to reflect any changes to care/need.

Timeframe:

3 months

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.6 Service Delivery/Interventions

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

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

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

How is achievement of this standard met or not met?	Attainment: FA
<p>Eight resident files were reviewed. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of one- three monthly medical review. The facility manager and clinical leader are responsible for the education programme and ensure staff have the opportunity to receive updated information and follow best practice guidelines.</p> <p>Residents' care plans are completed by the registered nurses. Care delivery is recorded by caregivers on each shift (evidenced in all eight residents' progress notes sighted). Progress notes are reviewed and evaluated by RNs on each shift. When a resident's condition alters, the registered nurses initiate a review and if required, arrange a GP visit or a specialist referral. The five caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, hoists, pressure relieving mattresses, wheelchairs, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Twelve residents and seven family members interviewed were complimentary of care received at the facility.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is well stocked for use. Wound assessment and wound management plans are in place for six residents (seven) wounds - one donor site from skin graft, three skin tears, (one resident has two skin tears), two chronic wounds, (leg ulcers) and one graze.</p> <p>The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. 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.</p> <p>Continence management in-service has been provided. Continence management in-services occurred in January 2013 with 13 staff attending. During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents from their bed to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.</p>	

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		

Corrective Action Required:

Timeframe:

STANDARD 1.3.7 Planned Activities

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There is an activities coordinator who works 35 hours per week Monday-Friday. The activities coordinator is currently completing the ACE programme. The activities programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility. Daily prompts of activities that are occurring are also announced over the intercom system.

The resident is assessed (with family involvement if applicable) and likes, dislikes, hobbies etc. are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. The activities programme is comprehensive, meeting the individual needs of the residents. The programme is evaluated and can be individually tailored according to residents' needs.

The activities coordinator described ways in which staff support residents achieving their own, personalised goals. Residents are able to participate in community activities as well as activities in the service itself.

Activities include (but not limited to): newspaper readings, outings, exercise programme, Tai Chi, cooking classes, men's club, music, crafts, shopping, happy hour, reading, and quizzes.

The facility has its own van for outings and residents described that there were two van outings per week, so that everyone has an opportunity to attend at least one outing per month. The van seats eleven residents.

The residents described going out for lunch, to picnics in the park and feeding the ducks, going shopping, to places of interest, concerts and movies, and also socialising with residents from other local aged care facilities who visit the facility.

Volunteers from the retirement village help out with church activities and services.

The activities coordinator described 1:1 interactions and time spent with residents who are unable or prefer not to join in group activities'.

Resident meetings are held two monthly and are chaired by the facility manager. Residents are able to provide feedback on activities at the residents' meeting and verbally to the activities coordinator.

Relatives meetings are held four monthly.

Twelve residents and seven family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

There is at least a one- three monthly review by the medical practitioner. D16.4a Care plans are reviewed and evaluated by the registered nurses three monthly for hospital residents and six monthly for rest home residents or when changes to care occur. There are short term care plans to focus on acute and short-term issues. Two STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. However there is an improvement required around short term care plans. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections and wounds. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.

ARC D16.3c: All initial nursing assessment/care plans were evaluated by an RN within three weeks of admission.

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

Audit Evidence**Attainment:** FA**Risk level for PA/UA:****Finding Statement****Corrective Action Required:****Timeframe:****Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.****Audit Evidence****Attainment:** PA**Risk level for PA/UA:** Low

Short term care plans were evidenced in use which documented when there was a change in resident's condition resulting in a change to the plan of care.

Finding Statement

Four of six short term care plans reviewed had not been evaluated or signed off when the issue had been resolved or transferred into the long term care plan.

Corrective Action Required:

Ensure short term care plans are evaluated and signed off by a registered nurse when resolution has occurred or the condition and its management have been transferred in to the long term care plan.

Timeframe:

3 months

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

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

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L **How is achievement of this standard met or not met?****Attainment:** FA

There is a referral policy. Referral to other health and disability services is evident in a sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Referrals are initiated by the service. The referral is co-ordinated by the clinical leader with input from registered nurses, when the referral is not to a specialist. A letter from the GP is then required.

D16.4c; the service provided an examples of where a residents condition had changed and the resident was referred to the dietitian.

D20.1 discussions with the clinical leader, two registered nurses and one enrolled nurse identified that the service has access to (but not limited to); physiotherapist, wound care specialist, geriatrician, speech language therapist, hospice nurses and dietitian.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

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

ARC D21 ARHSS D21

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

How is achievement of this standard met or not met?

Attainment: FA

Transfer information is completed by the registered nurses and communicated to support new providers. The information meets the individual needs of the transferred resident. Bereavement-Terminal Care and Transfer/Discharge of Residents Policies describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident's file.

The clinical leader also described that the DHB "yellow envelope" initiative is used for transfers to promote continuity of care and exchange of information.

Seven relatives interviewed confirmed they are well informed about all matters pertaining to residents, especially if there is a change in the resident's condition

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by an RN and a verification form is signed. Any packaging errors discovered at this time are fed back to the pharmacy. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications.

Medication administration was observed in the hospital, rest home and serviced apartments. Medications and associated documentation is kept in the locked medication trolley in the rest home/hospital and the serviced apartments. Medication trolleys are stored in locked treatment rooms when not in use.

RN's are responsible for administering medication. Medications are reviewed one- three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts.

Controlled drugs are stored in a locked cabinet inside a locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Caregivers complete a medication competency and take responsibility for second checking controlled medication. Controlled drugs are checked weekly. Medication fridge is monitored weekly.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Reconciliation of medication was evidenced completed in the file of a respite resident reviewed. Resident photos and allergies are on all the drug charts.

An annual medication administration competency is completed. Medication competency assessments are completed as new RN staff are employed.

There is a self-medicating residents policy in place. A self-medication assessment checklist is available and has been completed and reviewed six monthly for two residents reviewed in the rest home who self-administered inhalers. Two residents interviewed who self-administer their inhalers stated that they inform the RN when they need an inhaler replaced and advise of any increased use.

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards.

D16.5.e.i.2; Fourteen of sixteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. (two were recent admissions)

A medication audit was completed in August 2013 and corrective actions were evidenced signed off as having been completed.

Improvements are required to ensure that medications are signed for at time of administration.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Fourteen medication charts reviewed evidenced medication signing charts were correctly completed.

Finding Statement

(i) Gaps were evidenced in two of sixteen medication signing charts reviewed. No rationale for medication not signed for/given was documented in progress notes or on the medication signing sheets.

Corrective Action Required:

Ensure medications are signed for at time of administration.

Timeframe:

immediate-1 month

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The service has a large workable kitchen that contains a walk-in chiller and a pantry. The menu is designed and reviewed by a Registered Dietitian. There is a five weekly rolling menu. D19.2 staff have been trained in safe food handling.

There is a Food Services Supervisor who is a Chef who works Monday -Friday and has completed NZQA modules 167 and 168. There are two part time cooks and each have completed NZQA modules 167.

All meals are cooked in the main kitchen and are transferred to the apartment area via a trolley. Trays of food are then removed from the trolley and placed in warmed bain maries. Caregivers serve the food from bain maries in kitchen area for apartment residents. The main meal is served in the evening.

Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets. Residents with special dietary needs have a nutritional profile completed on admission. This is reviewed six monthly as part of the care plan review and monthly by an RN to ensure that they are current. Changes to residents dietary needs are communicated to the kitchen. The chef was able to demonstrate that residents likes and dislikes were known to the kitchen staff and that alternatives are provided for residents should they dislike any food items on the menu. Interviews with twelve residents overall spoke positively about the food service. A Food Satisfaction Audit was completed in January 2013 and comments from this audit provided an opportunity to further improve the service. Residents had commented that the food was highly spiced which was not to their taste. Residents interviewed state that this is no longer an issue. Residents reported that they enjoy having a cooked breakfast once a fortnight, and that the food is well presented and hot. The lunchtime service was observed in the rest home/ hospital and serviced apartments. Caregivers were observed serving and assisting those residents who required assistance with meals. The meal service was not rushed and meals were served hot. Residents are weighed monthly or more frequently at intervals prescribed by the GP. The clinical leader checks the weight recordings monthly and monitors for any increase or decrease in residents weight. The service has both platform (wheelchair access scales) and sit on weighing scales. The chef makes up the dietary supplementary drinks as per the dietitian instructions. The registered nurses and caregivers administer the dietary supplementary drinks to residents and sign that they have been given as prescribed. The Chef (Food Services Supervisor) provides a monthly report to the facility manager.

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

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

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There are implemented policies to guide staff in waste management - Waste Management - general waste, Waste Management - medical, and Waste Management - sharps. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled and there is appropriate protective equipment and clothing for 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.

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

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

How is achievement of this standard met or not met?	Attainment: FA
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The building holds a current Certificate of Public Use which expires in October 2013. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2013. Health and Safety meetings include maintenance and preventative maintenance.

The facility has three floors. In the basement level there is a parking area for cars and mobility scooters. The laundry and cleaning stores are located on this level. The ground floor has 50 resident rooms, for hospital and rest home care, including larger rooms that are available for palliative care. The care centre is divided into three wings and includes; lounges, dining areas and the main kitchen. The ground floor also includes a large foyer area that includes; a library, administration offices, the hairdresser, offices (such as the manager and clinical leader) and staff room.

The first floor includes 29 serviced apartments, lounges, dining area and small kitchen. There are two lifts and six stair wells.

The facility is carpeted with vinyl surfaces in dining areas, bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet. The corridors are carpeted. Hand rails are appropriately installed. There is adequate space around the facility for storage of mobility equipment.

There are outside areas with shade and seating.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

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

ARC E3.3d ARHSS D15.3c

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

How is achievement of this standard met or not met?

Attainment: FA

There are adequate numbers of toilets and showers with access to a hand basin and paper towels. All resident rooms have ensuites. Communal toilets are located near the lounges and dining rooms in all areas.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.4 Personal Space/Bed Areas

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Residents rooms are of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites. The lounge areas in each area are spacious. The 29 serviced apartments are large enough to provide rest home care, including the care of residents who may require the use of a hoist. Residents interviewed reported that their rooms are spacious and allow room for personal furniture items and uncluttered space to mobilise.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

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

ARC E3.4b ARHSS D15.3d

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

How is achievement of this standard met or not met?

Attainment: FA

There are two lounge areas and separate dining area in the hospital and rest home area. (Care Centre). There is a kitchenette area in the main dining area of the hospital and rest home where families/visitors can make a warm beverage when visiting. The kitchenette area in Matai wing was observed being used by visitors who made a hot drink. There is a lounge area at the end of each wing. The rest home wing Matai has a small kitchenette to allow residents to make hot drinks independently. The communal lounge and dining room in the serviced apartments is spacious and allows for a number of different activities. Seating and space is arranged to allow both individual and group activities to occur. There is a large activities room for entertaining, crafts, movies and games.

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

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

STANDARD 1.4.6 Cleaning And Laundry Services

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

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

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

How is achievement of this standard met or not met?	Attainment: FA
<p>There are Housekeeping, and Laundry policies and procedures in place. The laundry has an entrance for dirty laundry and an exit for clean and is designed to have a dirty to clean flow. There are procedures for the management of the machinery. The Ecolab manual includes instructions for cleaning. Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Laundry and cleaning processes are part of the internal audit programme.</p> <p>The laundry assistant was able to describe the infection control measures that were implemented during a recent outbreak of vomiting and diarrhoea at the facility with regards to the management of infected laundry/linen.</p> <p>The service has a secure area for the storage of cleaning and laundry chemicals. Chemicals are labelled. Laundry chemicals are within a closed system to the washing machine. Material safety data sheets are displayed in the laundry and chemical storage areas. The laundry and cleaning areas have hand-washing and drying facilities.</p>	

Residents and family members interviewed expressed satisfaction with the laundry service and stated that clothing was returned promptly and was neatly folded and put away in drawers or hung in wardrobes.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.7 Essential, Emergency, And Security Systems

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The emergency and disaster manual includes (but not limited to), dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. Regular fire drills are completed. Emergencies, first aid and CPR are included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Last fire drill occurred 12-Jun-13. There is a staff member across all shifts with a current first aid cert.

The service has alternative cooking facilities (gas cooker, BBQ,) available in the event of a power failure. Battery operated emergency lighting is in place for two hours. There are also extra blankets available. There is a civil defence kit for the whole facility which is located in the basement. There is ample water storage available on site (a minimum of three litres per person per day for three days). The civil defence folder, located at the nursing stations, includes procedures specific to the facility and organisation.

Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. There is an indicator panel in each area which displays the location of call. The serviced apartments also include call bells in resident rooms and ensuites. Those residents assessed as requiring rest home level care in the serviced apartments have the option of having a call bell pendant so that a call bell is always accessible. One rest home resident living in a serviced apartment was observed to have a call bell by her chair which she could access to call assistance when required. The resident stated that her call bell was answered promptly and that "she never had to wait long until a caregiver appeared to provide assistance when summoned."

There is an entrance and foyer area on entering the facility and a library is located in the foyer area.

Visitor's book and a resident sign out book are available. The facility has security cameras which monitor within and around the exterior of the facility.

There are door alarms on the exterior doors of the facility. Security lighting operates at night and the front gate to the village closes at 10.30pm and reopens at 6.30am. Access to the village and facility during 10.30pm and 6.30am is via the nurse call system.

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.8 Natural Light, Ventilation, And Heating

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

ARC D15.2f ARHSS D15.2g

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

How is achievement of this standard met or not met?

Attainment: FA

General living areas and resident rooms are appropriately heated and ventilated. There is under-floor heating throughout the facility. All rooms have external windows with plenty of natural sunlight. Residents and families interviewed confirmed that the facility is always warm and well ventilated.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

How is achievement of this standard met or not met?

Attainment: FA

The restraint minimisation and safe practice policy includes restraint/enabler procedures. There is a documented definition of restraint and enablers which is congruent with the definition in the standard.

Any assessment of use of enablers is based on information in the care plan, discussions with residents and on staff observations of residents. There is a restraint and enabler register with two residents using a bedrail as restraint and one resident using a bedrail identified as an enabler.

The resident with the enabler confirms that it is a voluntary aid and used to help her get in and out of bed.

Staff including the caregivers interviewed state that any use of an enabler is voluntarily and is decided on by the resident.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 2.2 SAFE RESTRAINT PRACTICE

Consumers receive services in a safe manner.

STANDARD 2.2.1 Restraint approval and processes

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There is a responsibilities and accountabilities description in the restraint policy that includes responsibilities for key staff in the service. The service has an approval process (as part of the restraint policy) that is applicable to the service.

The clinical leader provides oversight of the restraint process as described by the clinical leader and there is a designated registered nurse who is the restraint coordinator. She is able to describe her responsibilities.

The process of determining any use of restraint is discussed and agreed to by the clinical leader, the GP and the family is involved in the decision making process. Other staff are involved with input into the decision as required including the activities coordinator who is also part of the approvals group.

The resident file reviewed with restraint indicated that key people identified signed off the use of restraint and are present at the three monthly review of the use of the restraints.

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

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

STANDARD 2.2.2 Assessment

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

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

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

How is achievement of this standard met or not met?	Attainment: FA
A restraint assessment that includes strategies tried, risks, cultural needs and any issues is completed as part of the consent and assessment form in use. Interventions and risks identified through the assessment process are transferred into care plans (sighted in one file reviewed where restraint is identified). Restraint documentation identifies the involvement of family. Assessments are undertaken by the RN (restraint coordinator) and/or the registered nurse on duty, clinical leader, activities coordinator and the GP with input from the family. Assessments are completed as required for individual residents. A restraint assessment that has been comprehensively documented is in place for the resident identified as using restraint i.e. a bed rail.	

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

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;

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

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

STANDARD 2.2.3 Safe Restraint Use

Services use restraint safely

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

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

How is achievement of this standard met or not met?	Attainment: FA
<p>Monitoring and observation processes are included in the restraint policy. Approved restraints are documented in the policy. The care plan is documented for residents requiring restraint that identifies interventions and care required. Falls risk and challenging behaviour assessments and plans are completed. A restraint register is in place with correct identification of the resident using bed rails (two).</p> <p>Staff are trained in restraint minimisation and managing challenging behaviour - last provided in May 2013 (training records sighted).</p> <p>The resident requiring restraint is monitored hourly when restraint is in use - monitoring forms sighted as being completed.</p> <p>Frequency of monitoring is tailored to individual resident needs with one resident being monitored two hourly.</p> <p>The assessment and consent form identified that other strategies had been tried prior to restraint being used and all risks associated with the use of restraint is documented.</p> <p>The restraint coordinator and the clinical leader describe restraint being used as the very last strategy after other interventions have been tried.</p>	

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

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

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

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

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
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Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.4 Evaluation

Services evaluate all episodes of restraint.

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

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

How is achievement of this standard met or not met?

Attainment: FA

The restraint evaluation includes the areas identified around future options to avoid the use of restraint, review of frequency of use and effectiveness as part of the care plan and restraint review and the impact the restraint has had on the resident. They also review the behavioural management plan and any incidents relating to the behaviours in the context of using restraint.

Family have participated in the evaluation for the use of restraint for the resident requiring this in the file reviewed.

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

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

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

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		

Corrective Action Required:

Timeframe:

STANDARD 2.2.5 Restraint Monitoring and Quality Review

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The clinical leader and the restraint coordinator state that the use of any restraint is reviewed at the time of the three monthly individual resident care plan evaluation. The restraint approval meetings are held three monthly with the first meeting held in July 2013 (noting that the first restraint in the service was used in April 2013).

The restraint coordinator reviews and updates the restraint register at least monthly and as any resident is identified as using restraint.

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

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

STANDARD 3.1 Infection control management

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

Lansdowne has an infection control programme in place. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. There is a two monthly health and safety meeting which includes discussion and reporting of infection control matters and consequent review of the programme. Minutes are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

A registered nurse is the infection control officer at Lansdowne Park. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) officer maintains his practice by attending annual infection control updates. The IC officer and IC team (comprising of

representation of staff from all areas, including kitchen, household and care staff) has good external support from the local laboratory infection control team and IC nurse consultant. The infection control team is representative of the facility.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.3 Policies and procedures

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There is comprehensive infection control policies that supports the Infection Control Standard SNZ HB 8134:2008.

D19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by an external provider and reviewed and updated annually. Last review conducted 10-Aug-13. Lansdowne Park's infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment., personal protective equipment, medical waste disposal and sharps and spills management.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.4 Education

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

Infection control training is provided by the infection control officer. Training on infection control occurred in 14-Mar-13 with 20 attendees. Hand washing assessments of staff are completed annually. Resident education is expected to occur as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. Resident and relative meeting minutes include feedback on infection prevention and control.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: PA Low
Infection surveillance is an integral part of the infection control programme and is described in Lansdowne Park's infection control and surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. Infections are discussed at two monthly RN/quality meetings, two monthly health and safety/IC meetings and monthly staff meetings. There is an improvement required around the completion of trend analysis of infection rates for the facility. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical leader and facility manager. On interview the infection control officer advised that infection surveillance captures all infections within the facility. A recent case of diarrhoea and vomiting in June 2013 affecting three residents and five staff members was managed appropriately - isolation of residents, limiting of visitors, staff informed at handover times, and increased awareness of hand hygiene. This was reported to appropriate authorities.	

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: PA

Risk level for PA/UA: Low

Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. Infections are discussed at monthly staff meetings, two monthly RN/clinical meetings and two monthly health and safety/ infection control meetings.

Finding Statement

While individual trending of infection for residents is occurring there is no overall analysis of trends documented for the facility by use of the 'Analysis Form' which forms part of the IC quality system/manual.

Corrective Action Required:

Ensure that trending and analysis of infections is fully completed.

Timeframe:

3 months