**Rosaria Rest Home 2006 Limited**

**Current Status:** **08-Aug-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance 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**

An unannounced surveillance audit was conducted on the 8 August 2013. The audit examined the criteria specified for an unannounced surveillance audit and followed-up on the 15 requirements raised at the previous certification audit in September 2012. This audit verified that thirteen of these issues have been resolved. The matter regarding dating decanted food items is on-going, as are some elements of the medicine management system.

There are six new improvements required. These are related to the activities programme; management of medicines; the provision of food and nutrition services; secure storage of chemicals and medicines; calibration and checking of medical equipment; the use of an external security gate that inhibits the ability of independent rest home level residents to leave the premises as and when they wish; and external surfaces in some areas around the building which present a risk of tripping or slipping.

On the day of audit there are 17 residents in the home, the majority of whom are non-English speaking and all are over the age of 65 years. There is one person identified as a boarder who has lived in the home for some time. There are no significant changes to the scope, size or complexity of services since the previous audit.

**Audit Summary AS AT** **08-Aug-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | 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  08-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

|  |  |  |
| --- | --- | --- |
| **Organisational Management** | Day of Audit  08-Aug-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

|  |  |  |
| --- | --- | --- |
| **Continuum of Service Delivery** | Day of Audit  08-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

|  |  |  |
| --- | --- | --- |
| **Safe and Appropriate Environment** | Day of Audit  08-Aug-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

|  |  |  |
| --- | --- | --- |
| **Restraint Minimisation and Safe Practice** | Day of Audit  08-Aug-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

|  |  |  |
| --- | --- | --- |
| **Infection Prevention and Control** | Day of Audit  08-Aug-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Rosaria Rest Home**

Rosaria Rest Home 2006 Limited

Surveillance audit - Audit Report

Audit Date: 08-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Rosaria Rest Home 2006 Limited |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Rosaria Rest Home | 26 Roberton Road | Avondale | Auckland |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 08-Aug-13 **End Date:** 08-Aug-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | NZRPN  BSocSci,DIp MS  NZQA 8086 | 8.00 | 4.00 | 08 -Aug-2013 |
| Auditor 1 | XXXXXXXX | RCN, BA, Lead Auditor 8086 | 8.00 | 4.00 | 08 -Aug-2013 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX | RN,MBA,NZQA US 8086 |  | 2.00 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16 | **Total Audit Hours off site** *(system generated)* | 10 | **Total Audit Hours** | 26 |
| **Staff Records Reviewed** | 5 of 15 | **Client Records Reviewed** *(numeric)* | 5 of 17 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 5 |
| **Staff Interviewed** | 5 of 15 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 1 |
| **Consumers Interviewed** | 5 of 17 | **Number of Medication Records Reviewed** | 10 of 17 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

# Declaration

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

I confirm that The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 10 day of October 2013

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

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

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

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

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

# Services and Capacity

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rosaria Rest Home | 26 | 17 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Executive Summary of Audit

General Overview

An unannounced surveillance audit was conducted on the 8 August 2013. The audit examined the criteria specified for an unannounced surveillance audit and followed-up on the 15 requirements raised at the previous certification audit in September 2012. This audit verified that thirteen of these issues have been resolved. The matter regarding dating decanted food items is ongoing, as are some elements of the medicine management system.

There are six new improvements required. These are related to the activities programme; management of medicines; the provision of food and nutrition services; secure storage of chemicals and medicines; calibration and checking of medical equipment; the use of an external security gate that inhibits the ability of independent rest home level residents to leave the premises as and when they wish; and external surfaces in some areas around the building which present a risk of tripping or slipping.

On the day of audit there are 17 residents in the home, the majority of whom are non English speaking and all are over the age of 65 years. There is one person identified as a boarder who has lived in the home for some time. There are no significant changes to the scope, size or complexity of services since the previous audit.

1.1 Consumer Rights

The service adheres to the principles of open disclosure and notifies residents and their families where necessary and appropriate, of any matters that may impact on them. The matter related to advocacy which required improvement at the previous audit is resolved. There is evidence the service provides residents with information and contact numbers for independent advocates in a form that they can understand.

There have been no known complaint investigations by the office of the Health and Disability Commissioner since the previous certification audit in 2012. The service is recording all minor and major complaints. Only major complaints are entered on the complaints register and there have been none of these received. There is sufficient detail recorded about minor complaints and evidence that these are resolved quickly at the lowest level. This satisfies the improvement required at the previous audit.

1.2 Organisational Management

The quality and risk management system is being maintained. There is regular monitoring of all service areas via internal audits, and monthly collection, collation and analysis of quality data.

Staff training is planned and coordinated by the RN/manager and the quality assurance and administration staff member. Staff education includes on- line self-directed learning, monthly in-service sessions, study days and presentations by external experts. Staff competency assessments and performance appraisals occur regularly.

There are sufficient numbers of care staff and auxiliary staff allocated on all shifts, seven days a week to meet the needs of residents who are assessed as requiring rest home level care. The RN on is site 40 hours a week and available on call 24 hours a day and seven days a week (24/7).

1.3 Continuum of Service Delivery

Resident and family/whanau interviews confirm their satisfaction with the quality of care provided by the service. One area identified previously as requiring an improvement related to resident understanding of the admission agreement is now fully attained. The service provides appropriate service provision for residents at rest home level of care. Each stage of service provision is undertaken by suitably qualified and experienced staff.

The assessment, planning, provision and review of care is provided within time frames that meet the residents' needs and complies with contractual requirements. Where there are temporary changes in a resident's condition this is identified on the resident's care plan and shown in progress notes. Evaluation of residents' care planning and needs is clearly documented. The five areas related to service provision, assessment, planning, interventions and evaluation identified for improvement in the previous audit are now fully attained.

There is a limited activities programme in place. It does not identify how residents' interests and strengths and cultural needs are supported. This is an area identified that requires improvement.

The service has policies and procedures in place that reflect safe medicine management systems. Staff who administer medications have been assessed as competent to do so. One area related to 'as required' (PRN) medication identified for improvement from the previous audit remains unmet. All other previous findings are now fully attained. New areas identified for improvement relate to standing orders, documentation of residents' allergies, medication reconciliation and return of unused medicines to the pharmacy.

The service has two cooks. One who cooks European meals and one who cooks Chinese meals. Residents express satisfaction with the food and fluid offered at the service. The menus for both European and Chinese meals have been reviewed by a registered dietitian and identify they are satisfactory for aged care services. An area identified for improvement in the previous audit related to expiry dates not being placed on decanted foods remains unmet. In addition, new areas identified for improvement include kitchen cleaning and equipment and not documenting changes to the approved menu.

1.4 Safe and Appropriate Environment

There is a current building warrant of fitness. The previous areas requiring improvement relating to the condition of dining room furniture, appropriate grab rails and sufficient supplies of water stored on site, are resolved. There is are two new requirements in the environment. The first is to ensure that the functionality of medical equipment is regularly checked and calibrated where necessary, and the second to improve an external deck, off the laundry room, which presents a risk for slipping. The owner has a plan to repair or replace the decking before the end of this year..

2 Restraint Minimisation and Safe Practice

There are no residents who require physical restraint or enablers, but there is an environmental restraint. There are electric gates installed in the driveway that are opened by entering a code or from the inside office where a CCTV enables staff to see who requires access or exit. The gates are in place for two residents who tend to wander from the home and cannot find their way back. There is a requirement to review the use of these gates or implement processes so the freedom of independent residents is not inhibited.

There are clear policies and procedures in place if physical restraint or enablers are required. The definition of an enabler is congruent with the standards. Staff education on restraint minimisation is provided during orientation/induction and bi-annually as part of the in-service education programme.

3. Infection Prevention and Control

Three areas related to education identified as required improvements in the previous audit are now fully attained. The results of surveillance of infections are analysed and reported at all levels of the service. Where trends are identified, the service implements actions to reduce the rates of infections.

Summary of Attainment

* 1. Consumer Rights

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

|  |
| --- |
| Consumer Rights Standards (of 12): N/A:9 CI:0 FA: 3 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:5 PA:0 UA:0 NA: 0 |

* 1. 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

|  |
| --- |
| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:17 PA:0 UA:0 NA: 0 |

* 1. 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | PA Moderate | 0 | 0 | 1 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Moderate | 0 | 2 | 1 | 0 | 0 | 5 |

|  |
| --- |
| Continuum of Service Delivery Standards (of 12): N/A:3 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 3 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:14 PA:3 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | PA Low | 0 | 0 | 1 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | PA Moderate | 0 | 0 | 1 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 1 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

|  |
| --- |
| Safe and Appropriate Environment Standards (of 8): N/A:5 CI:0 FA: 1 PA Neg: 0 PA Low: 1 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:1 PA:2 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |  | 0 | 0 | 0 | 0 | 0 | 5 |

|  |
| --- |
| Infection Prevention and Control Standards (of 5): N/A: 2 CI:0 FA: 3 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:4 PA:0 UA:0 NA: 0 |

|  |
| --- |
| **Total Standards (of 50) N/A:** 26 **CI:** 0 **FA:** 18 **PA Neg:** 0 **PA Low:** 1 **PA Mod:** 5 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 41 **PA:** 6 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Rosaria Rest Home 2006 Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:08-Aug-13 End Date: 08-Aug-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.7 | 1.3.7.1 | PA  Moderate | **Finding:**  The generic activities plan sighted does not identify how activities undertaken are meaningful or appropriate to the current group of residents in the facility. It identifies that activities only occur for one hour per day. There are ten Chinese speaking residents and the caregiver who undertakes activities (after completion of her care giving duties) cannot speak any Chinese. Resident attendance records identify there is very poor attendance for activities offered.  **Action:**  Ensure activities are planned and provided to develop and maintain resident strengths and interests in a manner that is meaningful. | Three months |
| 1.3.12 | 1.3.12.1 | PA  Moderate | **Finding:**  (i) PRN medicines are given on a regular basis. One chart identifies that a PRN medicine has been given daily (records sighted for a one month period).  (ii) Standing orders do not meet best practice requirements. (Removed on day of audit)  (iii) There is no evidence of pharmacy reconciliation.  (iv) One resident with a known allergy does not have this information transferred to the care plan and one medicine chart does not identify if there are any known allergies.  (v) Not all unused medicine is being returned to the pharmacy and the panadol is being given to residents other than the person it has been prescribed for.  **Action:**  Ensure all medicine processes comply with current legislative requirements and safe practice guidelines. | Three months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.13 | 1.3.13.5 | PA  Moderate | **Finding:**  (i) Not all decanted food is labelled to identify expiry dates or preparation dates.  (ii) Not all kitchen areas are cleaned to a satisfactory standard. There is a build-up of dirt and dust around fridge areas and on some of the kitchen wall areas.  (iii) Some equipment is not suitable for use in the kitchen, such as a kitchen trolley which is rusting.  (iii) Changes to menu are not documented and therefore cannot be included when the dietitian undertakes a review.  **Action:**  Ensure all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. | Three months |
| 1.4.2 | 1.4.2.1 | PA  Low | **Finding:**  a) i) Maintenance records show that medical equipment such as the sphygmomanometer, thermometer, blood sugar testing equipment and weigh scales have not been checked or calibrated since February 2012. ii) The paint surface is badly eroded at the bottom of the legs of each table in the dining room which poses an infection risk.  b) An external deck off the laundry room requires repair or replacement, so that it does not pose a slip or trip hazard for residents, and  c) Cobblestones / paving in the driveway are loose and uneven. Both these ares present a risk of falls for residents. .  **Action:**  a) Ensure medical equipment is checked by approved servicing agents annually. Repaint the legs on the dining room tables.  b) Ensure the external deck is safe for use by residents, and  c) ensure the driveway surface is even and safe for use by residents. | Six months |
| 1.4.6 | 1.4.6.3 | PA  Moderate | **Finding:**  It is observed that the doors into the sluice room and the medicines room are not securely locked despite there being locks and notices in place.  **Action:**  Ensure that chemicals and medicines are stored securely and are not accessible by unauthorised people. | one week |
| 2.1.1 | 2.1.1.4 | PA  Moderate | **Finding:**  There are no processes in place for independently mobile residents who are restricted by the electronic gates in the driveway.  **Action:**  Ensure that all residents who are assessed as safe and independently mobile, have the freedom to come and go from the site as they please. | Three months |

# Continuous Improvement (CI) Report

Provider Name: Rosaria Rest Home 2006 Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:08-Aug-13 End Date: 08-Aug-13

DAA: The DAA Group 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 1.1.9 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

There is evidence that staff maintain open, transparent communication with consumers (sample of family notification records, progress notes, accident/incidents reports for September 2012 to August 2013 are sighted). Interviews with one relative confirm that they are advised immediately there is a change in the resident’s health status. Access to interpreter services is available and these were used on audit day to assist with interviewing four Chinese speaking residents.

Staff are aware of their responsibilities in relation to open disclosure. There are Chinese staff employed and/or available on each shift to care for and communicate with Chinese residents and their families. The service has created a Chinese version of the residential agreement. The interpreter read its content and confirmed that it contains information about funded and unfunded services. Two new Chinese residents confirm the agreement was explained to them prior to and upon entry to the service.

The service complies with 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.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

There is evidence the previous corrective action related to advocacy is resolved. Each Chinese resident has printed information about independent advocacy services and contact numbers written in Chinese, displayed on their bedroom walls. The content of this information was verified by the translator and by interview with four Chinese speaking residents.

**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 1.1.13 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 previous corrective action related to recording more information and detail about complaint matters is now resolved. The RN who manages the complaints process has created a separate minor complaints log book, subsequent to corrective action follow up support and advice provided by the DHB. All matters are logged in the complaint register and identified as a minor or major complaint. The minor complaints log book records the date the issue is received, what it is about and who and how it was resolved.

There are eleven minor concerns logged since September 2012. Copies of the complaint forms are available in English and Chinese and are on display in the foyer of the home and in bedrooms. Five of five residents interviewed confirmed they had been informed about how to make a complaint. Staff are provided instruction on the complaints procedure at orientation (confirmed by review of the orientation records of two recent caregiver employed).

As per the requirement in ARC D13.3h, complaints procedures are included in the admission agreement which is now available in English and Chinese. There have been no complaints to the Health and Disability Commissioner.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

The service has a clearly defined scope, direction and goals which are documented in the service marketing literature available in English and Chinese. Current service delivery goals are documented in the 2013 quality improvement plan. Systems and methods for monitoring and reporting organisational performance are implemented and monitored. These include regular checks and audits of service delivery by the owner, the RN and other senior staff, and monthly collation and reporting of incidents and accidents, complaints and infections at staff meetings.

Interview with the RNs and review of her nursing portfolio confirm ongoing professional development. She has been in the role since October 2011 and attends regular nursing/clinical education and DHB study days in subjects related to care of older people and in relation to managing a care facility. She has completed training in interRAI and joined the New Zealand Nurses organisation NZNO infection control and manager’s group/forums.

The requirements of the Age Related Residential Care Contract A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; are met.

**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 1.2.3 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

Interview with the owner and the Nurse Manager reveal that the quality improvement plan is reviewed annually and all incomplete actions are transferred to the next years plan. Interview with three care staff, one activities person and two cooks reveal that staff understand the quality system and their role in it.

There is evidence that policies are reviewed at least bi-annually against standards, legislation and known best practice by the systems moderator/ external consultant who notifies the service when policy changes occur. Care staff confirm that they are kept informed about changes in policy at monthly staff meetings or via the communications book. There has been no policy review and update since the previous certification audit.

The quality management system is integrated with service delivery. Quality and risk issues such as accident/incidents, complaints, audit outcomes, infection control, health and safety, policy reviews and any other feedback or matters impacting on service delivery are presented, discussed and monitored at monthly staff meetings (confirmed by sample of staff meeting minutes reviewed from September 2012 to July 2013).

Areas requiring improvement, as identified from incident/accident reporting, complaints, consumer feedback or outcomes from internal audits, are documented on action plans for tracking and monitoring. There is evidence that corrective actions are developed and implemented (confirmed by interview with the RN and minutes of staff meetings which record discussions about improvements required). The RN is following up on a recent night staff initiated medicine error on the day of audit.

Business and service delivery risks are managed by ensuring staff understand and adhere to health and safety procedures. Health and safety is a regular discussion item at monthly staff meetings. Staff orientation/induction and the education programme includes information on health and safety (confirmed by review of two new care givers orientation records).

All newly identified hazards are reported and added to the hazard register as sighted and reported in interview with the owner who carries out maintenance. Environmental audits for safety are conducted regularly and reactive facility maintenance occurs. Chemical safety data sheets, which identify hazardous chemicals, are available in the sluice room where chemicals are stored.

Five residents' files demonstrate that clinical risks are identified in the service delivery plans, that informed consent has been obtained and that there is multidisciplinary team input.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

Review of the accident/incident reporting system and a sample of incident reports from September 2012 to August 2013 demonstrate a process that records incidents, documents any investigation of the incident and makes recommendations to prevent recurrence. All incidents and accidents are reported and discussed at shift handover (observed handover on audit day) and again at monthly staff meetings (sample of meeting minutes from September 2012 to July 2013 are reviewed). There are on average six falls per month. One resulted in (a repeat of) an arm fracture and transfer to public hospital recently, this is the only fall resulting in a fracture since the previous audit. The incident record shows that X-ray and review occurred within 90 minutes of the fall. There is a low rate of reported medicines errors. The RN identified a medicines error three days earlier and was following up with the night staff member who had erroneously administered a hypnotic as PRN when it had already been administered.

The owner and the RN are responsible for essential notification and reporting and both are conversant with the statutory and regulatory obligations. There have been no serious or sentinel events which required notification since the previous certification audit.

There is evidence that the service informs consumers and/or family/whanau of any adverse events (review of incident/accident records and sample of family notification records and interview with one relative confirms this).

The service meets the requirements of ARC D19.3a.vi.; D19.3b; D19.3c.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Human resources are well managed. There is evidence that new staff are recruited according to good employment practices (confirmed by interview with the owner and the RN and review of two recently employed caregivers). Applicants are police checked and the owner contacts referees. The suitability of prospective staff is assessed by the RN and other care staff by allocating them up to three duties before confirming an employment agreement. Individual employment agreements include a trial 90 day period. Each role has a job description. There is evidence the RN has a current practising certificate (sighted in personnel record).

There is regular and on-going staff training to facilitate safe and effective practice. Staff complete education that is related to the care of older people as per the requirements of ARC 17.6 and 17.8. Topics presented in 2013 include fire safety (fire drill on 22 March) diet and nutrition directly related to an underweight resident, falls prevention and lifting, managing challenging behaviour, dementia, hearing loss, wound care and infection prevention and control. Advocacy, consumer rights and cultural safety is scheduled for this month. All staff who administer medicines are competency assessed by the RN annually (confirmed by review of five staff records and interview with RN). A service general practitioner and the RN are available 24 hours a day seven days a week for advice and support. On-going staff performance appraisals occur annually as required in ARC 17.7 (confirmed by interview with the owner and the RN). The owner states he seeks feedback about the RN's performance from visiting health professionals to assist him in assessing her clinical competence.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is sufficient staff allocated to work on all shifts and this meets the minimum requirements of ARC D17.1 and D17.3. (confirmed by review of rosters and interview with staff, the nurse manager and the owner.)

There are three caregivers allocated to morning shift from 7am each day. One finishes at 1 pm, one at 2 pm and the other at 3 pm. There are two caregivers rostered for afternoon shift 3 pm to 11 pm. One works from 3 pm to 11 pm and the other from 4 pm to 8 pm. Night shift is covered by two caregivers. It is noted that English is a second language for both the care staff who work Friday and Saturday nights. The owner states he is available to translate if required (this is confirmed by interview with a caregiver).

The RN is on site Monday to Friday from 10 am to 6 pm and on call 24/7. The owner is also on site most days of the week.

There are two cooks employed, one English and one Chinese cook from 7 am to 1 pm and the Chinese cook returns from 3 pm to 6 pm. Care staff carry out cleaning and laundry services when resident numbers are low.

**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:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

Criterion 1.3.1.3 was an area identified for improvement in the previous audit and it is now fully attained. Two Chinese residents who are recent admissions and one Chinese relative confirm that all documentation related to the admission process was fully explained to them. The admission agreement is available in Chinese for residents who require this. All advertising identifies that the service caters for rest home level care residents.

**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 1.3.3 Service Provision Requirements**

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

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

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

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

Each stage of assessment, planning, evaluation and review is undertaken by the RN. Provision of services is undertaken by caregivers. All staff undertake appropriate education to ensure they can perform the role they are employed to do in a competent manner to meet residents' needs. This is confirmed during interview with five of five residents, one family/whanau member and a review of staff education. Discussion was held with the RN on the day of audit related to finding a senior RN at a nearby facility to use as a mentor to assist the RN to improve her overall knowledge. The RN agreed she is happy to do this and that she feels this would be advantageous to her professional development.

A review of five of five residents' files identifies that initial assessments are conducted by the RN the day of entry. This covers all aspects of care including communication, personal care needs, mobility and falls risk, continence needs, dietary needs and wants, and skin integrity.

Over a three week period a long term care plan is developed by the RN following assessments being undertaken via use of appropriate assessment tools, such as Coombes falls risk, Waterloo pressure area assessment, continence, pain and behaviour management as appropriate. This information is used to inform the resident's long term care plan and appropriate interventions are documented. Information is used by staff to guide all care provision and covers identified needs, wants, likes, any specific instructions and resident goals. Resident care plan reviews are conducted at least six monthly as sighted in all five file reviews undertaken. An area identified as requiring improvement from the previous audit related to assessments not being updated six monthly is now fully attained.

The RN uses the long term care plans to identify any specific concerns and updates the care plan when issues resolve. This is noted on two of the five care plans where a resident has had a short term infection.

Documentation in five of five file reviews identifies the GP admits residents within the required timeframe to meet contractual requirements and there are three monthly reviews documented. There is documentation to identify which residents are stable and suitable for three monthly reviews. One resident has monthly reviews identified and maintained.

Services are co-ordinated to promote continuity of care for residents. Progress notes are updated daily with the exception of one set of notes that shows it was sometimes two days between anything being written. Entries are made more frequently if there are any issues that arise as sighted in one resident's file following a fall when entries were made for both morning and afternoon shifts. Adequate information is reported during each shift handover, in the resident's progress notes and in the communication book to ensure resident's needs are met and that any concerns or issues are discussed and identified. Multidisciplinary reviews are conducted annually. This is evident in three of the five file reviews. Two residents have not been in the facility for 12 months.

Interviews with five of five residents and one family/whanau member confirms they receive services to meet their needs. One resident stated they would like to go out more. Refer comments in standard 1.3.7. (An interpreter was used for Chinese resident interviews).

Tracer methodology

: *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

Criterion 1.3.4.1 was identified as an area for improvement in the previous audit this is now fully attained. The service uses appropriate assessment tools and they are updated every six months or if there is a change in the residents condition as sighted in five of five file reviews. All residents have a continence, falls, skin integrity, and pain assessment. Currently there are no residents who have a behavioural assessment in place but the RN confirms they are used if required. Interviews with five of five residents and one family/whanau member confirm that they are given appropriate support to meet their needs and wants.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

One area was identified as required improvement in the previous audit it is now fully attained. Five of five care plan reviews identify appropriate supports and interventions are put in place to ensure all resident needs are met. Information identified during assessments is congruent with information shown on the care plans. Examples sighted identify that one resident with poor memory is required to be accompanied by a staff member or other responsible person if they leave the facility. The resident’s notes identifies the need for a high calorie diet and weekly and now monthly weighs.

Interviews with the cook and caregivers confirm they use the care plans to provide care to meet residents' needs. Care plans are individualised, clearly written and easy to follow.

Interviews with five of five residents and one family/whanau member confirm that they are satisfied with the care provided and that all their needs are being met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

This was identified as an area that required an improvement in the previous audit. It is now fully attained.

In the five of five file reviews undertaken the interventions shown on the care plan are congruent with assessment findings and requests made by other health care providers. Interventions are individualised to meet each resident’s needs. Examples sighted include input from a Maori Mental Health service for a resident who identifies as Maori. This is shown on the resident's care plan. During interview the resident stated they no longer use the community services organised by for them as they cannot speak te reo Maori.

The resident's file reviewed identifies that suggestions made by a registered dietitian have been followed up and the resident is gaining weight. Regular weighs were maintained as requested. There is clearly documented evidence that a resident who requires three monthly blood tests for diabetes has this followed up by the service.

Progress notes clearly show any specific requests made. The GP was not available on the day of audit. (The service has just changed GP services within the last few weeks and the new GP service has not yet reviewed any resident care).

During interview with the RN she confirms that she monitors follow up requirements and that if something is requested by another service with resident input, staff are informed during the per shift handover, in the progress notes and in the communication book. This is confirmed in documentation sighted and during staff interviews.

Resident and family/whanau interviews confirm that services provided are meeting resident needs. One resident asked to see the GP, this request was passed onto the RN on the day of audit.

**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:** PA Moderate

Resident interests are identified during the admission process. This is shown in five of five file reviews. This information is not used to inform activity planning to facilitate the activities offered. Residents' strengths and interests are not taken into account during the planning process. Over half of the residents in the facility speak either Mandarin or Cantonese and the caregiver who undertakes activities as part of her duties only speaks English. The service does not have a dedicated activities coordinator. The activities attendance records sighted identify very low attendance at activities such as board games and only van outings are well attended. The van can only take six residents at a time. Two Cantonese speaking residents said they only enjoyed the van rides, one resident stated he would like to undertake arts and crafts and go out on walks. This is an area identified for improvement.

No activities were undertaken on the day of audit. There is a weekly physiotherapy exercise class and a weekly Tai Chi class. Weekly Catholic mass is offered on site and residents are encouraged to go out with family/whanau and friends as they are able.

On the day of audit the owner/manager agreed that a person who can communicate with all residents would be advantageous to meet residents' needs.

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

Five of five file reviews show that resident skills and interests are identified as part of the admission process. There is a planned activities calendar which is generic and does not cater for identified strengths, cultural needs or interests. There are attendance records kept showing that the weekly van outing is the most popular activity. During discussion with the caregiver who undertakes activities after she has completed her caregiving duties, confirms there is a language barrier as she cannot speak either Cantonese or Mandarin. All resident bedrooms are capable of receiving Chinese television for residents who wish to have this. The caregiver said that she has one Chinese DVD which she shows on the large screen television in the lounge if required. No Chinese celebrations such as Chinese New Year are celebrated by the service. Residents are offered Catholic mass weekly. The caregiver confirms all residents follow the Christian religion.

**Finding Statement**

The generic activities plan sighted does not identify how activities undertaken are meaningful or appropriate to the current group of residents in the facility. It identifies that activities only occur for one hour per day. There are ten Chinese speaking residents and the caregiver who undertakes activities (after completion of her care giving duties) cannot speak any Chinese. Resident attendance records identify there is very poor attendance for activities offered.

**Corrective Action Required:**

Ensure activities are planned and provided to develop and maintain resident strengths and interests in a manner that is meaningful.

**Timeframe:**

Three months

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Evaluations are documented, resident focused and identify the degree of achievement or response the resident has had to the interventions shown. They are updated at least six monthly or sooner if there is a change in the resident's condition. Changes to the care plans are congruent with identified changes to the residents condition or needs. For one resident the care plan shows the change from weekly weighs to monthly weighs as the residents weight has increased. Another care plan identifies the change in mobility for a resident who is now using a walking frame. This was an area identified as requiring improvement in the previous audit and is now fully attained.

During interview with one caregiver she confirmed that if a change is noted in a resident's condition she reports this to the RN who undertakes an assessment of the resident and that changes are made to the care plan as appropriate.

Interviews with five of five residents and one family/whanau member confirms they are happy with services provided and that their needs are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

Policies and procedures are in place to identify how medicines management can be undertaken safely. They include each person’s responsibility and describe the process to be undertaken if residents self-administer medicines. Currently no residents are self-medicating.

Medication is prescribed by the GP on a typed prescription. Short course medicines are handwritten and the script is faxed to the service and to the pharmacy. Once the short course is completed the GP crosses out the instructions as there is no area to sign the finish date. (The facility has recently changed GP services and have not yet had any medications prescribed by the new service. During discussion with the RN it is thought the new service will use a different prescribing system). Medication is blister packed and there is a checking process in place when they are delivered to the facility monthly. Blister pack medication is stored in a locked medicine trolley. The door to the medication room is not kept locked - refer to comments in criterion 1.4.6.3. Staff sign for medicine as appropriate and identify if a medicine is refused by the resident for any reason. Caregivers who administer medicines are competent to do so. The RN stated she will have her competency checked by the gerontology nurse specialist next time she visits.

Currently there are no controlled medicines in use. The service has a documented system in place should they be required.

There is no evidence of pharmacy reconciliation. Not all unused medicines are returned to the pharmacy in a timely manner and the RN stated that the unused panadol is used for other residents on a PRN basis. The standing orders sighted were removed on the day of audit as they do not meet current best practice requirements. Not all required information relating to allergies is shown. These are all areas identified for improvement. One area identified for improvement from the previous audit related to PRN medicine remains unmet whilst other findings are now fully attained.

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

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

This was an area identified for improvement in the previous audit. Ten medication charts were reviewed this audit. All but one aspect of the previous finding have been fully implemented. The outstanding area relates to PRN medication. One medication chart identified that a resident is being given a PRN medicine (Zopiclone) on a daily basis.

There are standing orders in place which do not meet the current best practice requirements. They were removed on the day of audit.

There is a process in place to show residents' allergies. One resident with an allergy shown to Aspirin does not have this information transferred to their care plan and one chart had no indication if any allergies are known.

Medication arrives at the facility in blister packs and the RN checks each resident's medications against the doctor’s prescription and signs the sheet to show they have been checked. There is no documented evidence that the pharmacy undertakes any form of reconciliation.

There is a documented process to identify medicines that are no longer required or which are refused are returned to the pharmacy. In the drawer of the medicine trolley there are unused blister packs of panadol and other medicines. When asked why they had not been sent back to the pharmacy the RN said that the panadol is used as PRN medicines if a resident asks for panadol. These medicines have residents' names on them and cannot be used for anyone other than who they are charted for. They were removed on the day of audit.

**Finding Statement**

(i) PRN medicines are given on a regular basis. One chart identifies that a PRN medicine has been given daily (records sighted for a one month period).

(ii) Standing orders do not meet best practice requirements. (Removed on day of audit)

(iii) There is no evidence of pharmacy reconciliation.

(iv) One resident with a known allergy does not have this information transferred to the care plan and one medicine chart does not identify if there are any known allergies.

(v) Not all unused medicine is being returned to the pharmacy and the panadol is being given to residents other than the person it has been prescribed for.

**Corrective Action Required:**

Ensure all medicine processes comply with current legislative requirements and safe practice guidelines.

**Timeframe:**

Three months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service has a menu which has been reviewed and approved for aged care services by a registered dietitian on 30 April 2010 and reviewed in 2012. There is evidence that if the service has any concerns related to nutrition dieticians services are sought. Residents who have special nutritional needs and specific likes and dislikes have this clearly identified upon admission and identified in the kitchen on a white board. The service employs two cooks. One cook caters for Chinese residents and one for residents who choose European food. There are two menus and both are included in the dietitian review.

Regular fridge and freezer temperature recordings are undertaken to show that meet safe food practice requirements.

Interviews with five of five residents and one family/whanau member confirm they enjoy the food they receive and that their likes and needs are met.

There are areas of improvement required related to cleaning processes, use of appropriate equipment, the lack of recording menu changes and the dating of decanted foods. The dating of decanted foods was identified in the previous audit and remains unmet.

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

Not all decanted food is labelled to identify expiry or preparation dates. This was an area identified for improvement in the previous audit and remains unmet.

The kitchen is well equipped; however some equipment is showing signs of wear and tear and needs to be replaced. Examples include a kitchen trolley which is rusting and the use of wooden chopping boards. The cook confirms that the wooden chopping boards are placed in the dishwasher after each use. There is a cleaning programme in place for the use of surface areas but other areas of the kitchen show that cleaning does not include the moving of fridges and areas other than those used daily. The cook stated that there used to be cleaning service to do major cleaning but that the service was no longer being used. This was confirmed during interview with the owner/manager.

There was pickled pork shown on the menu for the day of audit but spaghetti bolognaise was served. When discussed with the cook she said she changed this as pickled pork is not available and that residents like her bolognaise. Changes to menu are not recorded so are not included in the dietitian review.

**Finding Statement**

(i) Not all decanted food is labelled to identify expiry dates or preparation dates.

(ii) Not all kitchen areas are cleaned to a satisfactory standard. There is a build-up of dirt and dust around fridge areas and on some of the kitchen wall areas.

(iii) Some equipment is not suitable for use in the kitchen, such as a kitchen trolley which is rusting.

(iii) Changes to menu are not documented and therefore cannot be included when the dietitian undertakes a review.

**Corrective Action Required:**

Ensure all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.

**Timeframe:**

Three months

**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 1.4.2 Facility Specifications**

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

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

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

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

There is a current Building Warrant of Fitness which expires on 22 June 2014. The previous improvement related to dining room furniture is resolved. There are new dining room chairs. There are improvements required around calibration and servicing of equipment and paint work on the legs of the dining room tables, and the repair or replacement of an external deck off the laundry.

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

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

a) Maintenance records show that medical equipment such as the sphygmomanometer, thermometer and weigh scales have not been checked since February 2012.

The paint surface is badly eroded at the bottom of the legs of each table in the dining room which poses an infection risk, and

b) It was observed that external deck off the laundry room requires repair or replacement to ensure that it is safe, and

c) The driveway near to the main entrance has cobblestones/paving which are uneven and loose.

The owners state they have a plan to replace or repair these surfaces before the end of the year. To date there have been no incidents of slipping or tripping by residents so the risk level is lowered to reflect this.

**Finding Statement**

a) i) Maintenance records show that medical equipment such as the sphygmomanometer, thermometer, blood sugar testing equipment and weigh scales have not been checked or calibrated since February 2012. ii) The paint surface is badly eroded at the bottom of the legs of each table in the dining room which poses an infection risk.

b) An external deck off the laundry room requires repair or replacement, so that it does not pose a slip or trip hazard for residents, and

c) Cobblestones / paving in the driveway are loose and uneven. Both these ares present a risk of falls for residents. .

**Corrective Action Required:**

a) Ensure medical equipment is checked by approved servicing agents annually. Repaint the legs on the dining room tables.

b) Ensure the external deck is safe for use by residents, and

c) Ensure the driveway surface is even and safe for use by residents.

**Timeframe:**

Six months

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

It is observed that the doors into the sluice room and the medicines room are not securely locked despite there being locks and notices in place. There is a requirement to ensure that chemicals and medicines are stored securely and are not accessible by unauthorised people.

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

It is observed that the doors into the sluice room and the medicines room are not securely locked despite there being locks and notices in place. There is a requirement to ensure that chemicals and medicines are stored securely and are not accessible by unauthorised people.

**Finding Statement**

It is observed that the doors into the sluice room and the medicines room are not securely locked despite there being locks and notices in place.

**Corrective Action Required:**

Ensure that chemicals and medicines are stored securely and are not accessible by unauthorised people.

**Timeframe:**

one week

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

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

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

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

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

The previous area requiring improvement in relation to emergency water supply is resolved. There is sufficient potable water stored on site to meet the needs of 26 residents. (confirmed by sighting of stored water supply)

**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:**

The previous area requiring improvement in relation to emergency water supply is resolved. There is sufficient potable water stored on site to meet the needs of 26 residents. (confirmed by sighting of stored water supply)

**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:** PA Moderate

The restraint minimisation and safe practice policies and associated procedures provide clear instructions for management of restraint and enablers. Although there is a documented protocol for use of environmental restraint, staff are not recognising that the electronic gates in the driveway are a form of environmental restraint. These prevent pedestrians and cars from entering or leaving the premises and need to be opened by entering a number code on the keypad or by a button in the office operated by staff. The owner and the RN state these are in place for the safety of two residents who are known to wander and cannot find their way back. This is noted in their care plans. The owner states there are three residents and various family members who know and use the number combination to open the gates. There is a need to ensure that all residents who are assessed as safe and independently mobile, have the freedom to come and go from the site as they please.

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

Staff are not recognising that the electronic gates in the driveway are a form of environmental restraint which prevent pedestrians and cars from freely entering or leaving the premises. The owner and the RN state these are in place for the safety of two residents who are known to wander and cannot find their way back. This is noted in their care plans. The owner states there are three residents and various family members who know and use the number combination to open the gates. There is a need to ensure that all residents who are assessed as safe and independently mobile, have the freedom to come and go from the site as they please.

**Finding Statement**

There are no processes in place for independently mobile residents who are restricted by the electronic gates in the driveway.

**Corrective Action Required:**

Ensure that all residents who are assessed as safe and independently mobile, have the freedom to come and go from the site as they please.

**Timeframe:**

Three months

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

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

There was an area identified for improvement from the previous audit (criterion 3.2.3) related to the education of the infection control coordinator. This is now fully attained. Documentation identifies that the infection control coordinator, who is the RN, attended an eight hour Bug Control Seminar in November 2012. She has also joined the New Zealand Nurses Organisations Infection Control group to maintain ongoing education. During interview the infection control coordinator is able to verbalise good knowledge and understanding of current infection control practices.

**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 3.4 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

There were two areas identified for improvement in the previous audit related to criteria 3.4.3 and 3.4.4. Both these areas have been addressed by the service and are now fully attained. Documentation sighted related to infection control education identifies that information gained by the infection control coordinator was shared with staff on the 23 November 2012. The education was evaluated by six staff and shows that education was relevant to the services provided and delivered in a manner understood by the staff.

During interview with caregivers they are able to verbalise their knowledge and understanding of infection control processes and standard precautions.

**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:**

**STANDARD 3.5 Surveillance**

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

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

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

Surveillance data for infection is collected and recorded in accordance to the requirements for rest home level care as identified in policies and procedures. This includes urinary tract infections, skin and wound infections, gastro type infections, eye infections, lower respiratory tract infections and multi-resistant organisms.

All staff are responsible for the reporting of suspected infections to the infection control coordinator. The infection control coordinator (RN) is responsible for ensuring appropriate action, notification and follow up is undertaken. During interview the infection control coordinator verbalised a clear understanding and knowledge of reporting and recording processes.

Monthly surveillance data is collected and collated by the infection control coordinator. Data is trended against previously collected data and used as an opportunity for improvement as required. The documented data sighted shows that the facility has a low infection rate and over an eight month period there have been three urinary tract infections, one wound infection and one chest infection. They have all been notified to the GP and treated accordingly. Three topical antibiotic creams have also been prescribed.

The infection control coordinator shares information with staff during monthly meetings, identifies changes to care on resident care plans, documents findings in resident progress notes and informs staff at handover. The owner manager is aware of findings as he works at the facility daily.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**