**Te Ata Resthome Limited**

**Current Status:** **10-Oct-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**

Te Ata Rest Home is a 28 bed facility offering rest home level of care. Strengths of the organisation as indicated from family and resident interviews are the caring, family orientated and homelike nature of the service.

There were three areas requiring improvement identified at the previous audit related to the orientation and training of the on call registered nurse, ensuring the staff are assessed as competent by an RN, and to clearly identify the role of the infection control coordinator. These are now addressed and improvements implemented since the previous audit. There are no areas of required improvements identified at this surveillance audit.

**Audit Summary AS AT** **10-Oct-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 |

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| --- | --- | --- |
| **Consumer Rights** | Day of Audit10-Oct-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** |

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| **Organisational Management** | Day of Audit10-Oct-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** |

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| **Continuum of Service Delivery** | Day of Audit10-Oct-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. |  | **Standards applicable to this service fully attained** |

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| **Safe and Appropriate Environment** | Day of Audit10-Oct-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit10-Oct-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit10-Oct-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** |

**Te Ata Rest Home**

Te Ata Rest Home Limited

Surveillance audit - Audit Report

Audit Date: 10-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Te Ata Rest Home Limited |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Te Ata Rest Home | 588 Teasdale RD | Te Awamutu |       |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 10-Oct-13 **End Date:** 10-Oct-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 | RN, B.Nursing, RABQSA | 8.00 | 4.00 | 10-Oct-13 |
| Auditor 1 |       |       |       |       |       |
| 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 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 8.00 | **Total Audit Hours off site** *(system generated)* | 6.00 | **Total Audit Hours** | 14.00 |
| **Staff Records Reviewed** | 4 of 27 | **Client Records Reviewed** *(numeric)* | 4 of 26 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 4 |
| **Staff Interviewed** | 5 of 27 | **Management Interviewed** *(numeric)* | 2 of 3 | **Relatives Interviewed** *(numeric)* | 2 |
| **Consumers Interviewed** | 4 of 26 | **Number of Medication Records Reviewed** | 8 of 26 | **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 Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 17 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Te Ata Rest Home | 28 | 26 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Te Ata Rest Home is a 28 bed facility offering rest home level of care. Strengths of the organisation, as indicated from family and resident interviews, is the caring, family orientated and homelike nature of the service.

There were three areas requiring improvement identified at the previous audit related to the orientation and training of the on call registered nurse, ensuring the staff are assessed as competent by an RN, and to clearly identify the role of the infection control coordinator. These are now addressed and improvements implemented since the previous audit. There are no areas of required improvements identified at this surveillance audit.

1.1 Consumer Rights

The residents and families report that there is a high standard of communication at the service. There is communication that reflects the services principles of open disclosure. Complaints are managed to meet policy requirements. At the time of audit the service has no outstanding complaints, with no complaints recorded to date in 2013.

1.2 Organisational Management

 Management ensures that services are planned and coordinated to meet residents' needs. The organisation's strategic and business plans identify their purpose, values, priorities and goals. Planning processes are reviewed annually and evaluated quarterly to measure achievement. Any deficits in service delivery are managed through corrective action planning.

The day to day operation of the facility is undertaken by staff who are appropriately experienced and qualified to undertake the role in a manner that ensures residents' needs are being met in a safe and efficient manner.

All quality and risk management processes are implemented to meet policy requirements. Policies and procedures reflect current accepted good practice. Incidents, accidents and untoward events are recorded, evaluated and discussed with family/whanau in a manner that is reflective of open disclosure principles. All quality actions are recorded and reported at staff and management level. Key components of service are explicitly linked to quality management systems. Quality data collection and findings are used as opportunities for improvement which are well documented.

Staffing levels and skill mix are maintained to meet the needs of the residents and exceed contractual requirements. There is a registered nurse on duty or on call at all times. The previous required improvement to provide records to validate that the required training and competencies have been undertaken by the on call registered nurse is now addressed.

1.3 Continuum of Service Delivery

The residents and family interviewed report satisfaction with the quality of care provided at the service. 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 nursing and care staff. The assessment, planning, provision and review of care is provided within time frames that meet the residents' needs and complies with contractual requirements. The assessment, care planning, review and evaluation processes are implemented at the service. Where there are temporary changes in a resident's condition the service uses an acute care plan to document the changed needs.

The activities programme supports the interests, needs and strengths of the residents. The residents and families interviewed express satisfaction with the activities provided.

A safe and timely medicine management system is observed at the time of audit. The registered nurses and senior caregivers are responsible for medicine management and evidence competency to perform the role. All staff who manage medicines are assessed as competent to do so. The previous area for improvement to ensure staff are assessed as competent by a registered nurse is now addressed and an improvement implemented since the last audit.

Residents express satisfaction with the food and fluid offered at the service. The menus are appropriate to the resident group and have been reviewed as suitable for residents living in long term aged care services.

1.4 Safe and Appropriate Environment

The facility has a current warrant of fitness. There are no alterations to the building since the last audit.

2 Restraint Minimisation and Safe Practice

The service have no residents requiring enabler use. The organisational policies identify that the service is a restraint free environment and if enablers are to be used, these are to be voluntary and the least restrictive option for the resident. Staff are able to demonstrate their understanding of the restraint minimisation policy and procedures and the definition of an enabler.

3. Infection Prevention and Control

The results of surveillance of infections are analysed and reported to staff and management. Where trends are identified, the service implements actions to reduce the rates of infections. The previous area for improvement to ensure the role of the infection control coordinator is clearly identified is now addressed.

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 | Not Applicable | 0 | 0 | 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 |

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 2 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: 0Criteria (of 48): CI:0 FA:4 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 |

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| 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: 0Criteria (of 34): CI:0 FA:17 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | 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 | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:14 PA:0 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 0 | 0 | 0 | 3 | 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 5 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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

1. Restraint Minimisation and Safe Practice

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 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 |

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

1. Infection Prevention and Control

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 0 | 0 | 0 | 3 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 3 CI:0 FA: 2 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: 0Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 3 |

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| **Total Standards (of 50) N/A:** 33 **CI:** 0 **FA:** 17 **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**Total Criteria (of 219) CI:** 0 **FA:** 38 **PA:** 0 **UA:** 0 **N/A:** 11 |

# Corrective Action Requests (CAR) Report

Provider Name: Te Ata Rest Home Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:10-Oct-13 End Date: 10-Oct-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

# Continuous Improvement (CI) Report

Provider Name: Te Ata Rest Home Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:10-Oct-13 End Date: 10-Oct-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

The two of two family/whanau interviewed confirm they are kept informed of the resident's status, including any events adversely affecting the resident. The service provider communicates effectively with residents and family members, with the two family/whanau and four residents interviewed stating that open communication is one of the strengths of the service. A family contact sheet is held in each resident's file. Evidence of open disclosure is documented in the family contact sheets, on the accident/incident form and in the residents' progress notes (evidenced in four of four residents' files).

The owner/manager interviewed reported that residents can access interpreter services if required. Access to interpreter services is documented in the interpreter service policy, which contains contact numbers for interpreter services.

The Aged Related Residential Care (ARRC) service agreement requirements are met.

**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 1.1.13 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

Complaints management is explained as part of the admission process, as confirmed at interview with two family/whanau and four residents. The complaints process is fully described in policy and shown in the residents' welcome book and complaints forms are easily accessible (as sighted at the onsite audit). The owner/manager includes the right to complain as part of the admission discussion and the service respects the resident's right to make a complaint. The sighted complaints procedure is easily accessible, responsive and complies with Right 10 of the Code.

The complaints register identifies that one complaint is recorded in 2012 and no complaints recorded to date for 2013. All complaints show in detail the corrective actions taken, by whom and that they have been resolved to the complainant's satisfaction. The complaints sighted have time frames that comply with Right 10 of the Code and the actions taken. There are no outstanding complaints.

Interviews with the two family/whanau and four residents confirm their understanding of the right to make a complaint. The six weekly residents' meetings are used as a forum for residents to voice any concerns.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

Te Ata Rest Home ensures services are planned and appropriate to the needs of residents at rest home level of care. The annual planning review meeting minutes sighted identify this was undertaken in April 2013 to set the goals for the upcoming year. The review is informed from quality data collected including the resident survey results, to ensure resident needs are met. The strategic business plan from April 2013 to March 2014 covers the priority, focus area, item, key actions and time frames. Organisational goals and mission are defined and monitored in the strategic plan and are regularly monitored through management reviews (minutes sighted for the 2013 management reviews, last meeting conducted in September 2013).

The service is a family owned and operated business, with three owners/directors. One of the owners/directors is the facility manager and one of the other owner/directors is a registered nurse and has worked as a registered health professional in aged care for 28 years. The owner/manager's experience has been in the facility management role since March 2011. The owner/managers have backgrounds in business management of larger national and international organisations. They are responsible for the overall administration and management operations. The manager's job description is sighted and includes authority, accountability and responsibilities.

The owner/manager is supported by a clinical manager (RN). The registered nurse job description was sighted and includes authority, accountability and responsibility for the clinical management.

ARRC requirements 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

Two of the owner/directors (who have the roles of facility manager and RN), five staff interviewed (one RN, two caregivers (one of these caregivers is a senior caregiver/coordinator), one activities coordinator and one cook) demonstrate knowledge and understanding of the quality and risk processes that are identified in policy. The quality objectives are reviewed annually (April each year), with the April 2013 to March 2014 quality objectives being based on the 2013 resident satisfaction survey results. The business continuity plan includes service/business risks, facility and risk hazards, and business continuity plan (April 2013). hazard/risk, likely hood, consequence/impact and mitigation, reduction and response options.

All policies and procedures sighted are current and referenced to current accepted good practice. There is a self-review schedule for the document review. These are also updated to reflect any legislative changed (eg, health and safety on 1 April 2013). Policy reviews are set from six monthly to two years dependant on the aspects of the service. There is electronic archiving of obsolete documents. The review history records what changes have been made to the document. All staff have secure login (username and passwords) to access the current version.

Key components of service are incorporated into the audit system and discussed at management review meetings as confirmed in meeting minutes sighted. The management review meetings are where all data collected is reported on. This includes audit results, falls, skin tears, infections, complaints, incidents and accidents, hazards and staff education. Management review meetings are conducted regularly. The minutes sighted for September 2013 include health and safety and risk management, quality reviews, training, infection control, staffing, general business.

The quality improvement data collected is analysed and evaluated and trended by the owner/manager and the owner/RN. If a trend is noted to be increasing then corrective action planning is put in place as required. Corrective actions are put in place for any deficit that is noted during internal or external audits and in response to complaints, resident requests and satisfaction surveys. The sighted 2013 resident satisfaction survey provides an overall positive feedback, with sighted resident feedback including 'the owners are very caring and helpful', 'all staff are wonderful and do a really good job' and 'kindness abounds here'.

Actual and potential risks are identified, documented and communicated to staff and residents as appropriate. The system used by the service identifies all hazards and if they cannot be eliminated they are added to the significant hazard register. Hazards are reviewed and evaluated at the management reviews and reported against the annual strategic and emergency management plans. A review of four staff files shows that as part of orientation staff must read and make themselves familiar with existing hazards.

ARRC requirements are met.

**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

The two owner/directors interviewed understand their responsibilities and obligations in relation to essential notification reporting. The owner/RN reports that an instance of nausea and vomiting is reported to the Public Health department in 2012 (though this was not confirmed as Norovirus when diagnostic results were received). Interviews with five staff confirm they fully understand and comply with incident and accident recording and reporting systems.

Incident and accident forms reviewed for July to October 2013 identify that all adverse events are recorded and reported using the incident and accident form. Information is trended and assists in ensuring the corrective actions put in place are relevant to each incident. The incidents and accidents sighted for August 2013 records seven incidents (this has decreased from July when there were 10 incidents). The analysis records that one resident had more than two falls in August 2013 and actions are implemented for this resident to assist in falls reduction (refer to standard 1.3.3). The resident has no recorded falls in September and to date in October 2013.

The ARRC requirements are met.

**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

A previous CAR (criterion 1.2.7.2) required the service to provide records to validate that the required training and competencies have been maintained by the on call registered nurse. The manager reports that this RN is no longer employed with the service. The two current RNs (one of these is the owner/RN) have completed all required training and competencies. There is one new employee (RN) that is currently in the process of completing the orientation, mandatory training and competency assessment (observed at the time of audit). The previous corrective action is now addressed and an improvement implemented since the last audit.

There is a system in place to record annual practising certificates for staff who require them. The service has due dates recorded for staff practising certificates noted for all staff who require them and these are current.

A review of four staff files (three caregivers and one kitchen assistant) and staff interviews confirm that the orientation process prepares staff for the roles they undertake. Human resources documentation sighted in the four staff file reviews identifies all processes are conducted in accordance with good employment practice and meet legislative requirements. All staff complete an orientation related to the role they undertake. Ongoing education includes compulsory in-service education and staff meetings, care training online and other e-learning modules (eg, medicine management, health & safety, infection control, clinical and housekeeping). The RN and two caregivers interviewed confirm the type and amount of education offered is appropriate. The service offers Age Care Education (ACE) for caregivers who do not already have a national qualification.

The four staff files reviewed and the training schedule sighted for 2013 identifies that the service plans, facilitates and records all education. Education is undertaken onsite and offsite and is presented by specialist providers as is appropriate. Staff are encouraged to attend education both in-house and off site related to the roles they perform, with the service making a number of topics compulsory for all staff (eg, fire evacuation, emergency procedures, elder abuse, advocacy and residents rights, dementia and challenging behaviours, manual handling, cultural safety, values and spirituality).

Interviews with two of two family/whanau members and four of four residents confirm all their needs are being provided for in a professional and safe manner. All residents and family/whanau interviewed expressed high praise for the quality of care.

The relevant rest home ARRC requirements are met.

**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 a documented staffing levels policy that ensures staffing levels meet the residents' needs. All staff undertake appropriate education and training to undertake their roles. If staff are off work for any reason the person is replaced. The owner/RN reports that the service does not use agency staff. All clinical care is well planned and identified on individual resident's care plans as identified in four of four residents' files reviewed.

The rosters sighted for the previous four weeks confirm that all shifts are covered by at least one staff member who holds a current first aid certificate. The owner/manager reports that all staff have a current first aid qualification. Management and staff interviews confirm additional staff are rostered as required to meet residents' needs. There is a RN on duty or on call at all times. The rosters evidence that there is 40- 60 hours a week of RN rostered hours, or more if needed. The rosters and interview with the owner/RN and care staff confirm that there are four caregivers for the morning shift (staggered start and finish times), three caregivers rostered for the afternoon shift (staggered start and finish times) and one caregiver on duty and another staff member on call for night duty. The morning and afternoon shifts have varying start and finish times to ensure that there are the most staff on duty at the busiest times of the day to meet the needs of the residents. In addition to the care staff, there are two diversional therapists on duty Monday to Friday, a dedicated cleaner and kitchen staff.

The four residents and two family/whānau interviews identify that services are delivered in an appropriate and safe manner to meet all required needs. The RN and two caregivers interviewed confirm that the rosters reflect the actual staffing numbers.

The relevant ARRC requirements for rest home level of care are met.

**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 1.3.3 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, provision of care and review/evaluation is undertaken by suitably qualified staff who are competent to perform their role. The four of four residents' files reviewed confirm that the registered nurse (RN) conducts the initial assessment and initial care plan on admission to the service and develops the long term care plan within three weeks. The care staff are suitably experienced and encouraged to complete the Aged Care Education (ACE) qualifications if they do not have a national qualification. Annual practising certificates are sighted for all staff that require them.

The initial and ongoing assessments include the physical, psycho-social, spiritual and cultural needs of the resident. The four of four residents' files evidence that the long term care plan is based on the assessed needs of the resident. The ongoing long-term care plans are individualised and personalised to the resident’s needs. The care plan identifies the nursing diagnosis/problem, desired goals and interventions. The care plan evaluation is conducted at least six monthly using the ongoing health assessment form review, as confirmed in the four of four residents' files reviewed.

The four of four residents' files evidence the initial medical review is conducted within two days of admission (where required). Ongoing medical reviews are conducted monthly or at least three monthly when the resident is assessed as stable (more frequently when required for the resident's changing needs). The exception for the three monthly medical review is recorded in the resident's progress notes (confirmed in the four of four residents' files reviewed).

The service is co-ordinated in a manner that promotes continuity of care. A verbal and written handover is provided at the start of each shift, the two caregivers report that adequate information is provided at handover, in residents' progress notes and on the communication sheet.

The four of four residents and two of two family/whanau interviewed report the residents receive care that meets their needs. All the residents and family interviewed spoke highly of the quality of care and friendly, homelike nature of the service. One resident commented that they are really impressed with the quality of care and service and one family member commented that 'optimum patient care' is provided.

Tracer example: Resident

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

The relevant rest home ARRC requirements are met.

**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 1.3.6 Service Delivery/Interventions**

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

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

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

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

The four of four residents' files reviewed have care plan interventions based on the residents' needs. The service has paper based assessment and care planning records. The care plan records the identified need, level of assistance required and desired outcomes or goals that are individualised to the resident’s needs. One resident reviewed has appropriate interventions and medical investigations to implement measures to reduce falls.

The two caregivers interviewed report the care plans provide accurate information regarding the individual needs and care required for the residents. The four of four residents and two of two family/whanau interviewed report satisfaction with the care provided and commented on the friendly and homelike nature of the service.

The relevant ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The activities co-ordinator reports activities plans are individualised to the resident’s needs. The activities are individualised and developed in conjunction with the resident and where appropriate their family. The activities assessments and plans are incorporated in to the long term care plan, as sighted in the four of four residents' files reviewed, evidence shows they are up to date and reflect individualised needs of the residents. The activities assessment include social pursuits, intellectual interests, creative pursuits, physical activity and outdoor interests.

A monthly activities plan (sighted) is developed based on the resident’s needs, interests, skill and strengths. The activities cover cognitive, physical and social needs. The four residents' files reviewed have activities and social assessments. The goals are updated and evaluated in each resident's file at least six monthly with person centred care plan reviews and multi-disciplinary reviews. The activities co-ordinator reports where residents have a specific need, the service endeavours to provide the resources for this.

Where possible residents' independence is encouraged to maintain links with family and community groups. Residents are provided with outings on a routine basis. One to one activities are planned to meet the resident's interests.

The four of four residents interviewed report they enjoy the range and variety of planned activities.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

The four of four residents' files reviewed evidence evaluations are recorded at least six monthly by the RN. The documented evaluations, using the ongoing assessment form, indicate the resident's progress in meeting goals. If there are changes the resident is re-assessed and the care plan is updated to reflect the changes. The four of four care plans sighted are individualised and personalised to the residents' needs. Any changes in the residents’ condition are written in the progress notes and discussed at the staff handover to oncoming staff (confirmed at interview with the two caregivers). One resident reviewed has their falls assessment and care plan updated to reflect the changes in the residents mobility and increased risk for falls.

Short term or acute nursing care plans are used to documented temporary changes in the residents' condition. An acute care plan documents the problem, treatment required and the outcomes of care.

The four of four residents and two of two family/whanau interviewed report involvement in the evaluation process and are satisfied with the care provided.

The ARRC requirements 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:** FA

The previous CAR (criterion 1.3.12.3) required all staff administering medicines to complete annual medicines management competencies and competencies to be assessed by a registered nurse. Previously, not all staff administering medicines have completed medication competencies as required with competency assessments being completed by a caregiver. All staff who assist in medicine management now have a documented competency assessment that is conducted by a RN. The previous corrective action is now addressed and an implemented improvement since the last audit.

Medicines for residents are received from the pharmacy in the Douglas Pharmaceutical Medico Pak delivery system. The signing sheet records the medicines are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the new medico Paks are delivered. Two staff (RN and senior caregiver) both check the Medico Paks for accuracy against the medicine order, then sign the top of the signing sheet to indicate the contents of the medico pack accurately reflects the prescribed medicines. A safe system for medicine management is observed on the day of audit.

Medicines are stored in locked medicine cupboards. There is a monthly stock rotation recorded for the medicines. There are no controlled drugs at the time of audit. The service's medicine fridge is monitored daily and temperatures are within recommended guidelines.

The eight of eight medicine charts reviewed are reviewed by the GP in the last three months, this is recorded on the medicine charts. All prescriptions sighted contain the date, medicine name, dose and time of administration with any allergies highlighted in red ink. The eight of eight medicine charts reviewed have each medicine ordered signed by the GP. Although not sighted in the medicine charts sampled, the owner/RN reports that the service has had difficulty with one GP practice, where the GP brackets and signs for all the medicine ordered. The auditor confirmed with the owner/RN that the criterion requires that the medicine management system needs to comply with legalisation, protocols and guidelines and that the Medicines Care Guides for Residential Aged Care requires that each medicine ordered is required to be signed by the prescriber. The owner/RN contact the GP practice on the day of audit to confirm the GP of the requirements in the standards and guidelines.

There are documented competencies sighted for the staff designated as responsible for medicine management. The competency includes a written test and observations in medicine management and the administration of subcutaneous medications (eg, insulin).

The RN reports that there are no residents assessed as competent to self-administer their medicines. The service has a self-administration competency for residents who are able to self-administer their medicines.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The four week rotating menu, with seasonal variations, is approved by a registered dietitian in 2010 as suitable for aged care residents. The manager reports that the service is in the process of developing a new menu (draft sighted) based on the residents' feedback, this menu will be reviewed by a dietitian. A nutritional profile is completed for each resident on admission (and updated when there are changes) and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. For example, the service provides diabetic meals and identified food allergy meals. The care staff manage the additional food supplements for the residents (eg, Fortisip).

Interviews with four of four residents and two of two family/whānau confirm they are overall happy with the food provided. The residents report that if there are items that they do not like on the menu, there are always alternatives offered.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer are in their original packaging or labelled and dated if not in the original packaging. Staff have undertaken food safety management education appropriate to service delivery.

ARRC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

Interview with the two owner/directors, one RN and two caregivers identifies that the facility has a no-restraint environment. Staff education includes restraint minimisation but the facility focuses on behavioural management techniques to avoid the use of restraint (last conducted August 2013). Policy shows that enablers are voluntary and that the least restrictive option would be used with the intention of promoting or maintaining resident independence and safety. Observation confirms that no restraint or enablers are in use at the time of audit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 Surveillance**

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

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

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

Infection control data is collected on urinary tract infections (UTIs), chest infections, wound infections, eye and ear infections and multi-resistant organisms. The monthly report of collected data is provided to staff. The surveillance data collected is based on guidelines from an aged care consultant. Infection control data is included in the quality audit programme.

All staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The data for August 2013 records three UTIs and six respiratory infections. The increase in the respiratory infections is reflective of seasonal norms. There is also an increase in residents with chronic obstructive pulmonary disease which correlates to the increased respiratory infections. The number of UTIs is consistent throughout 2013. There is also an annual analysis of infections identifying trends for the facility and for individual residents.

**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:**