**Radius Residential Care Limited - Radius Matua Lifecare**

**Current Status:** **16-Sep-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Radius Matua Lifecare is part of the Radius Residential Care Group. Matua Lifecare cares for up to 138 residents requiring rest home, hospital and secure dementia level care. On the day of the audit there were 17 residents receiving dementia level care, 60 receiving hospital level and 61 receiving rest home level care including five who live in serviced apartments within the care facility building.

The facility manager has many years of aged care management experience. She has been at the service for 13 years and was previously the clinical manager. She is supported by the Radius regional manager.

This audit has identified improvements required around aspects of medication management, and care planning.

**Audit Summary AS AT** **16-Sep-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  16-Sep-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit  16-Sep-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  16-Sep-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit  16-Sep-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  16-Sep-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  16-Sep-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Audit Results AS AT** **16-Sep-13**

**Consumer Rights**

The support provided to residents at Radius Matua is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance. Residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Residents and their families are kept informed.

Radius Matua supports three Maori residents. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided.

Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community.

Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

**Organisational Management**

Radius Matua has an organisational philosophy, which includes a vision, mission statement and strategic objectives. The Radius Matua facility manager has over 13 years of experience working at this facility. She holds a current annual practising certificate as a registered nurse.

The operational management strategies, and quality improvement programme, which includes culturally appropriate care, are in place to minimise the risk of unwanted events and to enhance quality.

Policies and procedures, supporting service delivery, are reviewed a minimum of every two years. Clinical guidelines are in place to support good practice. Resident assessment tools are linked with resident care plans and are reviewed every six months.

The internal audit programme monitors quality and risk indicators, including (but not limited to) adverse events, infections, complaints, clinical records, the environment, and resident and family satisfaction. Where results are less than acceptable, corrective action plans are put into place.

All residents and families interviewed confirm they have regular opportunities to provide input into care planning. In the event of an accident or incident, families are kept informed.

There is a registered nurse on duty at all times. Staffing numbers meets the requirements of the facility's contract with the district health board and the needs of the residents.

Education and training programmes are in place for staff.

**Continuum of Service Delivery**

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

The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. There is an improvement required around care planning. A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration. Resident files include notes by the GP and allied health professionals.

Medication policies reflect legislative requirements. Education and medicines competencies are completed by the clinical nurse leader and health care assistants responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around medication documentation and three monthly general practitioner reviews..

The activities programme is facilitated by a recreational coordinator who is an occupational therapist. The activities programme provides varied options of activities enjoyed by the residents. Each resident has an individualised plan. Community activities are encouraged, resident outings are arranged on a regular basis.

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

**Safe and Appropriate Environment**

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

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

Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. Staff interviews and files evidence current training in relevant areas. There are alternative energy and utility sources, an appropriate call bell system and security systems are in place.

**Restraint Minimisation and Safe Practice**

A comprehensive set of policies and procedures are in place in the event that an enabler or restraint use is indicated. At the time of the audit, there were no residents using an enabler or a restraint.

**Infection Prevention and Control**

The infection control coordinator position is shared between the rest home and the hospital clinical managers who are both registered nurses The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to the infection control meeting and the quality and staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

**Radius Matua Lifecare**

Radius Residential Care Limited

Certification audit - Audit Report

Audit Date: 16-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Radius Residential Care Limited |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Radius Matua Lifecare | 124 Levers Road | Matua | Tauranga |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 16-Sep-13 **End Date:** 17-Sep-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | RCompN, PGDipHSM, Health Auditor | 14.50 | 6.00 | 16-Sep-13 to 17-Sep-13 |
| Auditor 1 | XXXXXXXX | DipHED, RN, BSC, Health auditor | 14.50 | 6.00 | 16-Sep-13 to 17-Sep-13 |
| Auditor 2 | XXXXXXXX | MHADipPhys, RABQSA, lead auditor | 14.50 | 6.00 | 16-Sep-13 to 17-Sep-13 |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX |  |  | 2.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 43.50 | **Total Audit Hours off site** *(system generated)* | 20.00 | **Total Audit Hours** | 63.50 |
| **Staff Records Reviewed** | 15 of 150 | **Client Records Reviewed** *(numeric)* | 12 of 138 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 12 |
| **Staff Interviewed** | 21 of 150 | **Management Interviewed** *(numeric)* | 4 of 4 | **Relatives Interviewed** *(numeric)* | 17 |
| **Consumers Interviewed** | 13 of 138 | **Number of Medication Records Reviewed** | 29 of 138 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 20 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

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|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Radius Matua Lifecare | 151 | 138 | 5 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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1.4 Safe and Appropriate Environment

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

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2 Restraint Minimisation and Safe Practice

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3. Infection Prevention and Control

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Summary of Attainment

* 1. Consumer Rights

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

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| Consumer Rights Standards (of 12): N/A:0 CI:0 FA: 12 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:23 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | 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 | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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

* 1. Continuum of Service Delivery

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

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 9 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:18 PA:3 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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

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

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 5 **CI:** 0 **FA:** 42 **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  **Total Criteria (of 219) CI:** 0 **FA:** 90 **PA:** 3 **UA:** 0 **N/A:** 8 |

# Corrective Action Requests (CAR) Report

Provider Name: Radius Residential Care Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:16-Sep-13 End Date: 17-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.5 | 1.3.5.2 | PA  Moderate | **Finding:**  Six of 12 files sampled do not have interventions relating to all identified needs. Examples include weight loss, nutrition needs, pressure area care interventions, falls risk, pain and depression.  **Action:**  Ensure all identified needs have related interventions in the care plan. | 3 months |
| 1.3.6 | 1.3.6.1 | PA  Moderate | **Finding:**  Of the 30 wounds,14 have not been reviewed within the stated timeframe.  **Action:**  Ensure all wounds are reviewed within stated timeframes. | 3 months |
| 1.3.12 | 1.3.12.6 | PA  Moderate | **Finding:**  (i) Two of 29 PRN administration signing sheets have evidence of transcribing. (ii) Six of 29 medication signing sheets had signature gaps of the person administering medication. The facility has identified that transcribing and gaps in signing were an issue prior to the audit and is currently reviewing the process and procedures to eliminate issues and is working with the pharmacy regarding PRN medication sheets. (iii) Three of four rest home files and two of five hospital files do not have three monthly GP medications review noted in the medication chart or resident files.  **Action:**  (i) Ensure transcribing does not occur in medication charts. (ii) Ensure medications are administered as prescribed. (iii) Ensure three monthly GP medication review is documented. | 1 month. |

# Continuous Improvement (CI) Report

Provider Name: Radius Residential Care Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:16-Sep-13 End Date: 17-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

There is an implemented code of rights policy and procedure. Discussions with seven health care assistants (four hospital, two rest home and one who works in the dementia unit) and six registered nurses (three hospital, two rest home, and one who works in the dementia unit) identified their familiarity with the code. Interviews with 15 residents (seven from the rest home and eight from the hospital) and 17 relatives (seven from the hospital, five from the rest home and five from the dementia unit) confirmed service is provided in line with the code of rights. Code of rights/advocacy/complaints training is provided during new staff orientation and as a regular in-service topic (link 1.2.7).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

The service provides information to residents that include the code of rights, complaints and advocacy information. There is access to interpreter services if required. Information is given to next of kin or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with 15 residents (seven from the rest home and eight from the hospital) and 17 relatives (seven from the hospital, five from the rest home and five from the dementia unit) identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Six-monthly resident/relative meetings (minutes sighted) are held providing the opportunity to raise concerns in a group setting. There is a quarterly newsletter available to residents and families.

Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.

D6,2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy and Health and Disability Commissioner information.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service has policy aligned with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.

Discussions with 15 residents (seven from the rest home and eight from the hospital) and 17 relatives (seven from the hospital, five from the rest home and five from the dementia unit) confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

The spiritual and religious beliefs policy guides practice from an organisational perspective. Interdenominational services are held weekly. Contact details of any spiritual/religious advisors are available to staff. Religious dietary requirements identified through assessment and care planning are met as required. All relatives interviewed (seven from the hospital, five from the rest home and five from the dementia unit) and 15 residents (seven from the rest home and eight from the hospital) confirm the service is respectful.

A client satisfaction survey is carried out annually to gain feedback. In 2013, feedback has been received relating to satisfaction with food and satisfaction with the admission process. Plans are in place to conduct a comprehensive satisfaction survey, covering all aspects of the service, in November 2013.

D4.1a: Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

The information pack provided to residents and their families includes the home's philosophy of care. Discussions with 15 residents (seven from the rest home and eight from the hospital) confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they have adequate rights to choose within the constraints of the service, for example, meal times. Twelve care plans reviewed (five hospital, four rest home and three dementia) identify specific individual likes and dislikes.

The abuse & neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training is an annual requirement (link 1.2.7). All Radius facilities are required to hold copies of the "Elder Abuse & Neglect - a Handbook for those working with Elder Abuse" from Aged Concern.

Discussions with management, seven healthcare assistants (four hospital, two rest home and one who works in the dementia unit) and six registered nurses (three hospital, two rest home, and one who works in the dementia unit), two clinical nurse managers and two activities staff report there have been no identified incidents of abuse or neglect.

E4.1a Five families’ from the dementia unit state that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.4 Recognition Of Māori Values And Beliefs**

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

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

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

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

There is a specific Maori health care plan and a culturally safe care policy. Discussions with seven health care assistants (four hospital, two rest home and one who works in the dementia unit) and six registered nurses (three hospital, two rest home, and one who works in the dementia unit) confirm their understanding of the different cultural needs of residents and their whānau. There is a section in the assessment tool and care plan that includes identifying spirituality, religion and culture, psycho-social needs and family and significant others. In addition, there is a Maori care plan available if the individual resident wishes.

There were three Maori residents living at the facility at the time of the audit. One of the three Maori residents who identifies as Maori has a documented Maori health plan. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori healthcare providers regionally within New Zealand.

D20.1 I: The service utilises a Maori employee (enrolled nurse) as a Maori cultural advisor.

The Maori Health plan states that staff training sessions are provided two yearly for all staff (link 1.2.7). The service has documentation relating to culturally appropriate responses in particular settings.

Interviews with seven health care assistants (four hospital, two rest home and one who works in the dementia unit) and six registered nurses (three hospital, two rest home, and one who works in the dementia unit) confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Care planning includes consideration of spiritual, psychological and social needs. Fifteen residents (seven from the rest home, eight from the hospital) indicate that they are involved in the identification of spiritual, religious and/or cultural beliefs. Seventeen relatives (seven from the hospital, five from the rest home and five from the dementia unit) interviewed state that they feel they are valued, consulted and kept informed. Family involvement is encouraged e.g. invitation to facility functions.

D3.1g The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by six registered nurses (three hospital, two rest home, and one who works in the dementia unit).

D4.1c Twelve of twelve care plans reviewed include the residents’ social, spiritual, cultural and recreational needs.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

An implemented discrimination and harassment policy includes all aspects of this criterion. There is a staff policy in relation to gifts and gratuities and the management of external harassment. The following policies also support keeping residents safe from exploitation: code of residents’ rights, abuse and neglect, and complaints. Annual training is provided to staff across a number of topics such as: code of rights and communication (link 1.2.7). Fifteen residents (seven from the rest home, eight from the hospital) interviewed informed they were not exposed to exploitation.

A staff employment handbook and orientation package includes a code of behaviour. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Interviews with seven healthcare assistants (four hospital, two rest home and one who works in the dementia unit), six registered nurses (three hospital, two rest home, and one who works in the dementia unit), two clinical nurse managers and two activities staff confirm their understanding of professional boundaries.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. Policies are reviewed and approved by the clinical management committee at an organisational level. The good practice policy supports staff in ensuring good practice is intrinsic to care delivery. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The human resource manual includes pre-employment, and the requirement to attend orientation and on-going in-service training.

Radius Matua's facility manager oversees the internal audit and in-service education programmes with support from senior staff. Staff are informed when external training is available and financial support is considered. There is access to computer and Internet resources and search engines. There is organisational membership to Bug Control for infection control updates / training and expert advice.

There are monthly hospital, rest home and dementia unit staff meetings and six-monthly resident meetings.

Fifteen residents (seven from the rest home and eight from the hospital) and 17 relatives (seven from the hospital, five from the rest home and five from the dementia unit) interviewed spoke positively about the care and support provided. Seven healthcare assistants (four hospital, two rest home and one who works in the dementia unit), six registered nurses (three hospital, two rest home, and one who works in the dementia unit), two clinical nurse managers and two activities staff have a sound understanding of principles of aged care and state that they are supported by the service for on-going education.

A2.2: Services are provided at Radius Matua that adheres to the Heath & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring.

D1.3 All approved service standards are adhered to.

D17.7c.There are implemented competencies for healthcare assistants, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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 an open disclosure policy. The ‘communication with residents’ policy includes procedures to ensure that staff communicate well with residents and family members. There are six monthly resident/relative meetings attended by the facility manager and facility assistant coordinator allowing residents/relatives to raise issues. Plans are in place to increase the frequency of these meetings to quarterly.

Fifteen residents (seven from the rest home, eight from the hospital) state they were welcomed on entry and were given time and explanation about services and procedures.

Twelve incident reports were reviewed across the service. All twelve recorded family notification. Seventeen relatives interviews (five from the rest home, seven from the hospital and five from the dementia unit) confirm they are notified of any changes in their family member’s health status. The two clinical nurse managers who investigate incidents indicate there are processes in place to support family notification of events.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.

D16.4b: All seventeen relatives state that they are informed when their family members health status changes.

The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

Policies and training support staff in providing care and support to enable residents to make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with seven health care assistants identify that consents are sought in the delivery of personal cares. Written consent includes the signed admission agreements and consent for transporting, photographs and provision of care. All 12 resident files (four from the rest home, three from the dementia unit and five from the hospital) reviewed has signed consent forms signed by the family/whanau/EPOA. Advanced directives / resuscitation policy is implemented in 12 resident files reviewed. All advance directives are completed by the resident where able, the GP and discussion with family members is documented.

D13.1: There were 12 admission agreements sighted and eight had been signed on the day of admission.

D3.1.d: Discussion with 17 family members (five from the rest home, seven from the hospital and five from the dementia unit) identified that the service actively involves them in decisions that affect their relative’s lives.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception.

D4.1e; The residents’ files include information on residents family/whanau and chosen social networks.

Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.

D4.1d; Discussions with 17 relatives (five from the rest home, seven from the hospital and five from the dementia unit) identify that the service provides opportunities for the family/EPOA to be involved in decisions.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources**

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

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

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

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

The client information pack informs visiting can occur at any reasonable time. Interviews with 15 residents and 17 relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident’s life are documented in the care plans and there is a family communications/contact sheet in resident files where staff document when family have been contacted.

The service has strong community support and engagement.

D3.1.e Discussions with 15 residents and 17 relatives verify that they are supported and encouraged to remain involved in the community. There are a number of ways Radius Matua support on-going access to community services, for example: RSA, a variety of community activities and functions, links to the local bowling club and garden centres, and the Blind Foundation.

D3.1h: Discussions with 17 families verify that they are encouraged to be involved with the service and care.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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 complaints policy and procedure states that residents/family/whanau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.

A complaints procedure flow chart is included in the policy and is included in the information pack for residents on entry. Policy states that the complaints process is to be visible and available in public areas.

Interviews with 15 residents (seven from the rest home, eight from the hospital) and 17 relatives (five from the rest home, seven from the hospital and five from the dementia unit) are familiar with the complaints procedure and state any concerns or complaints are addressed.

The complaints log/register includes the date of the incident, complainant, summary of complaint, and signature when the complaint is resolved. There have been 10 lodged complaints in 2013. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint.

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

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

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

**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

Radius Matua is part of the Radius Residential Care Group care for residents requiring hospital, rest home and dementia level care. During the audit there were 61 residents receiving rest home level care, 60 receiving hospital level care and 17 receiving dementia level care.

The facility manager reports monthly to the regional manager on a range of operational matters in relation to Radius Matua including strategic and operational issues, incidents and accidents, complaints, and health and safety. The Radius mission statement states that:

"We deliver a quality lifestyle with an innovative approach to care that enables us to maintain the wellbeing, dignity and independence of our residents"

Radius has an organisational philosophy, which includes a vision, mission statement and objectives including a quality/risk management framework and process policy. Annual business quality/risk management plans are in place for the facility. A quality/risk management plan for 2013 has been developed for Radius Residential Care and Radius Matua has developed site-specific strategies including:

1. Creating a performance culture

2. Excellence

3. Consumer participation

4. Clinical effectiveness

5. Effective workforce

6. Risk management

6. Shareholder value

7. Innovation and new ventures

The service has a documented structure that supports continuity of management and care delivery.

The Radius Matua facility manager has 13 and ½ years of experience working at the facility, initially as a registered nurse, then as a clinical coordinator of the hospital and dementia unit. She has been a clinical manager for five years and has nine years of experience as a phlebotomist. She holds a current annual practising certificate as a registered general and maternity nurse.

The organisation provides annual conferences for their managers and annual regional conferences.

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

ARC,D17.3di (rest home), D17.4b (hospital), The manager has maintained more than eight hours annually of professional development activities related to managing an aged care facility.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

During the temporary absence of the manger, Radius Matua is managed by the assistant facility coordinator. If the facility manager is absent for more than one week, an interim manager is provided either on a contractual basis or is provided by the regional manager.

D19.1a; A review of the documentation, policies and procedures and from discussions with staff it is identified that the service’s operational management strategies, and quality improvement programme, which includes culturally appropriate care, are in place to minimise the risk of unwanted events and to enhance quality.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

There is an organisational quality/risk management plan - 2013 that includes clinical/care related risks, human resources; health and safety; environmental/service; financial; as well as site specific risks/goals identified for Radius Matua. Business plan targets are linked directly to the Radius Strategic Plan and include the following categories:

1. Clinical leadership and management

2. Clinical effectiveness

3. Consumer participation

4. Workforce effectiveness

5. Risk management

6. Taking ownership of the business and services provided

7. Effective financial leadership and management

8. Marketing.

There are organisational policies to guide the facility to implement the quality management programme including (but not limited to); continuous quality improvement programme policy, continuous quality improvement methodology policy, quality indicator data collection policy and internal audit timetable. There is evidence that the quality system continues to be implemented at Radius Matua.

Staff have designated portfolios including incidents and accidents, training, restraint, health and safety and infection control. Interviews with seven health care assistants (four hospital, two rest home and one who works in the dementia unit) and six registered nurses (three hospital, two rest home, and one who works in the dementia unit) confirm that quality data and outcomes are discussed at monthly rest home, hospital and dementia unit staff meetings (meeting minutes reviewed). The facility manager reports that she is responsible for providing oversight of the quality programme. There are monthly quality (‘SQUIRM’) meetings where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff.

The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed every two years at the national level by the clinical managers group with input from facility staff. Clinical guidelines are in place to assist care staff with such issues as constipation, delirium, congestive heart failure, diabetes, dementia, falls prevention, incontinence, nutrition and hydration, skin care and wound management. Assessment tools completed are linked with resident care plans and are reviewed six monthly. Examples of internal audits include monitoring care delivery compliance, care plans compliance, clinical records, medications, hand washing, and privacy.

D5.4 The service has the appropriate policies and procedures to support service delivery. Policies and procedures are appropriate for service delivery. Policy manuals are reviewed two-yearly. New/updated policies are sent from head office . New policies and procedures are put in the staff room with a signing sheet for staff to sign once they have read and understood the documentation (verified in interviews with seven healthcare assistants and six registered nurses). Staff have access to manuals (nurses stations and staff room). Policies are up to date and are located electronically on the Radius intranet.

Monthly reports by the facility manager to the regional manager are provided on service indicators. The quality (SQUIRM) meetings are minuted and with a set agenda including (but not limited to): health & safety, incident and accidents, complaints/compliments. Information is provided to staff through the various meetings and on staff notice boards.

a) There are monthly accident/incident reports completed by the clinical managers that break down the data collected across the service.

b) The service has linked the complaints process with the quality management system. Monthly manager’s reports, provided to the regional manager, include any complaints received. Staff meeting minutes includes the discussion of complaints.

c) There is an infection control data collection form, which records all infections for each month. Infection control rates, outbreaks and results of internal audits are reported during the staff meetings and through clinical indicator reports for benchmarking. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the staff, and registered nurse meetings.

d) Health and safety is an agenda item at the staff meetings. Any new hazards are discussed.

e) The restraint committee reports through the three-monthly restraint meetings with feedback provided to staff and RN meetings. Restraint use is also reported to the organisation through the clinical indicator reports. Restraint internal audits are completed yearly and results are forwarded through the monthly manager meetings.

Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. Further evidence may be requested by the regional manager when indicators are above the benchmark. The service collects internal monitoring data (internal audits) with the audit schedule being implemented at Radius Matura by the facility manager. The audit programme includes (but is not limited to); care plans, care delivery compliance, health and safety, infection control, medications, code of rights, informed consent, vehicle compliance and restraint. Quality improvement data such as incidents /accidents, hazards, internal audit, infections are collected and analysed/evaluated at the quality meetings and staff are informed through the registered nurses and staff meetings. Minutes of meetings verify audit results are discussed.

Radius policy states a corrective action plan is required where compliance is under a predetermined threshold. Corrective action plans are developed for incident reports and all audits where there has been less than 95% conformity.

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

D19.2g: Falls prevention strategies are developed by aggregating and analysing data each month, including a consideration of the time of occurrence.

There is emergency and disaster planning in place for earthquakes, fire, emergencies and other disasters. This includes training and education for staff, monthly building compliance checks, six monthly evacuation trials, and ensuring adequate staffing in the event of an emergency. An organisational risk register identifies risks and risk ratings, identifies actions to prevent or minimize risks and person(s) responsible. The risk register covers areas such as clinical risk, human resources related risks, health and safety risks, environment/service related risks and financial risks. Each facility personalises the risk register to their site. Radius has terms of reference for the health and safety committee defining membership to include a health and safety officer and three health and safety representatives, all of whom have undergone formal health and safety training.

As part of the risk management and health and safety framework, there is an accident/incident reporting and open disclosure policy/procedure. There is evidence of monitoring indicators month by month including (but not limited to): falls (no injury, soft tissue, fractures), skin tears, medication errors and pressure areas.

When an incident occurs the health care assistant (or staff discovering the incident) completes the accident/incident form and the RN undertakes an initial assessment. The RN notifies family and the GP as required. The clinical nurse manager collects incident reports daily and reviews both the incident and actions taken. Where the action taken is not considered to have been comprehensive, the clinical nurse manager will investigate and escalate details to the facility manager. Ten incident forms sampled evidence detailed investigations and corrective action plans following incidents (link 1.2.4).

Monthly data is taken to the quality and staff meetings. The seven healthcare assistants and six registered nurses interviewed can describe the process for managing and reporting incidents and accidents.

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

D19.3c Discussions with the service (regional manager, facility manager and assistant facility coordinator) confirms their awareness of the requirement to notify relevant authorities in relation to essential notifications.

**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

Accident/incident analysis includes falls, skin tears, pressure areas, resident behaviour and medication incidents. The service has an incident and accident analysis form that includes the name, place, date and time, type, injury/site, cause, resident/staff/visitor, doctor notified, hazards identified and action(s) taken. The monthly aggregation of data is undertaken (eg, monthly summaries of ‘falls’ sighted) and outcomes are discussed at management, staff and quality meetings, evidenced in meeting minutes.

Ten incident forms were reviewed across the service. Clinical actions are well documented. Actions taken to minimise risk to individual residents are recorded.

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

D19.3c Discussions with the service (regional manager and facility manager) confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications.

**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

Of the 13 staff files reviewed, four were registered nursing staff. Current practicing certificates were reviewed. The facility manager reports a system is in place to check expiry dates. New registered staff are required to provide a practising certificate as part of the recruitment process. Practising certificates were also sighted for: GP's, physiotherapist, pharmacists, and podiatrist.

A recruitment, selection and appointment of staff policy is in place. Thirteen staff files were reviewed and all have evidence of annual performance appraisals, including a six-month performance appraisal following their hire date.

The organisation has a staff orientation policy. Radius Matua has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. The new staff member is buddied for two shifts with an experienced healthcare assistant (HCA). The facility manager identifies suitably skilled HCA to be the 'buddy'. Interviews with seven healthcare assistants and six registered nurses informed there is an orientation process provided that includes a period of being buddied.

In all 13 staff files reviewed there was a record that an orientation programme had been completed.

The service has an internal training programme directed by head office. There is an assigned in-service training manual that includes sessions required at orientation and then yearly. All sessions include a quiz, which is used at Radius Matua to embed information from the sessions provided. Challenging Behaviour and dementia are part of the training programme.

In addition to training requirements, there are healthcare assistant competencies (hand washing, manual handling, restraint, first aid) with a tracking sheet in place to monitor requirements.

Staff attendances at select mandatory training sessions for the past year (eg, abuse and neglect, accidents/incidents/open disclosure, cultural training, infection control, informed consent) are below 50% (evidenced on the staff training log presented during the audit). The assistant facility manager reports that poor attendance at mandatory training sessions has been identified as a shortfall for the facility. The service described addressing this issue through following up with staff to ensure they complete quizzes related to training sessions missed. Toolbox sessions are being used at handovers and for KPI requirements. Extra training sessions are being offered at different times to capture all shifts. These are back to back sessions which means staff are able to attend and cover several sessions in one day. The months training is planned and put out in advance for staff to view and acknowledge their attendance. The manager also stated that there have been 64 new employees to date this year, all have completed orientation which includes 30 hrs orientation time of buddying and training.

D17.7d: RN competencies include: hand washing, manual handling, restraint, medication, CAPD, and syringe driver. A tracking process is in place to monitor requirements.

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

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

E4.5f There are 24 healthcare assistants that have completed the required dementia standards, four healthcare assistants (employed November 2012 – February 2013) are in the process of completing the dementia standard and two healthcare assistants (employed August 2013) are yet to start.

**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

An acuity and clinical staffing ratio policy is in place that includes a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts. Time target is the software programme being utilised to build staff rosters. Casual staff are preferred over the use of agency staff. The facility manager and two clinical nurse managers, all whom are registered nurses, work full time.

Staff turnover is reported as being moderate. Recent staff changes since Radius Matua purchased the facility in 2012 have resulted in raising staff to resident ratios. Staff are adapting to this change.

The GP was interviewed and confirmed that staffing is appropriate to meet the needs of residents.

Fifteen residents (seven from the rest home and eight from the hospital) and 17 relatives (seven from the hospital, five from the rest home and five from the dementia unit) interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent and friendly.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual record and service register. These are paper based files.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Informed consent is obtained from residents/family/whanau on admission, for permission to display the resident’s name and taking of photographs.

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

Care plans and notes are legible and where necessary signed and dated. Policies contain service name. All resident records contain the name of resident and the person completing the form/entry.

Individual resident files kept demonstrate service integration that also contains GP notes and the allied health professionals and specialists records if applicable.

Communication with families is documented in the communication form and this was well used in 12 files reviewed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. NASC assessments are required for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the residents level of care requirements. There is a comprehensive information pack provided to all residents and their families for rest home, hospital and acute GP care. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the H&D Code of Rights,' complaints information, advocacy, and admission agreement. Fifteen residents (seven from the rest home and eight from the hospital) and 17 family members (five from the rest home, seven from the hospital and five from the dementia unit) interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Twelve resident files (four from the rest home, five from the hospital and three from the dementia unit), were reviewed. all had NASC approval and signed service agreements.

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

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

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

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

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

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

There is a policy and process that describe resident’s admission and assessment procedures. A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission. Activity assessments and the activities sections care plans have been completed by the diversional therapist.

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

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

All 12 files identified integration of allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. The GP interviewed spoke very positively about the service and describes effective communication processes.

D16.2, 3, 4: The 12 resident files (four from the rest home, five from the hospital and three from the dementia unit) reviewed, identified that in all 12 files a nursing assessment was completed within 24 hours and 10 of 12 files identify that the long term care plan was completed within three weeks. One resident has not yet been at the service for three weeks and another is for a resident on respite care. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. Ten of 12 care plans reviewed evidenced evaluations completed at least six monthly. Two residents had been in the facility less than six months.

Tracer methodology dementia:.

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

Tracer methodology rest home:

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

Tracer methodology hospital:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

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

Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Seventeen family members (five from the rest home, seven from the hospital and five from the dementia unit) and 15 residents (seven from the rest home and eight from the hospital), stated they were informed and involved in the assessment process.

ARC E4.2: Three resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a: Challenging behaviours assessments are completed for all residents in the dementia unit whose files were sampled.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

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

All rest home, dementia and hospital residents have an individualised long term care plan. Care plans are individually developed with the resident and family/whānau involvement is included where appropriate. Six of 12 care plans reviewed were evidenced to be up to date and have interventions relating to all identified needs. This is an area requiring improvement. Goals and outcomes are identified and agreed and how care is to be delivered is explained.

Areas covered in the 12 resident files (four from the rest home, five from the hospital and three from the dementia unit), sampled include (but are not limited to): behaviour, social and emotional needs, cultural needs, falls risk, ADL's, nutrition and social needs. Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. There is evidence that residents are seen by their GP at least three monthly. The care plan format is comprehensive and goal oriented. Notes are well maintained. Significant events and communication with families are well documented.

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

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

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

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

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

All rest home, dementia and hospital residents have an individualised long term care plan. Care plans are individually developed with the resident and family/whānau involvement is included where appropriate. Six of 12 care plans reviewed were evidenced to be up to date and have interventions relating to all identified needs. Goals and outcomes are identified and agreed and how care is to be delivered is explained.

Areas covered in the 12 resident files (four from the rest home, five from the hospital and three from the dementia unit), sampled include (but are not limited to): behaviour, social and emotional needs, cultural needs, falls risk, ADL's, nutrition and social needs. Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. There is evidence that residents are seen by their GP at least three monthly. The care plan format is comprehensive and goal oriented.

**Finding Statement**

Six of 12 files sampled do not have interventions relating to all identified needs. Examples include weight loss, nutrition needs, pressure area care interventions, falls risk, pain and depression.

**Corrective Action Required:**

Ensure all identified needs have related interventions in the care plan.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

The service provides services for residents requiring rest home, hospital level care and dementia care. Care plans are completed comprehensively.

Twelve resident files were reviewed for this audit: four rest home level residents; five hospital level residents and three dementia care residents.

Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans are evident (see CAR 1.3.5.2). Care plans evidenced at least six monthly care plan reviews. The use of short term care plans are evident. The care being provided is consistent with the needs of residents, this is evidenced by discussions with seven health care assistants who work both am and pm shifts and who work across rest home, hospital and the dementia unit, 17 family members (five from the rest home, seven from the hospital and five from the dementia unit), six RN’s (three from the hospital, two from the rest home and one from the dementia unit, the two clinical managers and the facility manager. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission.

There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses and gerontology nurse specialist. There is also evidence of community contact.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

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

Wound assessment and wound management plans are in place for 30 residents with wounds. Three residents have pressure areas. Of the 30 wounds 14 have not been reviewed within the stated timeframe. This is an area requiring improvement. On interview the six RN’s and the two clinical managers stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence in files of the wound specialist referrals.

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

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

Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans are evident (see CAR 1.3.5.2). Care plans evidenced at least six monthly care plan reviews. The use of short term care plans are evident. The care being provided is consistent with the needs of residents, this is evidenced by discussions with seven health care assistants who work both am and pm shifts and who work across rest home, hospital and the dementia unit, 17 family members (five from the rest home, seven from the hospital and five from the dementia unit), six RN’s (three from the hospital, two from the rest home and one from the dementia unit, the two clinical managers and the facility manager. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission.

There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses and gerontology nurse specialist. There is also evidence of community contact.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

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

Wound assessment and wound management plans are in place for 30 residents with wounds. Three residents have pressure areas. On interview the six RN’s and the two clinical managers stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence in files of the wound specialist referrals.

**Finding Statement**

Of the 30 wounds,14 have not been reviewed within the stated timeframe.

**Corrective Action Required:**

Ensure all wounds are reviewed within stated timeframes.

**Timeframe:**

3 months

**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 recreational coordinator is a qualified occupational therapist (OT) and has worked in the role for three months. She has worked in the facility as an OT for 12 years. She works 4.5 days a week. There are three additional activity officers who work in the facility (one for one year, one for two months and one for two weeks). Two of the officers work full time and one works short shifts over five days. The activities officer who works in the dementia unit is currently being orientated and is being mentored by the recreational coordinator and she has been booked to start dementia standards. All 12 resident files reviewed (four rest home, five hospital and three dementia) have recreation/activities assessments and reviews that are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge areas. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family.

Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. The hospital, rest home and dementia unit all have a separate weekly activities schedule. Activities include concerts, entertainers, movies, guest speakers, crafts, exercise, music/sing alongs, games, men’s group (facilitated by a male nurse), knitting group and outings (photos viewed of recent outing). There are also visits from community groups.

All 17 family members (five rest home, seven hospital and five dementia), interviewed stated that activities are appropriate and varied enough for the residents. All 15 residents (seven rest home and eight hospital), interviewed stated they were happy with the activities available and are given a choice regarding attendance.

D16.5d: All 12 resident files reviewed identified that the individual activity plan is reviewed at the same time as the care plan review.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

All initial care plans were developed by an RN within three weeks of admission and evaluated at least six monthly or if there is a change in health status. There is a three monthly review by the GP. There was documented evidence that evaluations were up to date in all 10care plans reviewed where the resident has been at the service for longer than six months. Overall changes in health status are documented and followed up. Care plan reviews are signed as completed by an RN. GP's review residents medication at least three monthly or when requested if issues arise or health status changes.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

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

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

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

D 20.1: Discussions with registered nurses identified that the facility has direct access to services including DHB nurse specialists, district nurses, podiatrist and physiotherapy services.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

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

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

Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All 29 medication charts reviewed had allergies (or nil known), documented. The service documents adverse reactions and errors on incident / accident forms. There is an improvement required around transcribing and administering medications as prescribed.

There is a locked cupboard that is used for controlled drugs. There are drug trolleys that are kept in the nurse stations which are locked when not in use. Medication rounds observed; all practice viewed was appropriate.

A medication competency has been completed annually by all staff who administer medication.

There is a policy and process that describes self-administered medicines. There are currently three residents in the rest home who self-administer medication (GTN spray, nasal spray and inhaler). All three residents have current annual competency checks.

D16.5.e.i.2: Twenty four of 29 residents charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed. There is an improvement required around GP documentation regarding three monthly reviews.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All 29 medication charts had allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms.

D16.5.e.i.2: Twenty four of 29 residents charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed.

**Finding Statement**

(i) Two of 29 PRN administration signing sheets have evidence of transcribing. (ii) Six of 29 medication signing sheets had signature gaps of the person administering medication. The facility has identified that transcribing and gaps in signing were an issue prior to the audit and is currently reviewing the process and procedures to eliminate issues and is working with the pharmacy regarding PRN medication sheets. (iii) Three of four rest home files and two of five hospital files do not have three monthly GP medications review noted in the medication chart or resident files.

**Corrective Action Required:**

(i) Ensure transcribing does not occur in medication charts. (ii) Ensure medications are administered as prescribed. (iii) Ensure three monthly GP medication review is documented.

**Timeframe:**

1 month.

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

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

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

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

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

The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. There is a rotating four weekly menu in place that was designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. An RN completes each resident’s nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen

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

The service encourages residents to express their likes and dislikes. The residents interviewed spoke very highly about meals provided and they all stated that they are asked by staff about their food preferences. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch.

The service has introduced afternoon tea events for residents and family members. Two afternoon teas have already occurred with good attendance from family members. The event is scheduled for every second Sunday.

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

Food audits are carried out as per the yearly audit schedule.

E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours.

D19.2: Kitchen staff have been trained in safe food handling.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident / accident reports reviewed involving waste, infectious material, body substances or hazardous substances. There is an emergency manual available to staff which includes hazardous substances. Seven HCA’s (two rest home, four hospital and one dementia unit), six RN’s (two rest home, three hospital, one dementia), one laundry person and two cleaners interviewed were able to describe hazard management.

There is an emergency plan to respond to significant waste or hazardous substance management. Waste management/chemical training occurs annually.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The building holds a current warrant of fitness which expires on 26 February 2014. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is identified the facility manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. The maintenance person is available on an on call basis. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly and these are maintained at (or just below) 45 degrees.

The facility's amenities, fixtures, equipment and furniture are appropriate for rest home, hospital and dementia level care. There is sufficient space to allow residents to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Resident’s bedrooms throughout the facility have resident's own personal belongings displayed. The facility is currently repainting bedrooms throughout facility, completing a number of bedrooms before starting the next section. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained.

E3.4d: The lounge areas are designed so that space and seating arrangements provide for individual and group activities.

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

All resident rooms have direct access to a hand basin and ensuite or communal showers and toilets. Communal showers and toilets have adequate signage. Visitor/staff toilets are well signed. Hand basins are located in all service areas. All toilets have access to hand basins and adequate hand drying facilities. Hand sanitizer gel is provided throughout the facility. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. The floor coverings are carpet and vinyl. The facility was clean and well presented.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

There is adequate space in all bedrooms for residents and staff. Seven HCA’s (two rest home, four hospital and one dementia unit), were asked if there was sufficient room and they confirmed they were able to move freely to provide cares. Doorways into residents' rooms and communal areas are wide enough for wheelchair, trolley and bed access. Fifteen residents (seven rest home and eight hospital) are happy with their rooms.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

The service has main lounges and adjacent dining areas in each service area. There are smaller lounge areas within the facility. Residents were seen to be moving freely throughout facility in wheel chairs and walking frames. Residents are able to move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements and give wheelchair access. Activities occur in the main lounges and residents are able to access their rooms for privacy when required. Fifteen residents (seven rest home and eight hospital) are happy with the communal areas.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

There are cleaning policies and processes. Cleaning audits occur. Corrective actions required are followed through the quality / risk management and staff meetings. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in locked areas. All chemicals are labelled with manufacturer’s labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence box is available (sighted). The facility manager stated that they have spare blankets and alternative cooking methods if required (viewed). There is sufficient water stored in a tank to ensure for three litres per day for three days per resident.

The staffing level provided adequate numbers of staff to facilitate safe care to rest home, hospital level and dementia level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme on 26 April 2011. Fire drills have taken place six monthly, and the last occurred on 14 August 2013.

There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse available on site and /or on call to all residents 24 hours per day, seven days per week.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

Restraint minimisation and safe practice policy & procedure includes; a) definitions, b) use of restraint is a last resort only, c) methods of restraint permitted within Radius, d) use of enablers, e) enablers permitted with radius, f) client rights, g) assessment, discussion & restraint alternatives, h) restraint alternatives are not effective, i) restraint care, j) monitoring and removal, k) restraint episode evaluation, l) risks associated with restraint, m) restraint coordinator, n) staff training, o) restraint meetings, and p) maintenance.

Related forms include: restraint assessment, discussion and alternatives form; restraint discussion and consent form; restraint monitoring form; enabler assessment and consent form; restraint register; enabler register; care plan for client requiring restraint; restraint episode evaluation form.

The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.

There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed. The restraint coordinator is the activities coordinator (occupational therapist).

There are no residents with enablers.

The restraint minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whanau, development of an enabler care plan, monitoring, reduction, removal and evaluation of enablers.

The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of the file of the resident with an enabler.

There are no residents using restraint.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

There is an infection control (IC) programme for 2013 that includes documented goals, success factors, education, surveillance and antimicrobial usage. The programmes content and detail is appropriate for the size and complexity of the services. There are IC policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. IC is part of the Radius benchmarking programme.

The IC programme is reviewed annually for the Radius group with the content and detail being designed to be appropriate for the size and complexity of each facility. The facility manager and the two IC coordinators are responsible for the development of site specific IC goals.

The IC coordinators could describe how an outbreak would be managed and reported. There have no outbreaks since the previous audit. There are guidelines and staff health policies for staff to prevent the spread of infection. These include, but not limited to; outbreak management policy and flow chart, pandemic plan and policy, food handlers sickness policy and hand hygiene policy.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The IC coordinators are the rest home clinical manager (RN) and the hospital clinical manager (RN). IC matters are taken to all staff meetings (minutes reviewed). The IC coordinators can access external DHB, IC nurse specialist, laboratories and GP's specialist advice when required. The coordinators comply with the objectives of the infection control policy and work with all staff to facilitate the programme. The coordinators have attended external IC training. Staff complete annual infection control education. Access to specialists from the DHB, laboratories and GP’s is available for additional training support. The coordinators have access to all relevant resident information to undertake surveillance, audits and investigations.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

D 19.2a: The IC manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. Policies include; antimicrobial guidelines, decontamination, food handler’s sickness policy, hand hygiene, management of staff with communicable diseases, MRO, outbreak management, pandemic plan, respiratory hygiene, scabies management, single use items, transmission based precautions, UTIs and waste management. Associated policies include: wound management policy, continence policy, laundry and kitchen policies. There are comprehensive infection control policies that support the Infection Control Standard SNZ HB 8134:2008. The infection control policies link to other documentation and uses references where appropriate.

Infection control policies are reviewed as part of the policy review process by Radius and input is sought from facilities when reviewing policies.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The IC coordinators have undertaken external IC training. The IC coordinators ensure training is provided to staff. Informal education is also provided. Availability of education was confirmed by seven HCA’s (two rest home, four hospital and one dementia unit), interviewed.

The orientation package includes specific training around hand washing and standard precautions. Training on infection control occurs. Hand washing is an annual competency.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved.

**Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Internal audit of infection control is included in the annual programme and occurs monthly. The analysis of the data is reported to facility meetings (minutes viewed). The IC coordinators use the information obtained through the surveillance of data to determine infection control education needs within the facility.

Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**