**Nazareth Rest Home Limited**

**Current Status:** **23-Sep-13**

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

Nazareth is currently a 46 bed rest home with 43 residents on the day of the audit. A partial provisional audit has been undertaken to assess the service's readiness to provide hospital level care.

The manager has been with the service for seven years and has extensive management experience in the District Health Board. She is supported by the clinical nurse manager who has over 15 years' experience in age care. There is an orientation and training programme already implemented.

The audit identifies that the building is suitable for hospital level care with 28 bedrooms, lounges and dining areas able to accommodate hospital level equipment. There are policies and processes appropriate for providing hospital level care.

Improvements required at the previous audit around care plans and assessments including wound care plans and medications signed for on administration have been addressed.

Improvements are required to documentation and implementation of a staffing rationale for hospital level care, employment of staff required for hospital level of care, development of a system to transport food that is hot to resident rooms and to a call bell system to access the registered nurse.

**Nazareth Rest Home**

Nazareth Rest Home Limited

Partial provisional audit - Audit Report

Audit Date: 23-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Nazareth Rest Home Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Nazareth Rest Home  | 14 Hillside Terrace | St Johns Hill | Wanganui |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
| A partial provisional audit has been undertaken to assess the service's readiness to provide hospital level care. |

|  |  |
| --- | --- |
| **Type of Audit** | Partial provisional audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 23-Sep-13 **End Date:** 23-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 | XXXXXXXXX  | MBA MN B Ed Adv Dip Child and Family RGON Dip Tchg Lead auditor | 4.00 | 4.00 | 23-Sep-13 to 23-Sep-13 |
| Auditor 1 |       |       |       |       |       |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXXXX |       |       | 1.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 4.00 | **Total Audit Hours off site** *(system generated)* | 5.00 | **Total Audit Hours** | 9.00 |
| **Staff Records Reviewed** | 8 of 52 | **Client Records Reviewed** *(numeric)* | 2 of 43 | **Number of Client Records Reviewed using Tracer Methodology** | 0of 2 |
| **Staff Interviewed** | 3 of 52 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 0 |
| **Consumers Interviewed** | 3 of 43 | **Number of Medication Records Reviewed** | 8 of 43 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXXXX (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 Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 22 day of October 2013

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

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

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

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

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

# Services and Capacity

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Nazareth Rest Home  | 46 | 43 |       | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Executive Summary of Audit

General Overview

Nazareth is currently a 46 bed rest home with 43 residents on the day of the audit. A partial provisional audit has been undertaken to assess the service's readiness to provide hospital level care.

The manager has been with the service for seven years and has extensive management experience in the District Health Board. She is supported by the clinical nurse manager who has over 15 years’ experience in age care. There is an orientation and training programme already implemented.

The audit identifies that the building is suitable for hospital level care with 28 bedrooms, lounges and dining areas able to accommodate hospital level equipment. There are policies and processes appropriate for providing hospital level care.

Improvements required at the previous audit around care plans and assessments including wound care plans and medications signed for on administration have been addressed. Improvements are required to documentation and implementation of a staffing rationale for hospital level care, employment of staff required for hospital level of care, development of a system to transport food that is hot to resident rooms and to a call bell system to access the registered nurse.

* 1. Consumer Rights

Not applicable.

1.2 Organisational Management

The directors and the manager set the philosophy of the service which is 'a caring happy community'. Nazareth's mission and vision flow from the vision of the Sisters of St Joseph which is 'fullness of life for the earth and its peoples - kii tonu te ao me te orokohanga a te tangata'

Nazareth Rest Home has a manager who has been with the service for seven years. She has relevant qualifications and is supported by the clinical nurse manager who is the second in charge in the absence of the manager. The clinical nurse leader has over 25 years total experience in nursing including 15 months experience in a hospital level care and a total of over 15 years in aged care nursing.

There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. The plan is to recruit more registered nurses and caregiving staff if required once the staffing policy for hospital level care has been documented.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes (rest home level only). There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for rest home level care with registered nurses on site each day. An improvement is required around documentation and implementation of a staffing rationale for hospital level care and employment of staff required for hospital level of care.

1.3 Continuum of Service Delivery

The medication management system includes the medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. The medication is in a locked room (pharmacy) and resident medication files reviewed indicate that there is already administration of medication as per policy. Medication is administered from a medication trolley by competent caregivers and registered nurses.

There are food service policies in place and the kitchen staff have all attended food handling training and a food safety course. The kitchen contains appropriate cooking and storage equipment. There is a preparation area and receiving area. Diets are modified as required. Residents are encouraged to be as independent as possible and each has a rehabilitation plan in place to encourage further development of skills and quality of life.

Improvements required at the previous audit around care plans and assessments including wound care plans and medications signed for on administration have been addressed. An improvement is required to developing a system to transport food that is hot to resident rooms.

1.4 Safe and Appropriate Environment

Chemicals are stored in a locked room and a locked cupboard. Appropriate policies are available and education on hazardous substances occurs at orientation and is included in the in-service education schedule. There is personal protective equipment.

The building holds a current warrant of fitness.

All 46 rooms were assessed as part of this audit to establish if they are able to be hospital rooms. The following wings are suitable for hospital beds as they have sufficient space for equipment and support including access for an emergency stretcher and hospital bed: Julian wing- 10 of 10 beds, Aroha wing - 11 of 11 beds and Catherine - 5 of 5 beds. In Joseph wing there are two of nine rooms can be used as hospital rooms (room numbers 41, 44). This gives the service a total of 28 hospital beds with the remaining 18 beds designated as rest home only.

There are 28 beds sighted at the audit that are able to be used for residents requiring hospital level care. Rooms have adequate personal space for the level of care required with adequate room for mobility equipment and extra staff. They all have the ability to have a hospital bed in the room and for residents to be transferred between rooms in a hospital bed.

There are two lounges and a large dining area along with a chapel and conservatory. All are used for activities and there is ample room for fallout chairs. There are chairs in corridors that allow residents to rest when navigating hallways and large hallways that allow beds, equipment and residents to move easily and safely.

There are outdoor areas that are easily accessible for residents with ramps and paths and an internal courtyard.

Cleaning and laundry services are monitored throughout the internal auditing system and the laundry has a clean/dirty flow with soiled linen transported from the sluice room in covered bins. Staff receive training at orientation and through the in-service programme.

Appropriate training, information, and equipment for responding to emergencies is provided. Staff have completed six monthly fire drills and these are planned to continue. There is a fire evacuation plan approved by the New Zealand Fire Service. All key staff hold a current first aid certificate. The facility is secured during the hours of darkness.

The facility is light, warm and airy. Smoking is only allowed outside away from residents' rooms and communal areas.

Call bells are currently installed.

An improvement is required to a call bell system to access the registered nurse before residents requiring hospital level care are admitted.

1. Restraint Minimisation and Safe Practice

 Not applicable

3. Infection Prevention and Control

Nazareth Rest home has an implemented infection control programme. The infection control programme its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service and is linked into the quality system. Infection control is incorporated into the quality/staff meetings and minutes are available for staff.

The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.

Summary of Attainment

* 1. Consumer Rights

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

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| Consumer Rights Standards (of 12): N/A:12 CI:0 FA: 0 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA:0 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | Not Applicable | 0 | 0 | 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 | PA Moderate | 0 | 0 | 1 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:3 CI:0 FA: 3 PA Neg: 0 PA Low: 0 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:7 PA:1 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 1 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Low | 0 | 2 | 1 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 5 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:10 PA:1 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | 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 | PA Low | 0 | 4 | 1 | 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: 7 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:16 PA:1 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

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

1. Infection Prevention and Control

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | Not Applicable | 0 | 0 | 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: 4 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:3 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 31 **CI:** 0 **FA:** 16 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 36 **PA:** 3 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Nazareth Rest Home Limited

Type of Audit: Partial provisional audit

Date(s) of Audit Report: Start Date:23-Sep-13 End Date: 23-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.8 | 1.2.8.1 | PAModerate | **Finding:**i) A roster and rationale for staffing with hospital residents is not yet developed. ii) Recruitment for hospital level care has not yet occurred. **Action:**i) Document and implement a roster and rationale for staffing at hospital level. ii) Employ appropriate registered nurses and staff as required for hospital level care.  | Prior to providing hospital level care |
| 1.3.13 | 1.3.13.5 | PALow | **Finding:**A system to keep food hot when transported to bedrooms has not yet been developed**.** **Action:**Develop a system to keep food hot when transported to bedrooms**.**  | Prior to providing hospital level care |
| 1.4.7 | 1.4.7.5 | PALow | **Finding:**Currently the clinical nurse leader or registered nurses do not carry pagers and at times the clinical nurse leader states that caregivers find the registered nurse difficult to find e.g. if they are doing a dressing**.** **Action:**Provide a call bell or pager system that enables caregivers to find the registered nurse or clinical nurse leader easily and quickly.  | Prior to providing hospital level care |

# Continuous Improvement (CI) Report

Provider Name: Nazareth Rest Home Limited

Type of Audit: Partial provisional audit

Date(s) of Audit Report: Start Date:23-Sep-13 End Date: 23-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXXX

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

**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

Nazareth Rest Home provides care for up to 46 rest home residents. At the time of the audit, there are 43 residents. Performance is monitored through an internal audit programme. Nazareth rest home has monthly staff meetings.

The manager has been in the position for seven years and has nine years prior management experience in the DHB. She has a Grad Dip Business Studies and is supported by a clinical nurse leader who has a current APC. The clinical nurse leader is an experienced registered nurse who has worked in rest homes for many years.

ARC,D17.3di (rest home): The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

There are two directors of Nazareth, one an accountant and one a Sister of St Joseph. The manager reports to the directors who in turn report to the board.

The directors and the manager set the philosophy of the service which is 'a caring happy community'. Nazareth's mission and vision flow from the vision of the Sisters of St Joseph which is 'fullness of life for the earth and its peoples - kii tonu te ao me te orokohanga a te tangata'

All 46 rooms were assessed as part of this audit to establish if they are able to be hospital rooms. The following wings are suitable for hospital beds as they have sufficient space for equipment and support including access for an emergency stretcher and hospital bed: Julian wing- 10 of 10 beds, Aroha wing - 11 of 11 beds and Catherine - 5 of 5 beds. In Joseph wing there are two of nine rooms can be used as hospital rooms (room numbers 41, 44). This gives the service a total of 28 hospital beds with the remaining 18 beds designated as rest home only.

**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 a temporary absence of the manager, the service is managed by the clinical nurse leader. The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning. These include policies related to management of residents requiring hospital level care e.g. wound management.

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

During a temporary absence of the manager, the service is managed by the clinical nurse leader. The manager was away for four weeks in 2013 and the clinical nurse leader took over the role. A plan was developed by the manager and the clinical nurse leader with key responsibilities documented.

The clinical nurse leader has been with the organisation since October 2011 and when interviewed reports she feels confident in filling the managers role in a temporary absence. The clinical nurse manager has a current APC and participates in at least eight hours training through the year. The clinical nurse leader has over 25 years total experience in nursing including 15 months experience in a hospital level care, two years’ experience in a brain injury rehabilitation unit and a total of over 15 years in aged care nursing.

**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 1.2.7 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

There is a human resources policy that establishes the requirements for vetting of qualifications and the maintenance of practising certificates for registered nursing staff. Relevant checks are completed to validate individual qualifications and experience. A record of practising certificates is maintained for three registered nurses and other health professionals including the pharmacist, GP's and the podiatrist.

Nazareth Rest Home has in place job descriptions for all positions. There is a total of 52 permanent staff. Human resources policies are in place. A comprehensive orientation programme is in place that includes the assessment of initial competencies.

A comprehensive in-service education programme is in place. The annual training plan covers a wide range of subjects and exceeds the required eight hours annually. Discussions with staff and a review of documentation demonstrates a commitment to the education of staff that is implemented into practice. Training in the past year has included the following: health and safety, restraint and challenging behaviours, hydration/fluid intake/weight loss, chemical safety, infection control, safe transferring/falls [prevention/mobility, care hygiene, skin management, pressure areas, security and emergencies, medical conditions.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including medication competencies.

Eight of eight files reviewed indicate that all staff have a signed contract, orientation, training completed and evidence of recruitment.

The manager is working at using palliative care and the DHB for further training that would be required if hospital residents were on site.

The registered nurses and the clinical nurse leader have a current APC.

**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:** PA Moderate

The staffing and skill mix policy includes a section on staffing levels rationale and is based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home residents, however has not been developed for the hospital residents.

The service contracts with allied health professionals on an as required basis. There is no plan in place in regards to services required for hospital residents i.e.: physiotherapist.

A roster and rationale for staffing is not yet developed however the manager is aware that there is a need for registered nurse cover at all times.

There is one nurse’s station that is used as a base for staff.

An improvement is required to documentation of a roster and rationale for staffing at hospital level and employment of appropriate staff for hospital level care.

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

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

The staffing and skill mix policy includes a section on staffing levels rationale and is based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of rest home residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The plan is to recruit more registered nurses and caregiving staff if required once the staffing policy for hospital level care has been documented.

**Finding Statement**

i) A roster and rationale for staffing with hospital residents is not yet developed. ii) Recruitment for hospital level care has not yet occurred.

**Corrective Action Required:**

i) Document and implement a roster and rationale for staffing at hospital level. ii) Employ appropriate registered nurses and staff as required for hospital level care.

**Timeframe:**

Prior to providing hospital level care

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

There is a policy for resident admission that includes an admission procedure and a resident assessment policy.

The CNL undertakes the assessments on admission. The initial support plan is completed within 24 hrs of admission and the long term care plan within three weeks. Evaluations and reviews are completed by the CNL.

D17.1 (b) Copies of registered nurses/GPs and other allied health providers practising certificates are copied and kept on file by the management team.

Two of two care plans and assessments are dated and signed. The improvement required at the previous audit is addressed.

**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:**

**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

Needs outcomes and goals of consumers are identified. A range of assessment tools are completed in resident files and reviewed at least six monthly including falls, pressure areas and continence. Nutrition and pain are assessed on admission and as needed and weights are monitored monthly.

Two of two resident files reviewed are dated, names on assessments, pain assessments completed and reviewed when there was a deterioration in condition for both resident files reviewed and all document appropriate assessments in place including a falls assessment for both. The improvement required at the previous audit is addressed.

**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 1.3.6 Service Delivery/Interventions**

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

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

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

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

Overall the lifestyle care plans are completed comprehensively. Two of two resident care plans were reviewed for this audit to follow up on requirements from the previous audit.

Care plans evidenced annual MDT reviews and six monthly care plan reviews.

The care noted on the plan is consistent with the needs of residents as evidenced by discussions with the CNL and manager.

The following improvements required at the previous audit are as follows: care plans document the care needed, issues noted in progress notes are followed up by a registered nurse and reflected in the care plan when changes are noted, care plans are updated when condition changes, any out of date information in the care plans is crossed off as changes occur and two of two residents have the interventions put in place following an incident when documented. The improvements required at the previous audit are addressed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 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

Wound care plans are in place for one resident reviewed with wounds. The wound is well documented with the following in place: wound plans reviewed in depth with assessments and reviews that fully describe the wound with the ability to evaluate the degree of improvement made. The progress notes also include progress against wound management. The improvement required at the previous audit is addressed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. The pharmacy room (medication room) is large and there is a lockable medication trolley that is used to administer medication.

Staff wear an apron that states do not disturb while they are giving medication.

Controlled drugs are stored in a locked safe in the locked pharmacy and the registered nurses and medication competent caregivers administer medications. The service uses four weekly blister packs. Medication charts have photo ID’s.

Eight of eight resident medication files sighted indicate that administration of medication is documented as per policy with a review by a GP three monthly.

There is a self-administered medicines policy and procedure. Advised there were no residents self-medicating on the day of audit.

Eight of eight medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

Medication profiles are legible and up to date.

There are no expected changes to the medication administration system when hospital level residents are brought into the service as medication will continue to be administered from the medication trolley.

Eight of eight medication signing charts did not have any gaps in signing by the administrator and any use of controlled drugs was signed for on the medication administration chart as well as the controlled drug register (the previous improvement is met).

Improvements required at the previous audit have been addressed as follows: Eight of eight resident medication files sighted indicate that medication signing charts are completed appropriately with no gaps in signing noted and all controlled drugs are signed on the controlled drug register and on the medication administration chart. The improvements required at the previous audit have been addressed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service has a workable kitchen. The kitchen and equipment is maintained in a clean manner. The service employs cooks and kitchen hands. There is a rotating four weekly seasonal menu in place. A nutritional assessment is completed on admission and resident nutritional needs are recorded in the kitchen. Storage of food is appropriate and fridge/freezer and food temperatures are monitored daily. The maintenance person also completes a check monthly.

Changes to residents’ dietary needs are communicated to the kitchen.

Special diets and resident likes/dislikes records are kept in the kitchen and the cook is familiar with resident needs.

The kitchen manual describes how special needs are catered for. Staff communicate with the cook daily to ensure that residents have an appropriate diet.

D19.2 Staff have been trained in safe food handling - last provided in September 2013.

Equipment is available on an as needed basis. Residents requiring extra assistance to eat and drink are assisted, this was observed during lunch.

There is already special equipment for eating e.g. lipped plates and thick handled spoons. The service has three trolleys (hold nine meals each) to deliver food to residents who are on bed rest currently. Currently all residents have breakfast in bed with hot porridge and all have thermal covers for dessert plates only. The manager is aware that there is a need to develop a system to keep main meals hot if there are residents on bed rest e.g. for hospital residents. The dietitian has reviewed the menus and provided training for staff September 2013.

An improvement is required to developing a system to keep food hot when transported to bedrooms.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

The service has three trolleys (hold nine meals each) to deliver food to residents who are on bed rest currently. Currently all residents have breakfast in bed with hot porridge and all have thermal covers for dessert plates only. The manager is aware that there is a need to develop a system to keep main meals hot if there are residents on bed rest e.g. for hospital residents.

**Finding Statement**

A system to keep food hot when transported to bedrooms has not yet been developed.

**Corrective Action Required:**

Develop a system to keep food hot when transported to bedrooms.

**Timeframe:**

Prior to providing hospital level care

**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

There are documented policies; procedures and an emergency plan to respond to significant waste or hazardous substance management. Chemical safety training provided May 2013. Chemicals are stored securely in a locked storage room. There is also a locked cupboard for cleaners.

Education on hazardous substances occurs at orientation. There is personal protective equipment. There is an accident/incident system for investigating, recording and reporting incidents. There was no incident or accident reports involving infectious material, body substances or hazardous substances sighted. There is an emergency manual available to staff which includes hazardous substances. There were no incidents or accidents documented for waste or hazardous substances.

The cleaner was observed to keep all chemicals beside her at all times and described the process for keeping these safe.

**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

There is a current BWOF, expiry date 22 June 2014 and a fire evacuation approval approved May 2008. There is a certificate from BPL Group Professional Engineers that states that following an evaluation of the Nazareth property regarding earthquake strength according to the Wanganui District Council Earthquake prone policy, Nazareth is awarded 97% of the new building standard - May 2012. There is a risk management plan that includes management of security, health and safety and emergency management. There is sufficient space so that residents are able to move around the facility freely. There is non-slip lino in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted.

Residents are able to bring their own possessions including furniture to their bedroom. There is a transportation of resident’s policy.

The 28 rooms designated as being suitable for hospital care are large, all have one and a half opening doors or an extra-large door and all have rails in the bathrooms. All rooms can accommodate equipment e.g. hoists, extra staff if required and all can be accessed by a hospital bed and ambulance stretcher.

There are outdoor areas that are accessible by residents using mobility aids. The internal courtyard is off the lounge in Aroha wing and can be accessed by any resident through the large lounge. Other seats and paths with grass areas are able to be accessed by residents in any wing.

**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

The following wings are suitable for hospital or rest home beds as they have sufficient space for equipment and support including access for an emergency stretcher and hospital bed: Julian wing- 10 of 10 beds - all rooms have a hand basin, larger than normal doors and access to one large shower and three large toilets all of which can accommodate hoists and extra staff.

Aroha wing - 11 of 11 beds, Catherine - 5 of 5 beds - all have ensuites (shower and toilet) and all can accommodate hoists and extra staff.

In Joseph wing there are two of nine rooms with one and a half doors and a hand basin in each room. Residents can access shower and toilet facilities close by that can accommodate hoists and extra staff.

There is a staff toilet and visitor’s toilet.

Hot water temperature monitoring occurs monthly or as required.

Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning.

**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

Resident’s rooms in the designated hospital rooms (28) are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites. There are two large open plan lounge areas, one off Aroha wing which also has access to the leisure lounge and the leisure lounge which is off Julian. Residents in the Catherine wing access either lounge as do the residents in Joseph.

The residents in Mary wing have a small lounge noting that this wing will remain a rest home wing. Residents requiring transportation between rooms or services are able to be moved from their room either by trolley, lazyboys, or wheelchair. Residents were sighted using a hoist in Joseph wing.

The service also has a hospital lazy boy/fallout chair that can be used for residents. Doorways into residents' rooms and communal areas are wide enough for wheelchairs, hospital beds and other mobility aids.

**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 two large lounges and a large dining room that already accommodates 46 residents with ease.

The dining room and lounges can accommodate hospital lazy boys; fall out chairs and beds if required.

Activities occur throughout the facility including activities in the two lounges, in the chapel and in the conservatory. Activities also occur in the courtyard and in outdoor areas.

Residents are able to access areas for privacy if required and there a number of alcoves where people can sit when walking through hallways.

There is a conservatory that is able to accommodate large chairs and beds and this is used as a lounge area and also used for activities. It is adjacent to the chapel.

**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

Cleaning and laundry services are well monitored throughout the internal auditing system - last audit in October 2012. Laundry has a clean/dirty flow and chemicals are stored securely. Staff receive training at orientation and through the in-service programme. There are appropriate policies and product charts. Cleaning rooms are locked when not in use.

The laundry and cleaning rooms are designated areas and clearly labelled. There are rooms available for storage of chemicals. All chemicals are labelled with manufacturer’s labels. MSDS are available in folders in the laundry and on walls.

The cleaner was observed during the audit to have the trolley with her at all times.

Staff receive training at orientation and through the in-service programme.

There is a sluice room and the laundry staff member describes transporting sluiced clothing down to the laundry in bins with lids.

**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:** PA Low

The NZ Fire Service approved the evacuation scheme on 28 May 2008.

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

Six monthly fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment.

Fire training and security situations are part of orientation of new staff.

Emergency equipment is available at the facility. Civil emergency boxes sighted. First aid training has been provided for staff.

There is emergency lighting at the facility. There is a large cupboard with civil defence material available. The manager stated that they have spare blankets and BBQs on site. An extra water tank has recently been put on site and there is sufficient stored water to support residents for at least three days in the event of an emergency.

Corridors are wide enough to allow residents to pass and to get to egress points quickly in the event of a disaster. A ramp has been put in from the first floor so that residents can access the outside area quickly noting that this is Mary wing that will remain as rest home only. There is a lift from the ground to the first floor.

An improvement is required to the provision of a call bell or pager system so that caregivers can access registered nurses quickly.

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

There is a call bell system with call bells in each room. Caregivers find the clinical nurse leader or registered nurse if they require support.

**Finding Statement**

Currently the clinical nurse leader or registered nurses do not carry pagers and at times the clinical nurse leader states that caregivers find the registered nurse difficult to find e.g. if they are doing a dressing.

**Corrective Action Required:**

Provide a call bell or pager system that enables caregivers to find the registered nurse or clinical nurse leader easily and quickly.

**Timeframe:**

Prior to providing hospital level care

**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

All bedrooms and communal areas have at least one external window. There are designated outside areas for residents to smoke.

General living areas and resident rooms are appropriately heated and ventilated. There are a combination of radiators and heat pumps.

The service is warm on the day of the audit.

**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:**

**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

The infection control practice is appropriate for the size, complexity, and degree of risk associated with the service. There is an established and implemented infection control programme that is linked into the risk management system. There are quality management meetings where there is discussion and reporting of infection control matters and the consequent review of the programme. Minutes are available for staff.

The responsibilities for the infection control co-ordinator are specified in the IC manual and include;

• Adopting and implementing policies/protocols/guidelines which are both practical and acceptable with the prime intention of reducing the risk of infection both to residents and staff.

• To adopt and adhere to these infection control procedures.

• Providing an advisory and educational service on infection control practices to staff, residents, and visitors, including methods of disinfection and sterilisation, participating in monitoring of significant infections, adherence to policies and environmental risks. (keep record of staff attendance and contents of session)

• Seek education to stay up to date with current safe practices.

• Provide new staff with relevant information during induction/orientation ensuring that they are aware of infection control principles in this facility.

• Invite the local laboratory to educate staff on infection control principles at least once a year.

• In case of an outbreak advice will be sought from GP and Laboratory services. The RN is responsible to for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation

• Designate a infection control coordinator.

The manager interviewed is well informed about practises and reporting and states that staff can contact the registered nurse, GP or clinical nurse manager if required and concerns can be written in progress notes. The infection control co-ordinator (the CNL) is responsible for the collection and collation of data.

The monthly infection data is entered into the infection register. All data is collated and analysed on infections monthly. Infection statistics are included in the staff/quality meetings.

**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:**