**Opunake Districts Rest Home Trust**

**Current Status:** **14-Oct-13**

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

**General overview**

The Cottage Rest Home provides residential care for up to 22 residents who require rest home level care and occupancy on the day of the audit was 21. Applications have been submitted by the service provider to increase the capacity of rest home beds from 20 to 22 since August 2012. Areas requiring improvement have been identified with use of one of these bedrooms as the bedroom is a designated fire exit.

The governing body is Opunake District Rest Home Trust. This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract.

This audit included a review of the 19 aspects of service provision identified in the previous audit as requiring improvement and all except four of these issues have been addressed. Six new areas have been identified as requiring improvement during this audit relating to: on-going medication management and challenging behaviour inservice education for staff; use of Whyte out correction tape in documentation; conversion of a room with a designated fire exit in to a resident bedroom; assessment and management of pain; medication documentation and management.

**Audit Summary AS AT** **14-Oct-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit14-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Organisational Management** | Day of Audit14-Oct-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit14-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit14-Oct-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **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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| **Restraint Minimisation and Safe Practice** | Day of Audit14-Oct-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Infection Prevention and Control** | Day of Audit14-Oct-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**The Cottage**

Opunake District Rest Home Trust

Surveillance audit - Audit Report

Audit Date: 14-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Opunake District Rest Home Trust |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| The Cottage | 1 Layard Street |       | Opunake 4616 |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
| Addition of two extra rest home beds by converting a single bedroom in to a double bedroom, and conversion of a staff sleepover bedroom in to a rest home room (see 1.4.2) |

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| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 14-Oct-13 **End Date:** 14-Oct-13 |
| **Designated Auditing Agency** | Health Audit (NZ) Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXXX | Lead Auditor, RN, RM, BN, ADipN | 8.50 | 7.50 | 14-Oct-13 |
| Auditor 1 | XXXXXXXX | RN, LA, 8086 | 8.50 | 5.00 | 14-Oct-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXXX | RN, BHSc Lead Auditor |       | 1.50 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 17.00 | **Total Audit Hours off site** *(system generated)* | 14.00 | **Total Audit Hours** | 31.00 |
| **Staff Records Reviewed** | 5 of 25 | **Client Records Reviewed** *(numeric)* | 4 of 21 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 4 |
| **Staff Interviewed** | 7 of 25 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 0 |
| **Consumers Interviewed** | 4 of 21 | **Number of Medication Records Reviewed** | 8 of 21 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

I confirm that Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 18 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| The Cottage | 22 | 21 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

The Cottage Rest Home provides residential care for up to 22 residents who require rest home level care and occupancy on the day of the audit was 21. Applications have been submitted by the service provider to increase the capacity of rest home beds from 20 to 22 since August 2012. Areas requiring improvement have been identified with use of one of these bedrooms as the bedroom is a designated fire exit.

The governing body is Opunake District Rest Home Trust. This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract.

This audit included a review of the 19 aspects of service provision identified in the previous audit as requiring improvement and all except four of these issues have been addressed. Six new areas have been identified as requiring improvement during this audit relating to: on-going medication management and challenging behaviour inservice education for staff; use of Whyte out correction tape in documentation; conversion of a room with a designated fire exit in to a resident bedroom; assessment and management of pain; medication documentation and management.

1.1 Consumer Rights

Open Disclosure procedures are in place to ensure staff maintain open, transparent communication with residents and their family. The issue identified during the last audit relating to the absence of documented evidence of communication with family members following adverse events or changes in a resident's condition has been addressed as a review of four resident's files provides evidence communication with family is documented in 'Family Contact Record'. Residents interviewed confirm there is good communication between them and staff. Visual inspection provides evidence the Code of Health and Disability Services Consumers' Rights (the Code) information is readily displayed along with complaint forms.

Systems are in place to ensure residents and their family are being provided with information to assist them to make informed choices and give informed consent. The area identified as requiring improvement during the last audit with retention of copies of enduring power of attorney (EPOA) documents where EPOA's are named remains as one of four files does not have a copy of EPOA documents although an EPOA is named.

The manager is responsible for complaints and a complaints register is maintained. The residents can use the complaints forms or bring issues up at residents' meetings. The manager advises there have been no complaints investigated by the Health and Disability Commissioner, District Health Board, Ministry of Health, Police, and Coroner since the previous audit at this facility.

1.2 Organisational Management

Opunake District Rest Home Trust is the governing body and have established systems in place which define the scope, direction, quality goals, scope of service, mission statement and philosophy. Reviewed in 'The Cottage Rest Home Strategic Plan 2013'. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service. Systems are in place for monitoring of the service provided at The Cottage, including regular monthly reporting by the manager to the Trust which meets monthly. The manager's monthly reports to the governing body include quality and risk management issues, occupancy, HR issues, and clinical indicators. Trust, staff/quality and residents monthly meeting minutes reviewed. The Cottage Rest Home is managed by a registered nurse who was appointed to this position in February 2010. The manager worked in a rehabilitation unit at a District Health Board prior to this appointment. Review of the manager's file provides evidence the manager is suitably qualified and experienced and maintains their knowledge and current practice. The manager is supported by a registered nurse who did not have a current practising certificate during the last audit. Both registered nurses (RN's) have current annual practising certificates and have undertaken training in relevant areas.

There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms and are individual logs of adverse events are retained in each resident's files. Areas requiring improvement relating to analysis and evaluation of quality improvement data, and development of corrective action plans to address areas requiring improvement were identified during the last audit. Improvements are still required to these aspects of service.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses and general practitioners (GPs) is occurring. Monthly in-service education sessions are provided for staff and staff are also supported to attend external education as appropriate. An area requiring improvement with the inservice education programme has been identified during this audit as staff have not received education on medication management and challenging behaviour since 2011. Review of five staff education records provides evidence that individual education records are maintained.

An area requiring improvement relating to documented staffing rationale was identified during the last audit and has been addressed. The minimum staff on duty at any one time is during the night shift (11pm and 7am) and consists of one care giver. A second staff member is available on the premises as a 'sleep-over' between 10pm and 6am. The manager/registered nurse is also on-call after hours. Care staff report they work well as a team to provide assistance to each other.

The issue identified during the last audit relating to staff not recording their designation following each entry in residents notes has been addressed. However, another area requiring improvement has been identified as staff are using Whyte out correction tape in resident documentation.

1.3 Continuum of Service Delivery

Clear time frames for service provision are defined and monitored. Assessments and support plans are current and include the required interventions. Short term plans are developed when required and reviewed as required. All previously identified areas of improvement regarding assessment and support planning have been addressed, however an additional area of improvement is identified regarding the process for assessing and monitoring residents who have chronic pain.

A meaningful activities programme is provided and residents are satisfied with the activities programme.

There is an appropriate medication management system. Medications are monitored by the registered nurse and the authorised prescriber. Administration is conducted by staff who have been assessed as competent. All previously identified areas of improvement regarding the medicines management system have been addressed, however two additional areas requiring improvement are identified. More regular checks of controlled drugs are required, as is full implementation of the resident self-medicating process.

Food and nutritional needs of residents are assessed and the menu is reviewed by a dietician. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements.

1.4 Safe and Appropriate Environment

The facility has been operating since 1990 as a rest home. Two separate applications have been made to the Ministry of health since August 2012 to increase the maximum number of beds from 20 to 22. One increase has been brought about by converting a large single bedroom in to a double bedroom, and the other increase is by converting a staff 'sleep-over' room in to a single bedroom. Improvements are required to the use of the staff sleepover room as this room is a designated fire exit. The areas identified as requiring improvement with hot water temperatures and maintenance have been addressed. The Cottage has a current Building Warrant of Fitness that expires on18 December 2013. No alterations to the building have been undertaken since the last certification audit. Review of documentation provides evidence of a letter from New Zealand Fire Service dated 08 July 2009 advising the fire evacuation scheme for the facility was approved 04 June 1999. A trial evacuation was last held on 11 October 2013 and the next one is scheduled for 23 October 2013.

2 Restraint Minimisation and Safe Practice

There are adequately documented policies, procedures and guidelines on the minimisation and safe use of restraints and enablers. All but one of the previously identified areas requiring improvement to the restraint process have been adequately addressed. The one remaining area of improvement relates to the assessment process/form.

3. Infection Prevention and Control

The infection control programme is clearly documented. The infection surveillance program is appropriate for the facility and the level of care provided. Use of antibiotics is monitored and overall infection rates are recorded and reported.

Summary of Attainment

* 1. Consumer Rights

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

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| Consumer Rights Standards (of 12): N/A:9 CI:0 FA: 2 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 48): CI:0 FA:4 PA:1 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Low | 0 | 6 | 2 | 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 | PA Low | 0 | 3 | 1 | 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 | PA Low | 0 | 0 | 1 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:1 CI:0 FA: 3 PA Neg: 0 PA Low: 3 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:14 PA:4 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | PA Low | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Low | 0 | 2 | 2 | 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:4 CI:0 FA: 6 PA Neg: 0 PA Low: 2 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:14 PA: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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | PA Moderate | 0 | 0 | 1 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 1 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:6 CI:0 FA: 1 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 36): CI:0 FA:1 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 | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | PA Low | 0 | 0 | 1 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | FA | 0 | 1 | 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: 1 CI:0 FA: 4 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:4 PA:1 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 | Not Applicable | 0 | 0 | 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 | 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: 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:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 25 **CI:** 0 **FA:** 17 **PA Neg:** 0 **PA Low:** 7 **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:** 39 **PA:** 10 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Opunake District Rest Home Trust

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:14-Oct-13 End Date: 14-Oct-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.10 | 1.1.10.7 | PAModerate | **Finding:**One of four resident's files reviewed has an Enduring Power of Attorney (EPOA) named/recorded but a copy of this document is not held on the resident's file. It is acknowledged the manager/registered nurse has asked the named EPOA to provide a copy of this document.**Action:**Provide confirmation that where Enduring Power of Attorney (EPOA) is named in resident files, that copies of these are held in resident notes. | Three months |
| 1.2.3 | 1.2.3.6 | PAModerate | **Finding:**There is documented evidence of collection, collation, and reporting of quality improvement data. However, there is minimal documented evidence this data is being analysed and evaluated to identify trends. This issue was also identified as requiring improvement during the last audit.**Action:**Provide documented evidence that quality improvement data is being analysed and evaluated to identify trends. | Three months |
| 1.2.3 | 1.2.3.8 | PAModerate | **Finding:**Internal audits and meeting minutes reviewed do not have clearly documented corrective action plans with timeframes and person/s responsible. This issue was also identified as requiring improvement during the last audit. **Action:**Provide documented evidence that corrective action plans with person/s responsible and timeframes identified, are being developed wherever areas requiring improvement are identified. | Three months |
| 1.2.7 | 1.2.7.5 | PALow | **Finding:**Medication management education and challenging behaviour education have not been provided on a regular basis. Medication management education was last provided in 24 November 2011 and is next scheduled to be provided 20 November 2013. Challenging behaviour education has not been provided since 17 August 2011 and was scheduled to be provided in June 2013 but the educator cancelled at the last minute. This session has been rebooked for January 2014.**Action:**Provide confirmation that: (i) medication management education has been provided on 20 November 2013 as scheduled; and (ii) challenging behaviour education has been provided. | Six months |
| 1.2.9 | 1.2.9.9 | PAModerate | **Finding:**Whyte out correction tape is used in resident documentation and in internal audits. That is, residents progress notes (one of four), informed consent form (one of four resident files), specimen signature chart (one), medication chart (one), and care plan audit (completed 24 August 2013) **Action:**Provide confirmation that Whyte out, or similar products, is not being used in any documentation. | Three months |
| 1.3.4 | 1.3.4.2 | PALow | **Finding:**The process for assessing and monitoring pain has not been defined within related policies. Pain assessments are not documented.**Action:**Include the assessment and management of pain within the related policies. Complete pain assessments for residents with identified on going pain issues. | 6 months |
| 1.3.12 | 1.3.12.1 | PALow | **Finding:**The organisation has not defined the requirements for checking controlled drugs within their medication policies. Evidence of the six monthly pharmacy check of controlled drugs has not been maintained in the controlled drug book.**Action:**Amend the controlled drug policy to include the required checks and implement. Maintain evidence of controlled drug audits/checks. | 6 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.12 | 1.3.12.5 | PALow | **Finding:**The self-medication process is not occurring in line with the requirements of the related policy. **Action:**Implement the self-medication process as per policy. For example: provide secure storage, complete the required assessment process and liaise with the GP. | 6 months |
| 1.4.2 | 1.4.2.1 | PAModerate | **Finding:**Room 8, which was used as a staff sleepover room, has been converted in to a resident bedroom. This room is a designated fire exit and the exit is blocked by the resident's furniture. The manager advises the Trust is considering creating a new fire exit in another area in this fire cell but has not proceeded with this yet. The manager also advises they are considering moving this resident to the one empty room they have in the facility but have not done this yet as the resident in room 8 has settled in to room 8, has moderate dementia and they do not want to cause them any unnecessary confusion. The family member of this resident was asked by the manager during this audit about moving their family member to another room and they agreed to this. This move is scheduled for the day after this audit (15 October 2013)**Action:**Provide confirmation the fire exit in room 8 is not obstructed by resident furniture. | One month |
| 2.2.2 | 2.2.2.1 | PALow | **Finding:**The restraint assessment process has been amended to include items b, c, d, f, and g, however further amendments are required to include items a,e and h. The previous area requiring improvement remains in place.**Action:**Continue with the required amendments to the restraint assessment process. | 6 months |

# Continuous Improvement (CI) Report

Provider Name: Opunake District Rest Home Trust

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:14-Oct-13 End Date: 14-Oct-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.9 Communication**

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

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

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

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

Criterion 1.1.9.1 was partially attained during the last certification audit and is now fully attained as four of four resident's files reviewed provide documented evidence of communication with family members. Resident files viewed have 'Family Contact Record' and there is evidence of contact with family recorded on these. Open Disclosure education provided on 23 January 2013 and attended by eight members of staff.

Open disclosure procedures are in place to ensure service providers maintain open, transparent communication with residents and their families. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms.

Residents interviewed (four rest home) confirm that staff communicate well with them. This finding confirmed during observations by auditors on the day of this audit. Residents interviewed confirm that they are aware of the staff that are responsible for their care.

The manager advises access to interpreter services is available if required via the DHB and interpreter services.

Visual inspection provides evidence the Code of Health and Disability Services Consumers' Rights (the Code) information is readily displayed along with complaint forms.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 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:** PA Low

Criterion 1.1.10.7 was partially attained during the last certification audit and remains partially attained as one of four residents reviewed has an Enduring Power of Attorney (EPOA) named/recorded in their records but a copy of this document is not held on the resident's files.

Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The manager/registered nurse and the registered nurse (RN) advise informed consent is discussed and recorded on the resident's admission to the facility.

Residents interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.

Residents' files (four rest home) reviewed demonstrate written and verbal discussions on informed consent have occurred and residents' files evidence signed informed consent forms. Residents' admission agreements are signed.

The ARC requirements are met.

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

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

Four resident files reviewed and include various consent forms - including advance directives where available.

**Finding Statement**

One of four resident's files reviewed has an Enduring Power of Attorney (EPOA) named / recorded but a copy of this document is not held on the resident's file. It is acknowledged the manager/registered nurse has asked the named EPOA to provide a copy of this document.

**Corrective Action Required:**

Provide confirmation that where Enduring Power of Attorney (EPOA) is named in resident files, that copies of these are held in resident notes.

**Timeframe:**

Three months

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has appropriate systems in place to manage the complaints processes. A complaints registers is maintained at the facility and has three complaints documented for 2013. The manager is responsible for complaints and a complaints register is maintained. Reporting of complaints occurs via monthly Trust Board and staff/quality meetings. The manager advises there have been no complaints investigated by the Health and Disability Commissioner, District Health Board, Ministry of Health, Police, and Coroner since the previous audit at this facility.

Residents (four rest home) interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held monthly and review of these minutes provides evidence of residents ability to raise any issues they have, and this was confirmed during interviews of residents.

A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of monthly managers reports to the Trust Board and staff/quality meetings provides evidence of reporting of complaints.

The ARC requirements are met.

**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

Opunake District Rest Home Trust is the governing body and has established systems in place which define the scope, direction, quality goals, scope of service, mission statement and philosophy. Reviewed in 'The Cottage Rest Home Strategic Plan 2013'. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

Systems are in place for monitoring of the service provided at The Cottage, including regular monthly reporting by the manager to the Trust which meets monthly. The manager's monthly reports to the governing body (reviewed) include quality and risk management issues, occupancy, HR issues, and clinical indicators. Trust, staff/quality and residents monthly meeting minutes reviewed.

The Cottage Rest Home is managed by a registered nurse who was appointed to this position in February 2010. The manager worked in a rehabilitation unit at a District Health Board prior to this appointment. Review of the manager's file provides evidence the manager is suitably qualified and experienced and maintains their knowledge and current practice. The manager is supported by a registered nurse who did not have a current practising certificate during the last audit (1.2.7.2). Both registered nurses (RN's) have current annual practising certificates and have undertaken training in relevant areas.

The Cottage Rest Home is certified to provide rest home level care and has contracts with the DHB to provide rest home, residential respite - rehabilitation support services, and long term support - chronic health conditions. The provider also has a contract with the Ministry of Health to provide residential - non aged and there is one resident aged less than 65 years of age who is funded via this contract.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

Criteria 1.2.3.6 and 1.2.3.8 were partially attained during the last certification audit and remain partially attained. There is an absence of documented evidence available to indicate quality improvement data is being analysed and evaluated to identify trends; and internal audits and meeting minutes reviewed have shortfalls identified but there are no clear corrective action plans to address these issues documented; the person/s responsible for implementation of the corrective action plan and timeframes for same are not documented (See criteria 1.2.3.6, 1.2.3.8 and link criterion 1.3.4.2)

A written quality and risk management plan/policy identifying the organisation’s quality goals, objectives, and scope of service delivery reviewed during this audit and includes statements about quality activities and review processes, including internal audits. Completed internal audits for 2013 reviewed along with clinical indicators for 2013. Resident satisfaction surveys completed in June 2013 and review of these surveys indicates acceptable levels of satisfaction. This finding confirmed during interviews of four residents.

A 'The Cottage Rest Home Strategic Plan 2013' reviewed and is used to guide the service delivery and quality programme and includes quality goals and objectives. Also reviewed documented values, mission statement and philosophy, which are displayed. Monthly staff/quality meetings are held along with monthly resident meetings. Meeting minutes reviewed and are available for review by staff. The manager is responsible for providing the Trust Board with monthly reports which they speak to at the monthly Trust Board meetings (reviewed).

'Health and Safety/Incident Form and Accident Form', internal audits, staff/quality meeting minutes, and resident meeting minutes reviewed. There is

documented evidence in various meeting minutes that issues identified as requiring follow through are discussed at subsequent staff/quality meetings, and resident meetings. Clinical indicators are recorded on a month by month 'Log of Incidents, Accidents, and Infections' and reviewed during this audit. Individual logs are also retained on each resident's file.

There is documented evidence of collection, collation, and reporting of quality improvement data but minimal documented evidence this data is being analysed and evaluated to identify trends (see 1.2.3.6). Staff interviewed (three care givers working morning and afternoon shifts) report they are kept well informed of quality and risk management issues including clinical indicators. Copies of these meeting minutes are kept in the staff office for review.

There is a hazard reporting system available and a hazard register. Chemical safety data sheets available identifying potential risks for each area of service. Planned maintenance and calibration programmes in place and reviewed and biomedical equipment has appropriate performance verified stickers in place.

With the exception of D5.4h, the requirements of the ARC are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Clinical indicators are recorded on a month by month 'Log of Incidents, Accidents, and Infections' and are collated at the end of each month. Reviewed during this audit. Individual logs are also retained on each resident's file. Quality/staff meeting minutes reviewed include reporting on numbers and types of clinical indicators.

**Finding Statement**

There is documented evidence of collection, collation, and reporting of quality improvement data. However, there is minimal documented evidence this data is being analysed and evaluated to identify trends. This issue was also identified as requiring improvement during the last audit.

**Corrective Action Required:**

Provide documented evidence that quality improvement data is being analysed and evaluated to identify trends.

**Timeframe:**

Three months

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

The majority of the internal audits completed have vague corrective actions documented or have attained 100% compliance.

A 'Quality Improvement Record' is used to document improvements to service delivery e.g. installation of two gas infinity hot water heaters, and a diesel powered generator.

**Finding Statement**

Internal audits and meeting minutes reviewed do not have clearly documented corrective action plans with timeframes and person/s responsible. This issue was also identified as requiring improvement during the last audit.

**Corrective Action Required:**

Provide documented evidence that corrective action plans with person/s responsible and timeframes identified, are being developed wherever areas requiring improvement are identified.

**Timeframe:**

Three months

**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

Staff are documenting adverse, unplanned or untoward events on a 'Health and Safety/Incident Form and Accident Form'. Resident files reviewed (four rest home) provides documented evidence of communication with family and GP on the 'Health and Safety/Incident Form and Accident Form', in resident progress notes, and in 'Family Contact Record'. Resident's files contain individual 'Log of incidents, accidents, infections'.

Evidence also reviewed during this audit of notification to family of any change in the resident’s condition. This finding confirmed during interviews of residents. Corrective action plans to address areas requiring improvement are documented on 'Health and Safety/Incident Form and Accident Form'.

Staff confirm during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions; policies and procedures; and staff education, which is confirmed via review of documentation. Staff also confirm they are completing accident / incident forms for adverse events.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Criterion 1.2.7.2 was partially attained during the last certification audit and is now fully attained as the registered nurse (RN) employed February 2012 has a practising certificate (number 048814) that expires 31 March 2014. An area requiring improvement has been identified during this audit with the inservice education programme as medication management education and challenging behaviour education has not been provided since 2011 (see 1.2.7.5)

Review of 2013 education planer and staff education records provides evidence of in service education, with the exceptions documented in 1.2.7.5. The manager is responsible for oversight of the in-service education programme and in-service education is provided monthly.

The manager advises they are currently exploring options for providing the ACE Education programme. Staff files reviewed (three care givers) have completed an ACE equivalent qualification. A review of five staff files (three care staff and two RN's) and education records provides evidence human resource processes are followed and are completed. An appraisal schedule is in place. Annual practising certificates reviewed and are current for staff who require them to practice. An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents.

Three of three care givers interviewed confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Monthly education planners for 2012, 2013 and preliminary for 2014. Individual staff training records as well as for each session reviewed.

**Finding Statement**

Medication management education and challenging behaviour education have not been provided on a regular basis. Medication management education was last provided in 24 November 2011 and is next scheduled to be provided 20 November 2013. Challenging behaviour education has not been provided since 17 August 2011 and was scheduled to be provided in June 2013 but the educator cancelled at the last minute. This session has been rebooked for January 2014.

**Corrective Action Required:**

Provide confirmation that: (i) medication management education has been provided on 20 November 2013 as scheduled; and (ii) challenging behaviour education has been provided.

**Timeframe:**

Six months

**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

Criterion 1.2.8.1 was partially attained during the last certification audit and is now fully attained. Documented rationale for determining service provider levels ('Roles and Skill Mix of Staff') reviewed and contains rostered numbers, staff skill mixes and other factors to be considered when determining staffing levels.

The minimum staff on duty at any one time is during the night shift (11pm and 7am) and consists of one care giver. A second staff member is available on the premises as a 'sleep-over' between 10pm and 6am. The manager/registered nurse is also on-call after hours.

Care staff interviewed (three care givers, one RN) report there is adequate staff available and that they are able to get through their work. Care staff report they work well as a team to provide assistance to each other.

Residents interviewed (four rest home) report staff generally answer their call bells in a timely manner, and that the care they receive is appropriate to their needs.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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:** PA Low

Criterion 1.2.9.9 was partially attained during the last certification audit and remains partially attained as new issues with documentation have been identified during this audit as staff are using Whyte out correction tape in resident documentation.

Resident information is entered in an accurate and timely manner into a register that is appropriate to the service and is in line with the requirements of NZHIS. Interview of the manager confirms resident's data is entered on the day of admission to the facility. Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed.

A visual inspection of the facility evidences that residents' information is stored in staff areas and is held securely and is not on public display. Clinical notes are current and accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifier. Resident documentation reviewed indicates staff record their name and designation and staff sign each entry in resident documentation.

Clinical staff interviewed (three caregivers, one RN and one RN/manager) confirm they know how to maintain confidentiality of resident information. Historical records are held on site and accessible.

ARC requirements are met.

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

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

Four residents notes reviewed and records are legible; staff are documenting their name and designation after each entry.

**Finding Statement**

Whyte out correction tape is used in resident documentation and in internal audits. That is, residents progress notes (one of four), informed consent form (one of four resident files), specimen signature chart (one), medication chart (one), and care plan audit (completed 24 August 2013)

**Corrective Action Required:**

Provide confirmation that Whyte out, or similar products, is not being used in any documentation.

**Timeframe:**

Three months

**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

Residents' files sampled confirm that each stage of service provision is completed by a suitably qualified person. All assessments and support plans are developed and reviewed by a registered nurse and/or the multidisciplinary team. Daily interventions and support with activities of daily living are implemented with the support of trained caregivers.

Timeframes for service delivery are met as is evident in four out of four residents' files sampled. This includes the 48 hour timeframe for the general practitioner (GP) assessment on entry, which was a previous area identified as requiring an improvement. Initial nursing assessments are completed on admission and a support plan is developed within 21 days. Short term care plans are also developed as and when required. A support plan review is completed (at a minimum) every six months. GP reviews are also completed every three months and the required GP exceptions are sighted. This was also a previous area identified as requiring an improvement. The GP interviewed confirms involvement in specialist referrals and medication reviews and states they are always contacted regarding any concerns in a timely and proficient manner.

Continuity of care is maintained. For example, GP entries and visits from allied health providers are sighted. Daily handovers between shifts also ensures continuity. During the audit a handover is observed and confirms accurate and comprehensive information is communicated. Residents' files are integrated and contain a section for allied health reporting. The required multi-disciplinary reviews are completed as required and the previous area of improvement regarding MDT reviews has been adequately addressed.

The remaining relevant ARC requirements are met. Support plans are comprehensive and include hygiene and grooming, skin and pressure, elimination, mobility, nutrition and fluids, rest and sleep, communication, emotional wellbeing, spirituality faith and culture, medical needs. A nutritional and activities assessment is also conducted.

Tracer methodology

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

The previous area requiring improvement regarding wound assessments and wound management plans (1.3.4.2) has been adequately addressed. Wound assessments and related plans are sighted in the files sampled, however two of the resident files sampled include residents who have chronic pain and are on prescribed opiate based medication. The process for assessing and monitoring pain has not been defined within related policies and pain assessments are not documented, thus a new area of improvement is allocated.

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

Two resident files sampled are those with chronic pain. There is currently no process in place for assessing, monitoring or the management of pain. The medication policy includes pain relief; however there is no specific policy on pain management.

**Finding Statement**

The process for assessing and monitoring pain has not been defined within related policies. Pain assessments are not documented.

**Corrective Action Required:**

Include the assessment and management of pain within the related policies. Complete pain assessments for residents with identified on going pain issues.

**Timeframe:**

6 months

**STANDARD 1.3.5 Planning**

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

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

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

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

The previous area requiring an improvement stating that support plans did not describe the support/interventions required (1.3.5.2) has been adequately addressed. All four support plans sampled are current and include the required support/interventions.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

6 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

Interventions sighted are commensurate with the residents' current needs. Interventions are detailed and documented clearly to guide staff. Resident support plans include resident goals, preferences and abilities. The GP interviewed is satisfied that clinical/nursing interventions are based on good practice and implemented in a timely and competent manner.

Interventions from allied health providers are also given due consideration and implemented. For example the interventions suggested by a clinical psychologist regarding the use of a behaviour management chart for one resident. The allied health section in the residents' file also includes the suggested/requested interventions as developed by other providers. For example the podiatrist and physiotherapist. All changes to interventions are recorded and updated as required.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The activities programme is developed by a designated activities coordinator. The activities coordinator is interviewed and states that a monthly plan is developed, with the residents' input. The programme is displayed and reflects a variety of activities, outings, exercises, entertainment and games. Regular external outings are provided and the facility has a van which seats up to eight residents.

The activities coordinator is on-site five days per week. The activity coordinator completes an assessment with the resident on admission and develops an activities care plan. These are sighted in all resident records sampled and include goals, action, evaluation and achievement. These are signed by the resident. Individual participation in activities is monitored and a weekly progress note made. Reviews of participation and response to the programme is completed every six months.

The residents are provided with an opportunity to give feedback on the activities programme. This is evident in the records of monthly resident meetings which demonstrate general satisfaction with the programme.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Support and the provision of interventions are reviewed in a regular manner. Six monthly reviews of support plans are conducted and the support plan is then updated if required. Daily progress notes are also completed by the caregivers on duty which assess daily response to interventions. Any changes to support interventions are documented and short term care plans are reviewed and signed off as required. The previous area of improvement regarding updating support plans to reflect changes (1.3.8.3) has been adequately addressed.

In addition and multi-disciplinary (MDT) review is conducted annually. These include a GP report, family report, pharmacy report, registered nurse report, care giver report, night staff report, activities coordinator and podiatrist report. Additional reviews include the three monthly medication reviews by the GP. The approval for three monthly GP reviews is sighted in four out of four files sampled.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

There are a range documented policies and procedures for all stages of medicine management. Policies sampled reflect current legislative requirements and safe practice guidelines with the exception of the controlled drugs policy. Controlled drug checks are conducted, however the timeframes for drug checks have been inconsistent and structured around the amount of medication used. The requirements for checking controlled drugs, including those completed by the pharmacy, are not defined in the related medication policies and an improvement is required.

 A robotics medication system is implemented. All medicines are prescribed by the GP using the pharmacy generated medication chart. The service has one prescribing GP for medical needs. All medication charts include identification and allergies. Three monthly medication reviews are evident in all eight medication records sampled.

Medications for the residents residing at the Cottage are dispensed by two pharmacies. The regular (robotics) medication is dispensed by a pharmacy in New Plymouth; however emergency medications are dispensed by a local pharmacy in Opunake. The local pharmacy does not provide the same administration sheet as the regular pharmacy, which resulted in some transcribing of medications onto administration records. This has since discontinued. The facility has also discontinued the use of standing orders, and keeps no stocked medication, thus the previous areas of improvement have been adequately addressed.

Medications are checked routinely on entry to the facility by a senior care giver every Sunday night. Non-packaged medication is safely stored in the medication trolley or the medication cupboard. A small medication fridge is provided and the previous area of improvement regarding monitoring of the fridge temperatures has been addressed.

Daily medications are administered from the secure medication trolley. There is a small locked and secure box in the medication cupboard which is used to store controlled drugs. Medications are administered by senior caregivers or the registered nurse. Competencies for medicine management and administration are conducted by the registered nurse. Medication competencies were conducted in (October 2012) and are currently due to be conducted again. The previous area of improvement regarding medication competencies has been addressed; however a required improvement has been allocated in 1.2.7 regarding the provision of 'regular' medication education. A lunch time medication round is observed and confirms competency of the senior care giver.

There is a documented process for the safe self-administration of medication. There are currently three residents who are self-administering medications; however the process of such is not occurring as required.

Medication errors are reported and investigated. There have been very few medication errors and remedial actions have been implemented as required.

The remaining ARC requirements are met. Policies comply with the Medicines Act 1981 and residents' medication is reviewed on entry to the facility. This includes medication reconciliation on entry.

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

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

There are currently three residents prescribed controlled drugs. Controlled drugs checks are consistently conducted inconsistently. Checks are completed when stock is received from the pharmacy, however timeframes for this differs depending on how much medication has been consumed. The controlled drug policy does not include the process and frequency for checking controlled drugs. It is also reported that a pharmacist has recently conducted an audit of the medication system, including the required six monthly checks of the controlled drugs, however records of this have not been maintained.

**Finding Statement**

The organisation has not defined the requirements for checking controlled drugs within their medication policies. Evidence of the six monthly pharmacy checks of controlled drugs has not been maintained in the controlled drug book.

**Corrective Action Required:**

Amend the controlled drug policy to include the required checks and implement. Maintain evidence of controlled drug audits/checks.

**Timeframe:**

6 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

There is currently three residents who are administering their own medication. These include an antibiotic cream, lactulose and cough medication. The medications are sighted on the bed side draws. There is also a couple sharing a double room. The wife is administering medication to her husband in the night and although a letter of agreement is sighted in the residents' records, this is not consistent with the requirements of the policy on self-administration of medication.

**Finding Statement**

The self-medication process is not occurring in line with the requirements of the related policy.

**Corrective Action Required:**

Implement the self-medication process as per policy. For example: provide secure storage, complete the required assessment process and liaise with the GP.

**Timeframe:**

6 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Residents are provided with a well-balanced diet which meets their cultural and nutritional needs. The menus have been reviewed by a registered dietician and confirm they are appropriate for the needs of the older person. Deviations from the menu, occurring as a result of the availability of fresh produce, are recorded.

Nutritional assessments are completed on entry. Special dietary needs are identified and the cook confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident.

Residents are weighed monthly and confirm nutritional needs are being sufficiently addressed. Where required, any additional nutritional support is clearly documented in support plans and appropriate interventions implemented. This includes referrals to a dietician as required. There are currently two residents requiring subsidised nutritional supplements and the GP monitors health needs at each review. There is also one resident who is actively trying to lose weight, and this is clearly documented (including related interventions) in the support plan.

Residents interviewed are satisfied with the food and this is also evident in the records of resident meeting minutes. The meal service is observed on the day of the audit. The lunch time meal is well presented and sufficient in quantity.

One of the three cooks is interviewed. All three also work as care givers and have the required food safety qualifications. Nutrition and safe food management policies define the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers and records of temperature monitoring are maintained. Guidance is provided for staff on environmental cleaning, storage, minimising risk of contamination and food hygiene principals.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The issues identified under criterion 1.4.2.1 in the last certification audit have been addressed; however, this criterion remains partially attained as a new area requiring improvement has been identified. Two new gas infinity water heaters have been installed in two wings and hot water temperatures are monitored weekly. Documentation reviewed indicates hot water temperatures do not exceed 45 degrees Celsius in resident’s areas; there is a planned maintenance programme in place; and repairs have been completed to the kitchen doors.

A new area requiring improvement relating to use of a bedroom (room 8) with a designated fire exit in it has been identified during this audit (see criterion 1.4.2.1 and link 1.4.7).

The Cottage has a current Building Warrant of Fitness that expires on 18 December 2013 which is displayed. No alterations to the building have been undertaken since the last certification audit although room 1 has been converted from a single bedroom to a double bedroom that is currently used by a couple, and room 8 has been converted from a staff sleepover room to a resident bedroom (see 1.4.2.1). There are call bells in both these bedrooms.

A visual Inspection of the facility provides evidence of safe storage of medical equipment, and the building, plant and equipment is maintained to an adequate standard. Corridors are of various widths but are generally wide enough to allow residents to pass each other safely; safety rails are secure and are appropriately located; minimal changes in floor surface and levels occur; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; floor surfaces and coatings are maintained in good order. The external areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside, e.g.: safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes.

Staff receive education in the safe use of medical equipment by suitably qualified personnel, and there is a system in place to review staff competency for specific equipment. This was confirmed via interview of staff and review of staff education records. Care staff interviewed confirm that: they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

ARC requirements are met.

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

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

Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. A maintenance person is employed for 20 hours a week and was interviewed during this audit. Maintenance person interviewed confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and reviewed during this audit along with current calibration / performance verified stickers in place on medical equipment.

**Finding Statement**

Room 8, which was used as a staff sleepover room, has been converted in to a resident bedroom. This room is a designated fire exit and the exit is blocked by the resident's furniture. The manager advises the Trust is considering creating a new fire exit in another area in this fire cell but has not proceeded with this yet. The manager also advises they are considering moving this resident to the one empty room they have in the facility but have not done this yet as the resident in room 8 has settled in to room 8, has moderate dementia and they do not want to cause them any unnecessary confusion. The family member of this resident was asked by the manager during this audit about moving their family member to another room and they agreed to this. This move is scheduled for the day after this audit (15 October 2013)

**Corrective Action Required:**

Provide confirmation the fire exit in room 8 is not obstructed by resident furniture.

**Timeframe:**

One month

**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

Review of documentation provides evidence of a letter from New Zealand Fire Service dated 08 July 2009 advising the fire evacuation scheme for the facility was approved 04 June 1999. A trial evacuation was last held on 11 October 2013 (false alarm) and the next one with NZFS in attendance is scheduled for 23 October 2013.

Documentation reviewed indicates that if a new fire exit is created as a result of using room 8 as a resident bedroom, that a new application for approval of a fire scheme may need to be submitted to NZFS (see link 1.4.2.1)

All staff have current first aid certificates and there is at least one certified first aid person on each shift.

The ARC requirements are met.

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

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

Review of documentation provides evidence of a letter from New Zealand Fire Service dated 08 July 2009 advising the fire evacuation scheme for the facility was approved 04 June 1999.

A trial evacuation was last held on 11 October 2013 (false alarm) and the next one with NZFS in attendance is scheduled for 23 October 2013.

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The Cottage staff are able to demonstrate that the use of restraint is minimised. There is currently one resident who has bed rails in place as a restraint. The restraint review process ensures alternatives are explored.

There are adequately documented guidelines on the use of restraints and enablers. Definitions are congruent with the requirements of the Health and Disability Sector Standards and staff interviewed are well versed with the correct definitions and their application in practice. There are also guidelines on the management of challenging behaviours.

The ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

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

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

The previous area requiring improvement regarding the restraint policy has been adequately addressed (2.2.1.1). The Restraint policy has been updated and now complies with the requirements of this standard.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

The previous area requiring improvement regarding the restraint assessment process (2.2.2.1) still requires some further amendments in order to fully comply with this standard.

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

 (a) Any risks related to the use of restraint;

 (b) Any underlying causes for the relevant behaviour or condition if known;

 (c) Existing advance directives the consumer may have made;

 (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

 (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

 (f) Maintaining culturally safe practice;

 (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

 (h) Possible alternative intervention/strategies.

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

The restraint assessment process has been amended to include to include b, c, d, f, and g, however further amendments are required to include items a, e and h. The previous area requiring improvement remains in place.

**Finding Statement**

The restraint assessment process has been amended to include items b, c, d, f, and g, however further amendments are required to include items a,e and h. The previous area requiring improvement remains in place.

**Corrective Action Required:**

Continue with the required amendments to the restraint assessment process.

**Timeframe:**

6 months

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

Restraint is used in a safe manner. The required restraint/enabler monitoring forms are in place, the bed rails are padded and the restraint registration and evaluation process is implemented. The previous areas requiring improvement regarding a restraint register (2.2.3.5) has been adequately addressed. The current restraint register is sighted and confirms one restraint in use.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

The previous area requiring an improvement regarding the restraint evaluation process (2.2.4.1) has been adequately addressed. The Restraint Registration and Evaluation Form currently in place includes the requirements of this standard.

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

 (a) Future options to avoid the use of restraint;

 (b) Whether the consumer's service delivery plan (or crisis plan) was followed;

 (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

 (d) Whether the desired outcome was achieved;

 (e) Whether the restraint was the least restrictive option to achieve the desired outcome;

 (f) The duration of the restraint episode and whether this was for the least amount of time required;

 (g) The impact the restraint had on the consumer;

 (h) Whether appropriate advocacy/support was provided or facilitated;

 (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

 (j) Whether the service's policies and procedures were followed;

 (k) Any suggested changes or additions required to the restraint education for service providers.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 Surveillance**

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

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

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

The infection surveillance programme is appropriate for the facility and the level of care provided. The use of antibiotics is monitored and infection data is maintained. Surveillance data is collated monthly and combined to allow for an overall view of infection activity and a level of analysis of data is occurring. The Cottage has very few reporting infections.

Note: An opportunity for improvement has been documented in standard 1.2.3 regarding the requirement to conducted a full and detailed analysis of all quality data.

**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:**