**Shona McFarlane Retirement Village Limited**

**Current Status:** **07-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**

Ryman Shona McFarlane is a modern facility that is part of a wider village. The service can provide care for up to 99 residents requiring rest home and hospital level care, including rest home care in 20 serviced apartments. Occupancy during the audit was 20 residents at rest home level care and 54 residents at hospital level care. There are currently no residents at rest home level care in the serviced apartments.

Shona McFarlane is managed by an experienced aged care manager and clinical manager (registered nurse) and they are supported by a stable staff.

Ryman Healthcare has an organisational total quality management plan and key operations quality initiatives that are implemented at Shona McFarlane. All residents and relatives spoke positively about the care and support provided by staff and management.

The one identified shortfall from the previous audit around interventions has been addressed. This audit has identified improvements required around updating care plans when needs have changed and dating opened eye drops.

**Audit Summary AS AT** **07-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 Audit  07-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

|  |  |  |
| --- | --- | --- |
| **Organisational Management** | Day of Audit  07-Oct-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  07-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 Audit  07-Oct-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  07-Oct-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| --- | --- | --- |
| **Infection Prevention and Control** | Day of Audit  07-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** |

**Shona McFarlane Retirement Village**

Shona McFarlane Retirement Village Limited

Surveillance audit - Audit Report

Audit Date: 07-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Shona McFarlane Retirement Village Limited |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Shona McFarlane Retirement Village | 66 Mabey Road | Avalon | Lower Hutt |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 07-Oct-13 **End Date:** 08-Oct-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXXXX | RCompN, PGDipHSM, Auditor certificate | 11.00 | 5.00 | 7-Oct-13 to 8-Oct-13 |
| Auditor 1 | XXXXXXXXX | RN, auditor certificate | 11.00 | 5.00 | 7-Oct-13 to 8-Oct-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXXX |  |  | 2.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 22.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 34.00 |
| **Staff Records Reviewed** | 7 of 115 | **Client Records Reviewed** *(numeric)* | 6 of 74 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 6 |
| **Staff Interviewed** | 19 of 115 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 4 |
| **Consumers Interviewed** | 6 of 74 | **Number of Medication Records Reviewed** | 12 of 74 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 25 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Shona McFarlane Retirement Village | 99 | 74 | 30 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Ryman Shona McFarlane is a modern facility that is part of a wider village. The service can provide care for up to 99 residents requiring rest home and hospital level care, including rest home care in 20 serviced apartments. Occupancy during the audit was 20 residents at rest home level care and 54 residents at hospital level care. There are currently no residents at rest home level care in the serviced apartments.

Shona McFarlane is managed by an experienced aged care manager and clinical manager (registered nurse) and they are supported by a stable staff.

Ryman Healthcare has an organisational total quality management plan and key operations quality initiatives that are implemented at Shona McFarlane. All residents and relatives spoke positively about the care and support provided by staff and management.

The one identified shortfall from the previous audit around interventions has been addressed. This audit has identified improvements required around updating care plans when needs have changed and dating opened eye drops.

1.1 Consumer Rights

Shona McFarlane strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Residents and relatives spoke very positively about care provided by the service and report excellent communication with staff and management. Complaints processes are implemented and complaints and concerns are actively managed and well documented.

1.2 Organisational Management

Ryman has a robust quality and risk management system that supports the provision of clinical care and support. This is implemented at Shona McFarlane. Policies and procedures are reviewed regularly and are updated to reflect best practice, legislation and standards. Key components of the quality management system link to the facility's monthly Ryman Accreditation Programme (RAP) committee meetings. An annual resident and relative satisfaction survey is completed and there are regular resident meetings.

Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Six monthly benchmarking reports are produced that include incidents/accidents, infections and complaints. These are used to provide comparisons with other facilities. Quality improvement plans are utilised at Shona McFarlane to document actions to improve or enhance a current process or system or actions to improve outcomes or efficiencies in the facility. There is an active health and safety committee.

The service has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support that meets requirements. There is a registered nurse/enrolled nurse journal club directed by head office whereby articles, research and questions are discussed.

There is a policy for determining staffing and skill mix for safe service delivery. Staff identified that staffing levels are good, staff turnover is low and interviews with residents and relatives demonstrated that they have adequate access to staff.

1.3 Continuum of Service Delivery

The registered nurse is responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is an improvement required to ensure changes to care are updated in the long term care plan to reflect current needs and interventions. Short term care plans are utilised. Resident files are integrated and include notes by the GP and allied health professionals.

The activity programme is developed to promote resident independence , involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the resident group. Spiritual and cultural preferences and needs are being met.

Education and medicines competencies are completed by all staff responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration. There is an improvement required to dating eye drop bottles on opening.

Food services and all meals are provided on site and transported to hospital wing in hot boxes. Residents individual food preferences and dislikes are known by staff serving the meals. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene.

1.4 Safe and Appropriate Environment

The building has a current warrant of fitness. There is a fire evacuation letter of approval. A reactive and preventative planned maintenance schedule is in place. Clinical equipment is calibrated and checked annually. The overall cleanliness of the facility bedrooms and communal areas is of a high standard.

2 Restraint Minimisation and Safe Practice

There is a restraint minimisation manual that is applicable to the type and size of the service. The service is restraint-free and there are two enablers in use. Training has been provided to staff around restraint and challenging behaviours.

3. Infection Prevention and Control

The infection control team at Shona McFarlane is integrated as part of the two monthly infection control/health & safety meeting. Monthly collation tables are forwarded to Ryman head office for analysis and benchmarking. The infection control nurse implements the surveillance, organises training and implements and reviews internal audits. There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed. A six monthly comparative summary is completed.

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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:4 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Low | 0 | 1 | 1 | 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 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 4 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: 0  Criteria (of 51): CI:0 FA:12 PA:2 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 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 | Not Applicable | 0 | 0 | 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:7 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:3 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | 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: 0  Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 34 **CI:** 0 **FA:** 14 **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:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 39 **PA:** 2 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Shona McFarlane Retirement Village Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:07-Oct-13 End Date: 08-Oct-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.8 | 1.3.8.3 | PA  Low | **Finding:**  Changes to residents health in the written evaluation are not reflected in the residents long term care plan. Rest home: one resident on controlled drug pain relief has not had a review of the pain assessment or changes made to the long term care plan for pain management ; one resident with weight gain has not had the short term care plan completed to monitor interventions and progress; one resident with wound pain does not have a pain assessment or pain management included in the long term care plan and there is no short term care plan for a current wound infection. Hospital: one resident has not had the long term care plan evaluated to reflect changes in condition on return from hospital; the long term care plan for one resident does not include cognitive and behavioural changes as per the written evaluation; the long term care plan for one resident does not include a lap belt as an enabler as per the written evaluation.  **Action:**  Ensure care plans and assessment tools reflect the residents current need and support required. | 3 months |
| 1.3.12 | 1.3.12.1 | PA  Low | **Finding:**  There are four bottles of eye drops in the rest home trolley that have not been dated on opening.  **Action:**  Ensure eye drops are dated on opening. | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Shona McFarlane Retirement Village Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:07-Oct-13 End Date: 08-Oct-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXXX

**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

Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with family including if an incident or care/medical issues arise. Access to interpreter services is identified in the community. This includes language support, the DHB, Hearing Association and the Blind Foundation. As there is a multi-cultured staff and residents, caregivers described being able to interpret for some residents when needed.

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

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

D16.4b Four relatives (two from the rest home and two from the hospital) stated that they are always informed when their family members health status changes. A review of nine incident forms shows all have documented that family or next of kin were contacted following the incident.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 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 in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. Complaints are documented on VCare. Complaints and verbal complaints reviewed for 2012/13 (seven) were tracked, indicating that they had been actioned according to timeframes and identified resolution. The monthly RAP meeting which is attended by all staff identified discussion of complaints and opportunities for improvement in service delivery.

The service had a complaint in November 2012 which was forwarded to the Health and Disability Commission regarding an incident involving a resident being in hoist and hoist tipped while resident in hoist and landed on bed. Meeting held with family three days after incident. The complaint was thoroughly investigated by Ryman and remedial actions taken including hoist removed out of circulation, new hoist purchased, review of current monitoring system had been completed and hoists checked by maintenance team. Every care team staff member went through additional education about moving residents; this included the use of hoists. Second meeting was held with family 4 weeks later to review. The Health and Disability Commission notified the service on 5 April 2013 that no further action would be taken. The incident form was reviewed during this audit and shows a thorough investigation including immediate review of the hoisting procedure for the resident by a physiotherapist and the actions noted above

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

**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

Ryman Shona McFarlane is a modern facility that is part of a wider village. It provides rest home and hospital level care for up to 79 residents. Additionally, there are 20 certified serviced apartments. Occupancy is 20 rest home residents and 54 hospital residents including one resident under the medical aspect of the contract. There are no rest home residents in the serviced apartments. Ryman has robust quality and risk management systems implemented across its facilities that are monitored closely by head office. To monitor organisation performance, the manager reports weekly to head office and RAP committee meetings occur monthly. There are organisational quality objectives and quality objectives specific to Shona McFarlane. These are around teamwork, palliative care management, meals (satisfaction), laundry (satisfaction) and health and safety. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme (RAP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation and there are clear guidelines and templates for reporting. The service has in place an experienced village manager who is supported by an experienced clinical manager. The village manager has worked for Ryman’s for 15 years, initially as a caregiver and then moving upward toward management roles. She previously managed another Ryman village for three years and has been in this role since September 2012. The clinical manager has 18 years’ experience in aged care in the United Kingdom and one years’ experience in aged care in New Zealand prior to commencing the current role five months ago. They are also supported by an assistant manager who is an enrolled nurse.

ARC,D17.3di (rest home), D17.4b (hospital): The manager has maintained at least eight hours annually of professional development activities related to managing a hospital. This includes the monthly Ryman manager development programme and attendance at a manager’s conference in April 2013.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

Ryman Shona McFarlane has a well-established quality and risk management system that is directed by head office. The RAP includes a schedule across the year for the following areas: RAP head office; general management; staff development; administration; audits/infection control/quality/compliance/health and safety; Triple A/activities. The head office RAP committee provides a monthly RAP programme that aligns with and supports the implementation in each service by way of their local RAP committee. The monthly checklist is implemented at Shona McFarlane at the onsite monthly RAP meetings which are attended by all staff and weekly management meetings.

Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with two registered nurses and 11 caregivers (who work across rest home and hospital) and review of meeting minutes demonstrate their involvement in quality and risk activities. The monthly staff meeting (full facility RAP meeting) included discussing and planning 2013 quality goals for the year.

Resident meetings are held on a two monthly basis in the rest home and in the hospital. Relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed. The last resident and relative survey was completed in 2012. Satisfaction was very high and action plans are completed. Areas of concern identified around teamwork, evening meals and laundry have been included as 2013 quality objectives and are being regularly reviewed.

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The quality and risk system is documented and links with associated policies/procedures. Management Resource Manual 2009 has been updated to align with the revised NZS 8134:2008. The RAP programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar.

There are adequate clinical policies and procedures to rest home and hospital level care. The monthly journal club (attended by registered/enrolled nurses), directed by head office, reviews the latest clinical practice articles. Topics that have been covered include (but are not limited to): professional development; scabies; warfarin use; pressure area prevention; enduring power of attorney/advance directives; care planning; palliative care; syringe drivers.

There are policies and tools for all clinical areas that are current.

The service has a comprehensive quality system that is implemented. A quality assistant checklist and RAP checklist is forwarded to head office each month to demonstrate implementation of the quality programme. a) There are comprehensive monthly accident/incident reports completed that break down the data collected across each area in the facility. Reports are provided from the manager to head office that includes a collation of staff incidents/accidents and resident incidents/accidents. Shona McFarlane provides a six monthly comparative summary report that includes recommendations for residents and staff and training conducted. These are also compared with the previous month. There is also an organisational report produced six monthly that benchmarks incidents/accidents across the organisation. b) The monthly manager's report includes complaints/concerns/compliments. All complaints are attended to through the monthly RAP meeting. Quality improvement plans are initiated where required. c) All infections are documented in a monthly summary report and discussed in the monthly RAP committee meetings and health and safety/IC meetings. Monthly reports to head office include a monthly summary of infections, statistics, clinical summaries and education. d) Health and safety is addressed through the two monthly health and safety meetings. A monthly quality assistant checklist is forwarded to head office. The hazard register is attached and this includes problems and resolution. e) The restraint approval group at Shona McFarlane is part of the monthly RAP management meeting. These meetings include any episodes of de-escalation and potential for restraint/enabler use. An internal audit is completed six monthly. There are currently no restraints in use at Shona McFarlane.

There is a comprehensive quality and risk management process in place. The service monitoring programme includes (but is not limited to); infection control, quality improvement, health and safety, service delivery, resident rights, managing service delivery, emergency and human resources. Monitoring in each area is completed monthly, six monthly or annually as designated by the RAP programme schedule. This is monitored and reviewed through reporting to head office. A monthly incident/accident and infection analysis is forwarded to head office.

Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a six month period. Reports and implementation of the quality system is monitored closely by head office.

The service continues to collect data to support the implementation of corrective action plans. The internal auditing annual schedule is implemented as per schedule.

Meetings are minuted including actions to resolve areas identified for improvement and quality improvement plans/action plans are developed when quality activities such as internal audits and satisfaction surveys identify areas for improvement.

Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings. A health and safety officer is appointed.

Risk management, hazard control and emergency policies and procedures are in place.

Ryman has tertiary level ACC WSMP to November 2013. Risk management, hazard control and emergency policies/procedures are in place.

Hazard identification and control occurs and hazards register in place. On-going hazards are identified through H&S meetings.

The organisation's benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

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

D19.2g Falls prevention strategies such as post falls assessments, two hourly rounds of all residents, low beds and landing mats are in use. The facility is taking part in the ACC Falls Preventing Harm, 18 months project to reduce falls. The village manager attended the first seminar of this project in September 2013.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH. The Public Health department was notified on 12 November 2013 of a norovirus outbreak.

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the monthly RAP committee meetings, two monthly health and safety meetings and monthly full facility meetings reflect a discussion of incidents/accidents and actions taken. A six monthly comparative analysis is completed of incidents for internal benchmarking across Ryman's facilities. In addition, each facility receives an analysis of the last three six monthly periods from which to identify trends and improvements. Falls rates are compared to indicators from the "Standard on safe indicators in aged care".

A review of incident/accident forms identified that nine of nine incident forms were fully completed and included follow-up. A falls protocol was completed where appropriate and this included neurological observation when resident has hit their head.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

A register of registered nurse practising certificates is maintained within the facility. The current general practitioners' registration is printed from the professional body's website. Allied health practitioners are asked to provide evidence of registration as appropriate (for example, physiotherapist and podiatrist) and a copy is retained by the facility.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (two registered nurses, one activities coordinator, one cook and three caregivers). All included their relevant induction books, referee checks and training and development records.

Shona McFarlane has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as (but not limited to) caregiver, senior caregiver, registered nurse, H&S rep, clinical manager and gardener. The orientation/induction training for caregivers, on completion, provides them with a level two national certificate in support of the older person equivalent qualification. The orientation process includes; full induction with all employees and caregiver modules followed by enrolment into the ACE programme to achieve ACE core, ACE advanced and/or ACE dementia, as appropriate, if not achieved prior to employment.

There is an implemented education plan 2013. The annual training programme well exceeds eight hours annually. Staff education and training includes the aged care education (ACE) programme for caregivers. There are a total of 56 caregivers, Twenty two have completed ACE and 11 are currently completing ACE. On-going training via in-service programme to meet MOH guidelines and any ad hoc training specific to the Village or resident needs. Attendance encouraged at full facility meetings to ensure participation in the Ryman Accreditation Programme. Yearly formal performance review for reflective practice and setting goals including up skilling or other training or qualification goals. Caregivers complete yearly comprehension surveys. In August 2013 the service initiated 'burst' education centres where RN's provide a short (five to ten minutes) education session for caregivers during handover on a subject requested by caregivers. Examples include denture care, teeth cleaning, cleaning shavers, skin integrity, reducing the risk of pressure areas, continence management and pain management.

Registered nurses are supported to maintain their professional competency and there is also a foreign trained nurse development programme. Staff training records are maintained. The journal club for registered nurses and enrolled nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion. Interviews with two registered nurses and two enrolled nurses identified that participation in the RN Journal Club is used to advise current practice and provide clinical updates and guidance. Yearly formal performance review specific to RNs for reflective practice and setting goals including up skilling or other training or qualification goals.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, syringe driver management and restraint minimisation.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

The determining staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.

The village manager advised that staff turnover has been moderate at 22% for the past year. Interviews with 11 caregivers who work both morning and afternoon shifts both areas stated that overall the staffing levels are fine and that the village manager provides good support.

Six residents (three rest home and three hospital) and four relatives (two rest home and two hospital) stated there always seem to be plenty of staff on duty and that call bells are answered promptly.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hrs. The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy.

The nursing care assessment and service delivery policy and nursing care assessment and planning interventions policy describe the responsibility around documentation. Activity assessments and activities care plans have been completed by the activity therapists.

There is a continuum of service delivery policy that includes guidelines for a) nursing care assessment, b) planning care interventions, c) service delivery/interventions, and d) evaluation and care plan review. Timeframes are identified for assessment, initial care plan, long term care plan and evaluations. Staff are familiar with the timeframes and files reviewed were overall kept up to date.

D16.2, 3, 4; An initial assessment is completed within 24 hours, initial care plan within 48 hours and long term care plan within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months. Six resident files were reviewed (three rest home and three hospital). All six long term files had the initial admission assessments and plans and long term care plan completed by the registered nurses within the required timeframe.

D16.5e; Medical assessments were documented in all six long term files within 48 hours of admission. Three monthly medical reviews were documented in six of six files by general practitioner. It was noted in three rest home resident files reviewed identified that the GP has assessed the resident as stable and is to be seen three monthly and monthly in three hospital resident files. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care.

One house GP interviewed stated that he visits regularly once a week and conducts three monthly resident reviews as required and attends to any other residents of concern to the RN. The family are encouraged to attend the three monthly reviews. The GP states he phones the families and keeps them informed on their relatives health status. The RN faxes the GP practice with any concerns during practice hours. He is available evenings, afternoons and weekends. The GP states he is happy with the RN assessments and calls to see residents are justified. He is happy with the standard of nursing care and says there is good team work among the staff. The GP initiates referrals in consultation with the RN.

Assessment tools completed on admission include a) full nursing body assessment b)Waterlow pressure area risk assessment, c) continence, d) mobility assessment e) coombes falls risk, f) nutritional assessment as applicable g) pain assessment h) wound assessment Assessments are reviewed when there is a change to condition or at least six monthly.

The staff interviewed (11 caregivers from rest home/hospital and two RN's) could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Duty Handover sheets note any residents requiring any special observations or needs. There is an RN to RN handover initially then the RN hands over to the caregiving team. Progress notes are maintained at least daily for rest home and each shift for hospital residents or more frequently as required. Six files reviewed evidence this is occurring.

The physiotherapist is contracted for 15 hours a week and the physiotherapy assistant provides three hours a day physiotherapy support as directed by the physiotherapist. The physiotherapist conducts an initial resident mobility assessment on admission. A resident moving and handling chart is then developed. The physiotherapist is currently updating charts and introducing a "traffic light" system that will be available in the resident’s rooms for clinical staff to follow. The RN enters any residents concerns into the physiotherapy communication book for attention at the next physiotherapists visit. The physiotherapist provides education for staff in safe manual handling and practical demonstrations. She also meets with staff informally for discussion and brief in-services.

Three rest home resident files sampled are as follows: 1) resident on controlled drug pain management, 2) resident with history of falls, 3) resident with chronic wound.

Three hospital level residents sampled are as follows: 1) resident recently admitted with deteriorating health, 2) resident with complex medical problems and challenging behaviour, 3) resident with weight gain.

Tracer Methodology: Rest home resident

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

Tracer Methodology: Hospital resident

*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 1.3.6 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

Six resident files were reviewed (three rest home, three hospital). Residents interviewed (three rest home, three hospital) report their needs are being appropriately met. Relatives interviewed (two hospital, two rest home) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. Care plan includes; cognitive/mood, sensory/communication, mobility, safety/risk, respiratory/cardiac, continence, medication, ADLs, skin, wound and pressure care, pain, dietary/diabetes management, and social, spiritual, cultural and sexuality. Interview with the clinical manager and two registered nurses verified involvement of families in the care planning process as appropriate. Relatives interviewed (two hospital, two rest home) confirm they are informed of any changes to their relatives health and interventions required to meet the resident’s needs.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and treatment plan and evaluations are in place for five ulcers and five pressure areas (one back, two sacral, one foot) in the rest home and two skins tears and two lesions in the hospital wing. Each wound folder has a wound and skin tear register. Evaluations, wound assessments and pain level is carried out at each dressing change. Wound mapping charts and photographs are evident as required. There is evidence of wound specialist input as required. The RN's interviewed described the referral process should they require assistance from the wound nurse specialist. Repositioning charts are evidenced in use and the use of pressure area resources. Staff attended skin care management and wound care education in May 2013.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the two RN's interviewed. Continence management education was provided in February 2013.

Weigh chair scales are used to weigh residents monthly. The scales were calibrated July 2013. Weight loss short term care plans include drink supplements, food and fluid monitoring, frequency of weighing, frequent in-between snacks and GP/Dietitian notification. The resident dietary requirements is reviewed and a copy sent to the kitchen. A dietician is available as required. Food and fluid monitoring charts are evidenced in use.

Coombes falls risks assessments are carried out on admission and reviewed at least six monthly or earlier if an increase in risk level is identified. The physiotherapist completes an admission mobility assessment for residents. Accident incidents are investigation for cause and corrective actions include the use of sensor mats, hip protectors, clutter free rooms and mobility aids available. A repeat falls analysis is completed for frequent fallers.

The previous shortfall related to interventions in care plans has been addressed (refer 1.3.8.3).

**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

There are five activity coordinators that provide an activity programme in the rest home, hospital areas and serviced apartments. The programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility. There is a core programme which includes the triple A (Active, Ageless, Awareness) exercise programme that was designed by the Ryman group and includes chair exercises for less active residents and more active exercise programme for mobile residents and serviced apartments. This is a comprehensive programme that meets the needs of all consumers. The programme is evaluated and can be individually tailored according to resident’s needs. There are different levels of the programme depending on the mobility level of the residents. The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that includes an activities assessment, 'your life experiences'. The activity and clinical care plans are reviewed at least six monthly with resident/family, RN and activity co-ordinators involved in the review. The care plan includes headings for comfort and wellbeing, outings, interests and family and community. A resident attendance list for activities, entertainment and outings is maintained. The activity team described the implementation of the 'Spice of Life', a resident focused programme to enable the village to support residents achieve self-setting goals. Group activities offered include crafts, movies, baking, card making, flower arranging, bowls, newspaper reading and bingo. Residents attend activities and entertainment in either unit as desired. Visitors to the site include SPCA and pets, Save the Children fund, variety shows, schools, and speakers Arthritis field officer. Resident participation is voluntary. One on one activities are provided for residents as assessed. There are regular Anglican and interdenominational church services. Ethnic groups/individual needs are met and staff communicate effectively with the residents using sign language and interpretation through the families. There are weekly drives in the home van and the wheelchair taxi is used as required.

Resident meetings are held bi-monthly and feedback to activities is provided at the meeting.

All six (three rest home and three hospital) residents and four (two rest home and two hospital) family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed at the time of care plan review.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against every goal and need identified in the care plan. Six of six resident files sampled (three rest home and three hospital) contained written evaluations completed six monthly. Short term care plans in place evidence regular evaluations with on-going problems transferred to the long term care plan. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly for rest home residents and monthly for hospital residents. Care plans are not always updated when needs change and this is an area requiring improvement.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Written evaluations on the long term care plan are completed six monthly. Risk tool assessments in place are evaluated six monthly. Short term care plans in place evidence regular evaluations with on-going problems transferred to the long term care plan.

**Finding Statement**

Changes to resident’s health in the written evaluation are not reflected in the resident’s long term care plan. Rest home: one resident on controlled drug pain relief has not had a review of the pain assessment or changes made to the long term care plan for pain management; one resident with weight gain has not had the short term care plan completed to monitor interventions and progress; one resident with wound pain does not have a pain assessment or pain management included in the long term care plan and there is no short term care plan for a current wound infection. Hospital: one resident has not had the long term care plan evaluated to reflect changes in condition on return from hospital; the long term care plan for one resident does not include cognitive and behavioural changes as per the written evaluation; the long term care plan for one resident does not include a lap belt as an enabler as per the written evaluation.

**Corrective Action Required:**

Ensure care plans and assessment tools reflect the residents current need and support required.

**Timeframe:**

3 months

**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

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by an RN in the hospital unit. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Any discrepancies are fed back to the pharmacy. The medication trolleys are kept in locked treatment rooms in the rest home and hospital areas. RN's in the hospital and senior caregivers in the rest home are competency assessed and responsible for administering medication. Annual medication competency and education was completed in July 2013. RN's complete syringe driver training and annual refreshers at Te Omanga hospice. Controlled drugs are stored in a locked cabinet in the hospital medication room. There are two controlled drug safes, one for injections and Liverpool care pathway hospital stock and the other for blister pack controlled medications. There is a medications standing orders in place. There are no self-medicating residents. Administration signing sheets are correct and complete. PRN medications are administered by the RN's only and have a time of administration recorded. Controlled drugs are signed as given by two medication competent staff. Controlled drugs are checked weekly. Medication fridge temperatures are monitored weekly. Pharmacy stock is checked for expiry dates weekly and drink supplements monthly. Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. All medication charts have photos. One out of 12 medication charts did not have an adverse reaction documented. This was rectified during the audit. The sample was extended by another six charts. All six charts had allergies/adverse reactions documented.

D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

There is an emergency trolley and oxygen available for use in an emergency. The equipment is checked weekly.

**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

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by an RN in the hospital unit. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Any discrepancies are fed back to the pharmacy. The medication trolleys are kept in locked treatment rooms in the rest home and hospital areas. Eye drops are delivered four weekly or as prescribed and checked on delivery by the RN on duty.

**Finding Statement**

There are four bottles of eye drops in the rest home trolley that have not been dated on opening.

**Corrective Action Required:**

Ensure eye drops are dated on opening.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

There is a qualified cook, cook assistant and morning and afternoon dishwasher on duty daily. Cooks have completed Food Safety Certificates (NZQA) and all kitchen staff attended safe food handling in-service in August 2013. The service has a large workable kitchen with a separate area for dishwashing, food preparation and cooking. There is a large walk-in chiller, fridges and freezers and a dry goods storage area. All dry goods are in sealed containers, labelled and off the floor. The menu is designed and reviewed by a registered dietitian at an organisational level. The summer menu is currently being reviewed and resident’s choice/preference is considered. There is a three monthly rolling menu. Stock is rotated when the weekly food order arrives. There are fridge, freezer and chiller temperatures recorded daily. Gas hobs and two combi ovens are used for the cooking of meals. All equipment in the kitchen was checked in August 2013. All meals and morning teas are cooked on site. The hot meal is at midday with a lighter tea. An alternative tea option is currently being introduced. Alternative meals are offered for those residents with dislikes or religious preferences. The cook receives a resident dietary needs form for each resident on admission and is notified of any changes to dietary requirements such as soft, pureed or modified diets or any resident with weight loss. All breakfasts are delivered on meal trolleys to the resident’s room. Diabetics are offered fresh fruit or canned fruit in natural juice if the menu dessert is too sweet. Meals are served from the bain-marie to residents in the rest home dining room. Meals are delivered in hot boxes to the hospital dining room. A supply of sandwiches and snacks are available for residents’ supper and overnight if required. Six residents interviewed (three rest home and three hospital) are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings.

There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets. Fridge and food temperature audits are completed six monthly. There was a 100 % compliance in July 2013.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

Legislation and regulatory requirements appear to be met for local authorities and the MoH. The building holds a current warrant of fitness which expires on 8 March 2014. The fire service evacuation approval letter is dated 1 June 2013. Fire security services carry out monthly fire safety equipment checks. The service employs a maintenance officer for the facility and town houses. Contractors are called in as required. Building maintenance is carried out when necessary and records maintained. Hot water temperatures are monitored three monthly with resident areas rotated throughout the year.

There is access to necessary and essential equipment. MOH have requested auditor comment on the planned maintenance programme and overall cleanliness of the facility as per letter dated 24 April 2013. There is a planned maintenance programme in place that includes electrical equipment checks. BV medical carry out functional and calibration checks on all clinical equipment. The four hoists have all been checked July 2013. There is a contracted physiotherapist (interviewed) has provided safe manual handling training March and October 2013. The overall cleanliness of the bedrooms, communal areas and bathroom facilities on the day of audit is good. The environment smelt pleasant. Environ clean are contracted to clean the carpets throughout the facility twice yearly and bedrooms as required.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

Shona McFarlane is restraint free. There are two residents using enablers. There is a restraint minimisation manual 2009 applicable to the type and size of the service. The policies and procedures are comprehensive, included definitions, processes and use of enablers.

The restraint minimisation manual includes that enablers are voluntary and the least restrictive option. Two enabler files were reviewed and included consents and assessments.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 Surveillance**

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

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

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

The surveillance policy states the routine/planned surveillance programme is organised and promoted via the RAP calendar. The IC/H&S committee meet monthly and also act as the IC committee. A monthly infection summary report is completed. The surveillance includes a) systematic surveillance, b) response to surveillance activities, c) development of the surveillance programme, d) standardised definitions, e) surveillance methods, f) reports and g) assessment of effectiveness of surveillance.

Surveillance methods and processes including implementation of an internal audit are appropriate for the size of this facility (rest home and hospital level). All infections are collected via the ' infection report form' and all collected and discussed at the RAP meetings. Following this the report information is entered onto the VCare system and a collated report of generated. Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.

The IC Officer then completes a monthly infection summary which is discussed at bimonthly H&S/IC meetings and a six monthly comparative summary is completed and forwarded to head office. All meetings held at Shona McFarlane include discussion on infection control. Internal audits are completed hand washing audit, April 2013 (100%), laundry hygiene audit, September 2013 (100%), kitchen hygiene audit, July 2013 (100%). Infections are benchmarked across the organisation.

The service had a norovirus outbreak in November 2012 with 11 rest home residents and 12 hospital residents being affected. In-service education was provided to all staff on day three of the outbreak and the 11 caregivers interviewed report that the outbreak management process was orderly and organised.

**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:**