**Trinity Home and Hospital Limited**

**Current Status:** **29-Oct-13**

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

**General overview**

Trinity Home and Hospital (Trinity) provides residential care for up to 62 residents who require hospital level, rest home, and dementia level care. Occupancy on the day of the audit was 56. The facility is operated by Trinity Home and Hospital Limited, which is a charitable Trust. The facility is managed by an experienced general manager who is supported by a clinical operations manager, who is a registered nurse. The operations manager provides oversight of clinical care and they are supported by a recently appointed clinical nurse leader and a team of registered nurses and care staff.

A major building programme is currently underway at Trinity Home and Hospital and stage one of a three stage programme is nearing completion. Stage one includes a new kitchen, laundry, dining room and staff facilities. All bedrooms are single and have wash hand basins. Staffing is stable with minimal turnover of staff. Residents and staff interviewed report the care provided is of a high standard. Staffing hours are increased if required to meet the needs of residents. Two areas requiring improvement have been identified during this audit relating to the management of the staff orientation programme, and documentation that evidences the kitchen is being cleaned.

**Audit Summary AS AT** **29-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  29-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit  29-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 Audit  29-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  29-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  29-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  29-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** |

**Audit Results AS AT** **29-Oct-13**

**Consumer Rights**

Resident's interviewed report that services are provided in a manner that is respectful of their rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs. Residents and family members interviewed state they are very happy with the service provided and report that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and of any significant change in the resident's condition. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code), as well as advocacy information is displayed in the main entrance as well as in resident areas. Complaint forms are also readily available at the main entrance.

During interviews, staff demonstrate an understanding of informed consent and informed consent processes. Residents and family interviewed confirm they have been made aware of and understand the informed consent processes and confirm that appropriate information is provided. The general manager is responsible for complaints and a complaints register is maintained. The residents can use the complaints issues forms or bring issues up at the residents' monthly meetings.

**Organisational Management**

Trinity Home and Hospital Limited is the governing body and is responsible for the service provided at Trinity Home and Hospital (Trinity). There is a business plan (2013 - 2014) as well as documented scope, direction, goals, vision, and mission statement for Trinity and these are reviewed during this audit. Systems are in place for monitoring the service provided at Trinity including regular monthly reporting by the general manager to the governing body. The general manager has a nursing background and has been in the current role since April 2008. The general manager has extensive health management experience and is supported by a clinical operations manager who was appointed in December 2012. The clinical operations manager is a registered nurse and has worked in various aged care management roles over the last 20 years. The clinical operations manager is supported by a recently appointed clinical nurse leader.

There is a quality system in place and review of quality improvement data provides evidence the data is being collected, collated, analysed and reported to staff meetings and registered nurse meetings. Copies of meeting minutes are available for staff to review in the staff room. The quality programme includes quality goals and objectives. There is an internal audit programme, risks are identified and there is a hazard register. Resident meetings are held monthly and residents are free to raise any concerns they have. Review of meeting minutes and interviews of residents indicates the service responds to any issues they have in a timely manner. Adverse events are documented on accident/incident forms and staff and family members interviewed report they are advised of adverse events. Family members report they are advised of any changes in their family members condition. Completed accident/incident forms are retained in individual resident's files.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RNs), enrolled nurses (ENs), pharmacist, dietician, and general practitioners (GPs) is occurring. There is evidence available indicating an in-service education programme is provided and in-service education sessions are provided at least monthly. Careerforce education modules are provided and staff are supported to complete these modules. Improvements are required to the management of the orientation programme as review of staff records indicates not all staff have completed an orientation within an appropriate timeframe, or have not completed an orientation. Individual education records are maintained for each staff member.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. Rosters reviewed and indicates 24 hour registered nurse cover is provided. The minimum amount of staff is provided during the night shift and consists of one registered nurse and four care staff. The clinical operations manager is on call after hours. All care staff interviewed report there is adequate staff available and that they are able to get through their work.

Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

**Continuum of Service Delivery**

Service delivery provides care to residents assessed as requiring rest home, dementia, and hospital level care. The registered nurses develop, review, update and evaluate residents 'Person Centred Care Plans' at least six monthly. Residents or their family have input into the development and review of care plans. Documentation provides evidence that families are kept well informed. Residents and family interviewed are very satisfied with the standard of care provided by staff.

There are three activity programmes in place for the three resident groups. The activity programmes supports the interests, needs and strengths of residents. Residents and family interviewed confirm they participate in the activities, and that the programmes have a wide variety of activities to choose from, and meeting minutes and surveys confirm this. Activities on the day of the audit were observed to be very well attended by residents, and some residents interviewed in the rest home report they like to undertake their own activities.

An appropriate medicine management system is implemented with policies and procedures clearly detailing service providers' responsibilities. Registered nurses are responsible for medicine management and have current medication competencies. Medication files reviewed evidence documentation of residents' allergies/sensitivities and three monthly medication reviews completed by the general practitioner. Weekly and six monthly checks of controlled drugs are completed. The medicine fridge temperatures are recorded daily and are within the recommended range.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. A dietitian has reviewed the menu, and there is a six week menu in place. Resident meetings are held monthly and food is a permanent agenda item. Meetings are facilitated by the general manager. There is an area requiring improvement as there are gaps in kitchen cleaning documentation. Documentation reviewed has not consistently been signed off indicating cleaning of the kitchen has been completed as per the schedule.

**Safe and Appropriate Environment**

A major building programme is currently underway at Trinity Home and Hospital and stage one of a three stage programme is due for completion in the next two weeks. Stage one includes a new kitchen, laundry, dining room, storage facilities, residents toilet, and staff facilities. Stage two is due to be started in early 2014 and is expected to take six to eight months to complete.

All bedrooms are single and have wash hand basins, and some bedrooms have their own en-suite. There is an adequate number of communal toilet and shower facilities in each area. All residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as a clinical staff member. There are lounges and dining areas throughout the facility. External areas are available for sitting and shading is provided in external areas. There is a secure external area in the Cullen wing, which is the secure wing for residents with dementia. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection of the facility provides evidence of sluice facilities in each area, chemicals and equipment are safely stored, and protective equipment and clothing is provided and is used by staff. There are appropriate systems in place to ensure the residents' physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site in a laundry with separate clean and dirty areas. There are appropriate monitoring systems in place to evaluate the effectiveness of the cleaning and laundry services. Staff have completed appropriate training in chemical safety.

**Restraint Minimisation and Safe Practice**

Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are least restrictive. There are currently residents using restraints and enablers, and restraint usage is actively minimised.

Systems are in place to ensure assessment of residents is undertaken prior to restraint usage being implemented. Three resident's files reviewed demonstrates restraint assessment and risk processes are being followed. The resident's files reviewed provides evidence of resident or family input into the restraint approval processes. Restraint evaluation processes are documented and implemented. The resident's files evidences each episode of restraint is being evaluated. Approved restraint for residents is reviewed at least monthly, and as part of the six monthly care plan review, and multidisciplinary review. Restraint usage across the facility is monitored and discussed at quality /staff meetings. Restraint review is completed on a regular basis.

**Infection Prevention and Control**

There is a comprehensive infection control programme in place at Trinity to minimise the risk of infection to residents, service providers and visitors.

The infection control programme implemented meets the needs of the organisation and provides information and resources for staff on infection prevention and control. The policies and procedures have been developed by an external infection control practitioner and are supported by staff.

Infection control education is provided as part of the in-service education programme and the infection control co-ordinator has attended recent infection prevention and control education. Review of documentation at Trinity provides evidence the process for surveillance of infections and reporting of infections is applicable to the size and complexity of the organization. Copies of graphs for infections are available in the staff room along with meeting minutes and staff interviewed report this information is available for them.

**Trinity Home and Hospital**

Trinity Home and Hospital Limited

Certification audit - Audit Report

Audit Date: 29-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Trinity Home and Hospital Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Trinity Home & Hospital | 47 - 61 Puriri Street | Hawera | South Taranaki |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 29-Oct-13 **End Date:** 30-Oct-13 |
| **Designated Auditing Agency** | HealthShare 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 (with APC), RM, ADN, BN | 16.75 | 11.00 | 29-Oct-13 to 30-Oct-13 |
| Auditor 1 | XXXXXXXX | Lead Auditor, RN (with APC), BN | 16.75 | 8.00 | 29-Oct-13 to 30-Oct-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX | MBA MN BEd Adv Dip child and Family, Dip Tchg, RGON, Lead auditor |  | 1.50 | 5-Nov-13 |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 33.50 | **Total Audit Hours off site** *(system generated)* | 20.50 | **Total Audit Hours** | 54.00 |
| **Staff Records Reviewed** | 9 of 65 | **Client Records Reviewed** *(numeric)* | 8 of 56 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 8 |
| **Staff Interviewed** | 18 of 65 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 8 of 56 | **Number of Medication Records Reviewed** | 16 of 56 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

I confirm that HealthShare Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 7 day of November 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Trinity Home & Hospital | 62 | 56 | 5 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Trinity Home and Hospital (Trinity) provides residential care for up to 62 residents who require hospital level, rest home, and dementia level care. Occupancy on the day of the audit was 56. The facility is operated by Trinity Home and Hospital Limited, which is a charitable Trust. The facility is managed by an experienced general manager who is supported by a clinical operations manager, who is a registered nurse. The operations manager provides oversight of clinical care and they are supported by a recently appointed clinical nurse leader and a team of registered nurses and care staff.

A major building programme is currently underway at Trinity Home and Hospital and stage one of a three stage programme is nearing completion. Stage one includes a new kitchen, laundry, dining room and staff facilities. All bedrooms are single and have wash hand basins. Staffing is stable with minimal turnover of staff. Residents and staff interviewed report the care provided is of a high standard. Staffing hours are increased if required to meet the needs of residents. Two areas requiring improvement have been identified during this audit relating to the management of the staff orientation programme, and documentation that evidences the kitchen is being cleaned.

1.1 Consumer Rights

Resident's interviewed report that services are provided in a manner that is respectful of their rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs. Residents and family members interviewed state they are very happy with the service provided and report that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and of any significant change in the resident's condition. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code), as well as advocacy information is displayed in the main entrance as well as in resident areas. Complaint forms are also readily available at the main entrance.

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1.2 Organisational Management

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There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RNs), enrolled nurses (ENs), pharmacist, dietician, and general practitioners (GPs) is occurring. There is evidence available indicating an inservice education programme is provided and inservice education sessions are provided at least monthly. Careerforce education modules are provided and staff are supported to complete these modules. Improvements are required to the management of the orientation programme as review of staff records indicates not all staff have completed an orientation within an appropriate timeframe, or have not completed an orientation. Individual education records are maintained for each staff member.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. Rosters reviewed and indicates 24 hour registered nurse cover is provided. The minimum amount of staff is provided during the night shift and consists of one registered nurse and four care staff. The clinical operations manager is on call after hours. All care staff interviewed report there is adequate staff available and that they are able to get through their work.

Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

1.3 Continuum of Service Delivery

Service delivery provides care to residents assessed as requiring rest home, dementia, and hospital level care. The registered nurses develop, review, update and evaluate residents 'Person Centred Care Plans' at least six monthly. Residents or their family have input into the development and review of care plans. Documentation provides evidence that families are kept well informed. Residents and family interviewed are very satisfied with the standard of care provided by staff.

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There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection of the facility provides evidence of sluice facilities in each area, chemicals and equipment are safely stored, and protective equipment and clothing is provided and is used by staff. There are appropriate systems in place to ensure the residents’ physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site in a laundry with separate clean and dirty areas. There are appropriate monitoring systems in place to evaluate the effectiveness of the cleaning and laundry services. Staff have completed appropriate training in chemical safety.

2 Restraint Minimisation and Safe Practice

Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are least restrictive. There are currently residents using restraints and enablers, and restraint usage is actively minimised.

Systems are in place to ensure assessment of residents is undertaken prior to restraint usage being implemented. Three resident's files reviewed demonstrates restraint assessment and risk processes are being followed. The resident's files reviewed provides evidence of resident or family input into the restraint approval processes. Restraint evaluation processes are documented and implemented. The resident's files evidences each episode of restraint is being evaluated. Approved restraint for residents is reviewed at least monthly, and as part of the six monthly care plan review, and multidisciplinary review. Restraint usage across the facility is monitored and discussed at quality /staff meetings. Restraint review is completed on a regular basis.

3. Infection Prevention and Control

There is a comprehensive infection control programme in place at Trinity to minimise the risk of infection to residents, service providers and visitors.

The infection control programme implemented meets the needs of the organisation and provides information and resources for staff on infection prevention and control. The policies and procedures have been developed by an external infection control practitioner and are supported by staff.

Infection control education is provided as part of the in-service education programme and the infection control co-ordinator has attended recent infection prevention and control education. Review of documentation at Trinity provides evidence the process for surveillance of infections and reporting of infections is applicable to the size and complexity of the organization. Copies of graphs for infections are available in the staff room along with meeting minutes and staff interviewed report this information is available for them.

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

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| Consumer Rights Standards (of 12): N/A:0 CI:0 FA: 12 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:23 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | 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 | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 6 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: 0  Criteria (of 34): CI:0 FA:21 PA:1 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | 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) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Low | 0 | 2 | 1 | 0 | 0 | 5 |

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| --- |
| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 11 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: 0  Criteria (of 51): CI:0 FA:20 PA:1 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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

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

1. Restraint Minimisation and Safe Practice

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **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 | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | FA | 0 | 1 | 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 |

|  |
| --- |
| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:0 FA:9 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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

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

|  |
| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 48 **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:** 99 **PA:** 2 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Trinity Home and Hospital Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:29-Oct-13 End Date: 30-Oct-13

DAA: HealthShare Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.7 | 1.2.7.4 | PA  Low | **Finding:**  Review of nine staff records indicates that: (i) four of nine staff have not completed an orientation; (ii) and four of the five who have completed an orientation have taken longer than three months to complete this. (iii) The orientation programme is managed by the resource manager who is not a registered nurse (see link 1.2.1 ARC D17.4baii). The Clinical Operations Manager and Clinical Nurse Leader advise they will take over management of the orientation programme.  **Action:**  Provide confirmation that all new staff complete an orientation in a timely manner that covers the essential components of the service provided. | Six months |
| 1.3.13 | 1.3.13.5 | PA  Low | **Finding:**  There are gaps in the kitchen cleaning signing schedule where documentation has not been signed off indicating cleaning of the kitchen has occurred.  **Action:**  Provide confirmation that kitchen cleaning is undertaken as per the cleaning schedule, and is signed off. | Three months |

# Continuous Improvement (CI) Report

Provider Name: Trinity Home and Hospital Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:29-Oct-13 End Date: 30-Oct-13

DAA: HealthShare Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

Eleven of eleven care staff (six caregivers - two from hospital one working morning and one working afternoon shift; two from rest home one working morning and one working afternoon shift; and two from dementia one working morning and one working afternoon shift; an enrolled nurse working morning shift in the hospital; one registered nurse working morning shifts in the dementia unit; two registered nurses in the hospital one working morning shift and one working afternoon shift; and the clinical nurse leader), the clinical operations manager/registered nurse, and the general manager demonstrate a knowledge of the Code of Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. All care staff interviewed confirm they have received recent education on the Code. Review of education records and staff files evidences education provided at various times throughout 2012 and 2013.

Visual observations during the audit indicates staff are respectful of residents and incorporate the principals of the Code in their practice. Staff observed knocking before entering resident's bedrooms.

Residents interviewed (five rest home and three hospital) and three family members of residents in the dementia unit confirm that staff respect their/their family members rights and most could recall receiving a copy of the Code.

Resident satisfaction survey completed October 2013 and collated results indicates residents are satisfied with the amount of involvement in decisions affecting their care, their privacy is respected and staff treat them with dignity and respect.

Copies of the Code observed at the entrances and are displayed in the corridors. All residents are provided with an information pack on admission and this includes information on the Code.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

Resident meetings are held monthly and are facilitated by the general manager (GM). The clinical operations manager (COM) and GM advise a local independent advocate is available for residents who has visited and talked with residents. Resident meeting minutes reviewed indicate feedback from residents on aspects of service delivery including the residents making suggestions concerning meals, laundry and activities programme. Residents receive a copy of the 'Welcome to Trinity' information booklet on admission and this includes information on the Code and residents rights.

Residents (five rest home and three hospital) interviewed report they are informed of their rights and some could recall receiving admission information including information booklets and information on the Code. Family members interviewed (three with family members in the dementia unit) report they received an information pack on admission and this included information on the Code and complaints processes. The Code - including large print posters, and advocacy details are displayed throughout the facility, and copies are available and accessible. Residents and family members confirm during interview they are given opportunity for discussion regarding these. Admission Agreement reviewed and includes information on the Code of Residents’ Rights. Signed Admission Agreements on residents files held in the administration office.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Residents and family members interviewed confirm they/their family member are receiving services appropriate to their needs and that staff treat them/their family member with dignity. Residents confirm they have a choice of what to do with their day and have a right to refuse if they do not want to participate. Residents also confirm their privacy is respected and they are able to be as independent as they desire/are able. Residents confirm they wear their own clothing and they have appropriate storage facilities in their rooms. They also confirm that it is a comfortable place to live in and their rights are respected, including any spiritual and cultural needs. These findings supported during review of residents' and family satisfaction surveys completed in October 2013.

Visual inspection of the facility provides evidence that all bedrooms are single and residents have dedicated areas to keep their personal property and possessions and the rooms are as personalised as resident's want them to be. Separate private areas are also available for residents to meet with family members if required. There is a suitable environment available for caring for a dying resident and their family. Communal hygiene facilities display appropriate signage and a safe locking system.

Residents' files sampled demonstrates residents' access to the spiritual and/or cultural care of their choice is recorded in the resident's admission documentation, which details spiritual affiliations and cultural aspects of care, and in the RN assessment and 'Person Centred Care Plans' (care plans) which identifies spiritual needs. Admission Agreement reviewed and includes information on the residents’ responsibility for safety, security and insurance cover of their personal belongings.

There is a chapel on site and church services are held on site twice a week as part of the activities programme.

Care staff interviewed confirm residents’ physical, visual, auditory and personal privacy is being maintained and they respect residents' spiritual and cultural needs. Care staff also confirm education on the Code of Rights and this finding confirmed during review of staff education records.

Appropriate policies and procedures are in place including policies to guide service providers acting on advance directives and maximising independence when they are caring for people where this is likely to be an issue. Policies and procedures also reviewed for cultural safety, spirituality, death and dying, and abuse and neglect.

Interview of GM and COM and review of complaints documentation indicates there have been allegations made against two staff members.

The allegation has been investigated and addressed by the GM and the staff members have been dismissed from Trinity.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Service provider's documentation reviewed includes appropriate Māori protocols and a Māori health plan. There are currently five residents who identify as Māori. Access to Māori support and advocacy services is available if required via a local Māori health provider and from the local DHB if required. There are also six members of staff who identify as Māori and some of them provide cultural support and advice if required.

Systems are in place to allow for review processes including input from family, where appropriate, for any resident who identifies as Māori. Iwi and family contacts are documented in residents' documentation as appropriate. Cultural assessments are part of all residents' care plans and was reviewed on all eight resident's files, plus an additional two resident care plans which were reviewed specifically to review the cultural component of care and cultural needs are documented. File of one resident who identifies as Māori reviewed and indicates families are involved in resident's care. During interview this resident confirms their cultural needs are met.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education provided 25 October 2013 and attended by 17 members of staff.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Service provider's documentation provides evidence appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Policies list access details to appropriate expertise (e.g. cultural specialists, and interpreters).

Residents' files sampled demonstrate that admission documentation identifies ethnicity, cultural and spiritual requirements and family/whanau contact details. All residents have a cultural assessment completed as part of the care planning process.

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. Church services are held on site as part of the activities programme.

Care staff interviewed confirm an understanding of cultural safety in relation to care, and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and house rules/codes of conduct. Policies and procedures which address any conflict of interest issues (e.g. the accepting of gifts and personal transactions with consumers) were reviewed. Expected staff practice is outlined in job descriptions and reviewed on staff files along with employment agreements. A review of the accident/incident reporting system, complaints register and interview of the GM and COM indicates there has been allegations made against two members of staff (see 1.1.3) that has been investigated by the GM and dealt with. The two staff members have subsequently been dismissed.

Residents interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

Systems are in place to ensure staff receive education which promotes good practice within the facility. Documentation evidences that policies and procedures are based on evidence-based rationales. Education by specialist educators is provided as part of the in-service education programme and this was confirmed during review of education records and interview of staff.

A quality improvement programme is implemented which includes family and residents surveys. Review of surveys completed in October 2013 indicates residents are receiving a service of an appropriate standard.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

Open disclosure procedures are in place to ensure service providers maintain open, transparent communication with residents and their families. Open disclosure education provided for staff in August 2013 as part of the inservice education programme.

Residents' files reviewed (three rest home, three hospital, and two dementia) provides evidence that communication with family is being documented in

'Family Contact Record' and in progress notes.

There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the 'Monthly Accident/Incident Analysis Form' which is a register of adverse events for each area.

Residents interviewed (five rest home and three hospital) and family members (three) confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff who are responsible for their care.

The GM and COM advise access to interpreter services is available if required via the local community, the DHB and interpreter services.

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:** FA

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 and in the information booklet. The COM, clinical nurse leader (CNL), and RN's (three) advise informed consent is discussed and recorded on the resident's admission to the facility. Appropriate consent forms reviewed on resident files reviewed (eight). Resident files reviewed have copies of EPOAs where EPOAs are recorded.

Staff interviewed (six caregivers, three RNs, one EN, CNL, and COM) demonstrate an understanding in relation to informed consent processes. Eight of eight residents and three family members (dementia unit) interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information is available to them and their choices and decisions are acted on. These findings supported during review of resident satisfaction survey completed in October 2013.

Eight of eight residents' files (three rest home, three hospital, and two dementia) reviewed demonstrate written and verbal discussions on informed consent have occurred and residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the informed consent as part of the Code of the Rights education and last provided January 2013 (confirmed by staff, COM, and CNL interviews).

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

The service has appropriate policies regarding advocacy/support services that specify advocacy processes and how to access independent advocates.

Resident meetings are held monthly and meeting minutes reviewed. Visual inspection provides evidence the Health & Disability Advocate details are displayed.

Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they attended education on the Code of Right which included advocacy and complaints as part of the inservice education programme. This was confirmed during review of staff education records.

Residents and family interviewed confirm that advocacy support is available to them if required. Some could recall that they received information on the Code and how to access the Health and Disability Advocate on admission. Visual inspection provides evidence the Health and Disability Advocate details are displayed along with advocacy information brochures. Admission pack reviewed and provides evidence advocacy, complaints and Code of Rights is included.

The ARC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by the visitors to the service (e.g. visitors are required to sign in and out). The activities programme includes access to community groups and there are systems are in place to ensure residents remain aware of current affairs, news etc. via, for example, reading of the newspaper each day.

Residents and family members interviewed confirm they can have access to visitors of their choice, and confirm they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a van is available to take residents on community visits. Some residents go out independently on a regular basis. Residents' files reviewed demonstrate that activity plans identify support/interest groups.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The 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 and two of these are from two family members relating to the one incident . Reporting of complaints occurs via monthly meetings and via GM reports to the governing body.

The GM reports there have been no complaint investigations by the Ministry of Health, District Health Board, Health and Disability Commissioner, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of this are given to all residents / their family as part of the admission process. Residents and family 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 interview of residents.

A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of combined staff/quality meeting minutes and quality indicators reports provides evidence of reporting of complaints. Staff interviewed confirm they have received education on complaints management.

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

Trinity Home and Hospital Limited is the governing body and is responsible for the service provided at Trinity Home and Hospital (Trinity). A 'Trinity Home and Hospital Annual Report April 2012 - March 2013 and Business Plan 2013 - 2014' reviewed. Also reviewed documented scope, direction, goals, vision, and mission statement for Trinity.

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 the service provided at Trinity including regular monthly reporting by the general manager to the governing body. Meeting minutes reviewed and combined staff/quality meetings, RN, and resident meetings are held monthly.

A written quality and risk management plan/policy identifying the organization’s quality goals, objectives, and scope of service delivery reviewed and includes statements about quality activities and review processes.

The general manager (GM) has a nursing background (does not retain an annual practising certificate) and has been in their current role since April 2008. The GM has worked in various health management roles in New Zealand over the last 27 years, the last seven years in aged care management. The GM is supported by a clinical operations manager who was appointed in December 2012. The clinical operations manager is a registered nurse and has worked in various aged care management roles over the last 20 years. The clinical operations manager (COM), who is responsible for clinical governance, is supported by a recently appointed (08 October 2013) clinical nurse leader (CNL). The COM and CNL have current practising certificates. The GM, COM, and CNLs CVs and personal files reviewed and there is documented evidence they attend education to keep themselves up-to-date.

Trinity Home and Hospital Limited is certified to provide hospital, rest home, and dementia level care and have contracts with the DHB to provide rest home, hospital, dementia, day care, residential respite, and long term support - chronic health conditions services. The provider also has a contract with the Ministry of Health to provide residential - non aged services.

The facility has 22 hospital level beds and 40 rest home level beds (24 rest home and 16 dementia). On day one of this audit there are 18 hospital level residents, 22 rest home level residents, and 16 dementia level residents. Five of the rest home beds are 'swing' beds and are able to be used for wither rest home or hospital level residents.

See 1.2.7.4 re ARC D17.4baii as the orientation programme is not being managed by the clinical nurse leader. This responsibility has traditionally been assumed by the resources manager who is an administrator. The COM and GM advise during this audit that responsibility for management of the orientation programme for clinical staff will now be assumed by the CNL.

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 1.2.2 Service Management**

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

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

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

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

There are appropriate systems in place to ensure the day-to-day operations of the service continues should the GM, COM, or the CNL be absent. The COM fills in for the GM and CNL should they be absent, and the CNL fills in for the COM. Twenty four hour registered nurse (RN) cover is provided. Job descriptions and interviews of the COM and CNL confirms their responsibility and authority for this role.

Services provided meet the specific needs of the consumer groups within the facility.

The requirements of the ARC are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

A 'Quality and Risk Management Plan' and 'Quality Improvement Guidelines' reviewed and are used to guide the quality programme and includes; purpose, scope, quality and risk strategies, quality improvement principles, quality goals and objectives, quality framework, and monitoring. There is an internal audit programme, risks are identified and there is a hazard register.

Quality indicators, including clinical indicators are documented on various registers and forms and reviewed as part of this audit. Review of quality improvement data provides evidence the data is being collected, collated, analysed and reported to staff via the combined staff/quality meetings, and registered nurses meetings. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings as well as evidence of reporting of trends and corrective actions required.

Internal audits reviewed and 'Audit Outcomes Form' with corrective actions required completed for audits.

Staff interviewed report they are advised of numbers of various clinical indicators during their meetings. Staff report copies of meeting minutes and graphs are available for them to review in the staff room (sighted).

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed that are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via meetings and notices. Staff report copies of policies are displayed in the staff room and they are required to read the policy and sign the staff signing sheet.

Health and Safety Manual available that includes relevant policies and procedures. 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 all biomedical equipment has appropriate performance verified stickers in place.

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:** 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

There is a planned and co-ordinated adverse event reporting system in place. Staff are documenting adverse, unplanned or untoward events on an 'Accident/Incident/Near Miss Report' which are then reviewed by the RN before being passed on to the COM for review. Adverse events are also entered on to the 'Monthly Accident/Incident Analysis Form' for the rest and hospital areas and for the dementia unit. Completed accident/incident forms are retained in individual resident's files. Adverse events reviewed on resident files and in a folder with analysis forms and graphs.

There is an open disclosure policy. Resident files reviewed provide evidence of communication with families following adverse events involving the resident, or any change in the residents condition. Confirmed during interview of family members.

Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions; policies and procedures; and professional codes of conduct, which was confirmed via review of staff files and other documentation. Policy and Procedures comply with essential notification reporting e.g. health and safety, human resources, infection control etc.

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

Monthly in-service education planners for 2013 provides evidence of planning of in-service education. The COM is responsible for oversight of in-service education programme. There is evidence available indicating an inservice education programme is provided for staff including the provision of inservice education sessions at least monthly.

Written policies and procedures in relation to human resource management are available and reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (nine of nine) along with employment agreements.

It has been policy at Trinity Home and Hospital Limited to complete criminal vetting of employees since 2009. Five of the nine files reviewed do not have evidence of criminal vetting and these files are from staff members who were employed prior to implementation of this policy. It is recommended that criminal vetting be undertaken of all who were employed prior to 2009 and who do not have evidence of criminal vetting having been completed on their staff files.

Improvements are required with the management of the orientation programme as review of staff records indicates not all staff have completed an orientation within an appropriate timeframe, or have not completed an orientation (see 1.2.7.4). The orientation programme is managed by the resource manager who is not a registered nurse (see link 1.2.1 ARC D17.4baii).

Individual records of education are maintained for each staff member but it is difficult to retrieve this information during this audit. The information is held in different formats (electronic and paper based) by more than one person. It is recommended that the current systems used to record staff attendance at education and completion of competency assessments be reviewed and simplified to make it easier to retrieve information. Completed competency assessments reviewed.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RNs), enrolled nurses (ENs), pharmacist, dietician, and general practitioners (GPs) is occurring.

Careerforce education modules are provided and staff are supported to complete these modules. There are 15 staff working in the dementia unit and eight have completed the dementia specific modules. Six are currently completing the dementia modules, and one staff member has recently enrolled to complete the dementia modules.

An appraisal schedule is in place and current staff appraisals sighted on staff files reviewed. Annual practising certificates are current for all staff who require them to practice.

Six of six caregivers 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 (see link 1.2.1 ARC D17.4baii).

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

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, is meant to take up to three months to complete and staff performance is reviewed at the end of this period.

As part of their orientation staff complete a 'Skills Record' which is meant to be completed within three months of starting. Four of the five completed 'Skills Record' reviewed on staff files have taken longer than the requisite three months to complete and some have taken in excess of six months to complete.

Orientation programme for staff covers the essential components of the service provided i.e.: The quality improvement programme; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation’s vision, values and philosophy.

**Finding Statement**

Review of nine staff records indicates that: (i) four of nine staff have not completed an orientation; (ii) and four of the five who have completed an orientation have taken longer than three months to complete this. (iii) The orientation programme is managed by the resource manager who is not a registered nurse (see link 1.2.1 ARC D17.4baii). The Clinical Operations Manager and Clinical Nurse Leader advise they will take over management of the orientation programme.

**Corrective Action Required:**

Provide confirmation that all new staff complete an orientation in a timely manner that covers the essential components of the service provided.

**Timeframe:**

Six months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is a documented rationale ('Staffing Rationale Policy') for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. Rosters reviewed and indicates 24 hour registered nurse cover is provided. The minimum amount of staff is provided during the night shift and consists of one registered nurse and four care staff. The clinical operations manager is on call after hours. All care staff interviewed report there is adequate staff available and that they are able to get through their work.

Residents interviewed report there is generally enough staff on duty to provide them with adequate care. Visual observations during this audit confirms adequate staff cover is provided.

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:** FA

Resident information is entered in an accurate and timely manner into a register (electronic and hard copy) that is appropriate to the service and is in line with legislative requirements. Interview of resource manager and office administrator 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 nurse’s stations in each clinical area, is held securely and is not on public display. Clinical notes are current and accessible to all clinical staff. The resident's national health index (NHI) number, name and date of birth are used as the unique identifier. Resident documentation indicates staff record their name and designation and staff sign each entry in resident documentation.

Clinical staff interviewed and the clinical nurse leader confirm they know how to maintain confidentiality of resident information. Historical records are securely stored and are accessible.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

Documented systems and processes are implemented to ensure resident’s entry into the service has been facilitated in a competent, equitable, timely and respectful manner. The service’s philosophy is recorded and communicated to residents, family, relevant agencies and staff and displayed at the facility. The admission agreement defines scope of service and includes all the contractual requirements. Residents' admission agreements evidence residents' or family sign off. The Clinical Nurse Leader and RNs interviews confirm access and entry processes are followed. This facility operates 24/7. The service provides information to potential referral sources. Resident information, and welcome pack was sighted with all relevant information for the resident and family is recorded. Residents' files reviewed demonstrate all needs assessments are completed for appropriate levels of care. Five residents, and family interviews confirm their input into the admission process. (Three of the eight residents interviewed couldn't remember).

Residents are assessed by a Needs Assessment and Service Co-ordination (NASC) agency prior to entry as being suitable for rest home level care, dementia level care, and hospital level care.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

Decline of resident entry to the service is documented, and the resident, and/or their family and agency are informed of the reason for this. The scope of the service provided by the organization is identified and communicated to all concerned. The Clinical Nurse Leader reports residents will be declined entry if not within the scope of the service or if a bed is not available at the time and referred back to the NASC service.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

A Clinical Operations Manager has been appointed within the last year, and more recently a Clinical Nurse Leader who have concentrated on improving clinical documentation, and this is evident during review of residents' files. Resident files reviewed provide evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with residents or family input and the service is coordinated to promote continuity of service delivery. Eleven of 11 clinical staff (one clinical nurse leader, three RNs, one EN, and six care givers) interviews confirm residents or family members are involved in all stages of service provision. Three of three family members (dementia unit) interviews confirm their input into the development of care plans. Five of the eight residents could remember having input, and three residents couldn't remember. Eight of eight residents' files (three hospital, three rest home, and two dementia) reviewed demonstrate that care plans are developed by the RNs. Care plans are signed off by the resident or family member, meet appropriate timeframes and demonstrate team approach into reviews and evaluations. Family records are maintained, sighted in all eight residents' files. There is a process to identify and respond to variances/trends e.g. accident / incident / unwanted events reporting system. Handover between shifts was observed for all three areas. The am RN hands over to all pm staff, and all residents are discussed. At interview the GP confirms that referrals are prompt and appropriate. The GP reports they refer residents to other health professionals as needed, e.g. wound specialist nurse, and dictation.

All files reviewed have documentation to evidence that residents are reviewed by a GP within two working days of admission and three monthly thereafter if the resident is stable.

Competency assessments are current for all RNs who are responsible for the management of medicines, and all clinical staff have current restraint competencies completed.

ARC requirements are met.

Tracer Methodology - Rest Home

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

Tracer Methodology - Hospital

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

Tracer – Dementia

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

Residents' needs, outcomes and goals are identified via the assessment process and are recorded in a timely manner. There are processes in place to seek information from a range of sources, for example; family, GP, specialists and referrer. Policies and protocols are in place to ensure co-operation between service providers and to promote continuity of service delivery. Residents' files reviewed provides evidence residents' discharge/transfer information from DHB or other health provider is available and appropriate resources and equipment are available. The Clinical Nurse Leader and RN interviews confirms that assessments are conducted in a safe and appropriate setting including visits from the GP. The GP visits three times a week, and interview confirms GP visits are conducted in a safe and appropriate setting, usually the resident's room. Residents and family interviewed confirm their involvement in their assessments, care planning, review, treatment and evaluations of care. Eight of eight residents' files evidence risk assessments on admission are conducted and recorded, and are completed at least six monthly, more often if level of risk increases. Assessments include falls, mobility, skin, pain, continence, cultural assessment, and dietary requirements. InterRAI assessments are also completed at least six monthly and are evidenced on residents files.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

Eight of eight residents' files reviewed provide evidence residents' care plans are individualised and integrated. The long-term goals are identified by the residents, family, and staff, with interventions, and reviews occur at regular intervals, at least six monthly or as needs change. Residents and family have input into their care planning, confirmed at resident and family interviews. Clinical staff interviewed report that care plans are accurate and up to date. The facility ensures access to regular GP care, and the GP at interview confirms they visit Trinity Home and Hospital on a regular basis three times per week.

ARC requirements are met.

**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:**

**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

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans. The GP documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement. Resident and family interviews confirm their current care and treatments meet their needs. 'Family Contact Record' and progress notes record family communications, sighted in all eight residents' files reviewed.

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

There are two diversional therapists who develop and implement the three activity programmes. Activities are provided seven days per week, and specific activities are carried out by care staff on Saturdays and Sundays for residents in the dementia unit. Residents, family, and staff interviews confirm the activity programmes include input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. Residents' meeting minutes, and results of surveys indicate that the activities provided are a highlight for residents. Residents and family interviews confirms this.

Eight of eight residents' files reviewed provide evidence that individual social profiles are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being. Interview with the diversional therapists confirms the activity programmes meet the needs of the resident groups and the service has appropriate equipment. Activities attendance records are maintained and are sighted. Resident interviews confirm their past activities are considered and that the programmes are varied, interesting and there is lots to choose from. The residents in the dementia unit, have '24 Hour Clocks' forms completed that guide staff with regards to motivational and diversional therapy over a 24 hour period. For example two dementia residents are able to go swimming.

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

All residents' files reviewed provide evidence that evaluations of care plans are within stated timeframes, that is at least six monthly. Evaluations are conducted by the RNs with input from, residents, family, care staff, and activity staff. Families are notified of any changes in resident's condition, evidenced in all eight residents' files reviewed. Residents and family interviews confirm their participation in care plan evaluations. (three residents could not remember). There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, including physiotherapist, podiatrist and dietitian. Residents' files evidence referral letters to specialists and other health professionals. Short term care plans are in place for short term changes in condition, and evidence of the care plans updated reflecting any changes.

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

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

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

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

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

Service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. Residents’ files reviewed, provide evidence completed referral forms / letters to demonstrate resident referral to and from other services. Residents' files reviewed provide evidence family contact records and progress notes document family involvement and facility communication with them, as appropriate. Interviews with the GP, Clinical Nurse Leader, and staff confirm referrals are made to other health professionals as appropriate.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

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

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

Residents files reviewed provide evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files. Interview with the Clinical Nurse Leader confirms transfers and discharge is co-ordinated and copies of documents are provided.

ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

Medicines are dispensed and delivered by the pharmacy using the Douglas Medico Pack system. Each medicine prescribed is signed by the GP. Each resident has an individual medicines profile with a current photo of the resident, and medicine prescription form, an individually dispensed packs, and medicine signing sheets. The GP completes a medicine reconciliation on admission for residents. A controlled drug register is maintained and evidences weekly and six monthly checks. Controlled drugs are stored securely in a metal safe, and bulk supply is not held on site. Medicines requiring refrigeration are stored in a dedicated fridge in the medication room. The temperatures are recorded on a daily basis and are within the recommended range for medicines

Medicine reviews by the GP are recorded in the medicine charts at least three monthly confirmed in 16 of 16 medicine files reviewed. Medicines are managed safely, and there is evidence RNs are signing off as the dose is administered, observed during medication rounds.

Staff responsible for medicine management (RNs) have received on going education, and have current medicine competencies, 8 August 2013.

The medicines policy includes a section on the self-administration of medicines, and currently there are no residents who are self-administering their own medicine. The GP at interview reports they have not been made aware of any medication errors. Medicine management audit completed June 2013.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Menus are planned and reviewed at regular intervals by a dietitian. The last review was in May 2013. There is a six weekly menu in place. Trinity provides meals on wheels to residents in the community.

Resident meetings are held monthly and these are facilitated by the General Manager and food is a permanent agenda item.

Residents and family interviewed report the food service is very good, and confirm that their preferences are met, adequate fluids are provided including protein drinks and smoothies. Snacks are available in all areas between meals, e.g. fruit, bread, sandwich fillings, biscuits, and bananas.

Seven of eight residents' files reviewed (three hospital, three rest home, and one dementia unit) demonstrate regular monthly weighing and monitoring of individual’s resident’s weight. Nutritional needs, dietary profile sheets completed on admission and copies of these are held in folders in the kitchen for each area and reviewed during this audit. Residents care plans identify nutritional needs and interventions are documented. Residents' likes/dislikes are written on a Whyte board.

Residents are referred to their GP for further investigation if they experience any unintentional weight loss. Referrals are also made to the dietitian if required.

Visual inspection of the kitchen and food areas evidences the areas are maintained, however, the kitchen is tired, and a new kitchen is due to be opened in two weeks. Fridge, freezer and food temperatures are monitored daily.

Interview with the cook and Resource Manager, and review of staff files, confirms the three cooks have completed Food Safety certificates (167 & 168) 26 October 2013.

There is an area requiring improvement as there are gaps in kitchen cleaning documentation. Documentation reviewed has not consistently been signed off indicating cleaning of the kitchen has been completed as per the schedule. (See 1.3.13.5.)

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

Food service manual including policies, procedures reviewed along with monitoring records - including food temperatures, and fridge / freezer temperature recordings for the kitchen.

A visual inspection of the kitchen and food areas evidences the kitchen is old, wooden surfaces are worn. A new kitchen is due to open in two weeks and this kitchen reviewed during this audit. New kitchen is large and is built to commercial standards.

**Finding Statement**

There are gaps in the kitchen cleaning signing schedule where documentation has not been signed off indicating cleaning of the kitchen has occurred.

**Corrective Action Required:**

Provide confirmation that kitchen cleaning is undertaken as per the cleaning schedule, and is signed off.

**Timeframe:**

Three months

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facilities and are accessible for staff. Hazard Register sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and chemical safety last provided 10 July 2013. Monthly visits by Ecolab and copies of these reports reviewed during this audit.

A visual inspection of the facility provides evidence of the provision and availability of protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled. For example: goggles/visors, gloves, aprons, footwear, and masks viewed in sluice rooms. Clothing is provided and used by staff. Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. Three sluice facilities are available throughout the facility for the disposal of waste and hazardous substances (one in each area).

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

A major building programme is currently underway at Trinity Home and Hospital and stage one of a three stage programme is due for completion in the next two weeks. Stage one includes a new kitchen, laundry, dining room, storage facilities, residents toilet, and staff facilities. Stage two is due to be started in early 2014 and is expected to take six to eight months to complete. Stage two involves converting the area currently being used as the kitchen and laundry in to 18 hospital level bedrooms. Stage three involves converting two rest home bedrooms and a quiet room in the Aotea wing in to a lounge and dining room.

Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. GM and COM interviewed and 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 along with current calibration / performance verified stickers in place on medical equipment. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 01 December 2013.

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 wide enough in all areas and allow residents to pass each other safely; safety rails are secure and 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; transitions between surfaces or coverings are without abrupt change in level or gradient; and floor surface changes are identifiable by the resident. 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. There is a large secure external area in the dementia unit with gardens and pets.

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 e.g. hoists competency. Physiotherapist interviewed and confirm they are responsible for providing safe handling education for staff. 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 and family 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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

All bedrooms are single and have wash hand basins. Four bedrooms have their own ensuite facilities and two bedrooms have partial ensuite with toilets and wash hand basins. There is an adequate number of communal toilet and shower facilities. Visual inspection evidences toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.

Hot water temperatures are monitored at least weekly and are adjusted if they are not being delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).

All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and washbasin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

Visual inspection evidences that all hospital bedrooms have double leaf doors to allow for easy access for mobility aids. The majority of the bedrooms are large and there is adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

Visual inspection evidences adequate access is provided to lounges, dining rooms, and other communal areas throughout all areas within the facility. Residents observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

A major building programme is currently underway at Trinity Home and Hospital and stage one of a three stage programme is due for completion in the next two weeks. Stage one includes a new laundry.

Cleaning policy and procedures, and laundry policy and procedures are available. Product user charts, chemical safety data sheets for chemicals used in the facility, and cleaning and laundry task sheets reviewed. There are policies and procedures for the safe storage and use of chemicals / poisons.

All linen is washed on site in the laundry and there is adequate dirty / clean flow. Laundry person interviewed and describes management of laundry including transportation, sorting, storage, laundering, and return to residents.

Visual Inspection evidences the implementation of cleaning and laundry processes. The effectiveness of the cleaning and laundry services is monitored via Ecolab monthly visits and via the internal audit programme. Visual inspection of the facility evidences: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste - i.e. sluice room/facilities in all areas; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Residents interviewed state they are satisfied with the cleaning and laundry service.

ARC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

Letter from New Zealand Fire Service reviewed dated 22 June 2010 confirming approval of fire evacuation scheme on 03 October 1995. The last trial evacuation was held on 01 August 2013.

Staff interviews and review of files provides evidence of current training in relevant areas. There is at least one designated staff member trained on each shift with appropriate first aid training. All RN's and diversional therapists who take residents out and collect day care residents have current first aid certificates.

Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase (see 1.2.7.4) and at appropriate intervals. Staff records sampled evidences current training regarding fire, emergency and security education. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.

A visual inspection of the facility evidences: information in relation to emergency and security situations is readily available/displayed for service providers and consumers; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations. A visual inspection of the facility evidences: emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.

An appropriate call bell system that is easily used by the resident or staff to summon assistance if required and is appropriate to the resident group and setting, e.g. call bell system. Call bells are accessible / within easy reach, and are available in resident areas. There are two call bell systems in place - one in the dementia unit and one for the rest home and hospital areas. There is an emergency call system in place for staff from the dementia unit to summons assistance from staff in the hospital and rest home area if required.

Residents interviewed confirm they have a call bell system in place which is accessible and staff generally respond to it in a timely manner

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The environment is smoke free.

Residents interviewed confirm the facilities are maintained at an appropriate temperature.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are least restrictive. There are 18 residents using restraint and nine residents using an enabler. Sensor mats and low beds are used to try and minimise the use of restraint. Documentation reviewed for consent, assessment, monitoring and review.

ARC requirements 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

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy, that include responsibilities for key staff at an organisational level and the service level. There is an RN who is the restraint co coordinator, and they are able to describe the role and responsibilities of the position. The restraint committee is part of the quality/staff meetings minutes reviewed - minutes sighted..

The ARC requirement is met.

**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:** FA

The 'Restraint /Enabler Pre Assessment/Questionnaire/Consent Form' identifies key relevant aspects of this standard, and is completed for residents using restraint and enablers, sighted in the residents' files reviewed. Assessments are undertaken by the RN with the resident and their family.

The ARC requirement is met.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

The restraint assessment identifies that the key relevant aspects of this standard is included in any assessment of restraint. There is an assessment process and it includes consultation with the resident and family. A restraint register in maintained that records all restraint and enabler users.

Monitoring forms reviewed provide evidence that residents using restraint are monitored on a regular basis, information is recorded on the monitoring form.

ARC requirement is met.

**Criterion 2.2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:**

(a) Only as a last resort to maintain the safety of consumers, service providers or others;

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

(d) When the environment is appropriate and safe for successful initiation;

(e) When adequate resources are assembled to ensure safe initiation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:**

(a) Details of the reasons for initiating the restraint, including the desired outcome;

(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

(c) Details of any advocacy/support offered, provided or facilitated;

(d) The outcome of the restraint;

(e) Any injury to any person as a result of the use of restraint;

(f) Observations and monitoring of the consumer during the restraint;

(g) Comments resulting from the evaluation of the restraint.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

Restraint evaluation processes are documented in the restraint minimisation and safe practice policy. The residents' files evidence that each episode of restraint is being reviewed monthly by the restraint co coordinator and evaluated at least six monthly, and more often based on the risk of the restraint being used.

Restraint practices are discussed at restraint meetings, which is part of the quality/staff meetings. Restraint is also reviewed as part of the six monthly care plan evaluation, and multidisciplinary reviews, sighted in residents' files.

The ARC requirement is met.

**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:**

**Criterion 2.2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n 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

Approved restraint for each resident is reviewed at least monthly, and as part of their care plan review, and multidisciplinary review. These reviews are completed with family and resident involvement.

Restraint usage across the facility is monitored and discussed at the restraint/quality/staff meetings, minutes sighted. A restraint minimisation and safe practice audit was completed May 2013.

The ARC requirement is met.

**Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:**

(a) The extent of restraint use and any trends;

(b) The organisation's progress in reducing restraint;

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

(g) Whether changes to policy, procedures, or guidelines are required; and

(h) Whether there are additional education or training needs or changes required to existing education.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

Trinity has infection control management systems along with infection control policies and procedures to guide staff on all matters relating to infection control. The infection control (IC) policies and procedures meet the needs of the organisation and provide information and resources to inform the staff on infection prevention and control. The facility uses the 'Bug Control NZ Infection Prevention and Control Manual 2013'. Care staff interviewed confirm the infection control policies and procedures provide them with adequate guidance. The 'Infection Control Review and Plan 2013' was reviewed in January 2013. The infection control co coordinators are the Clinical Nurse Leader and a senior RN. The senior RN is responsible for the collection and analysis of data.. The Resource Manager is responsible for graphing the data. The 'Infection Control Statistics Report' is presented at the monthly quality/staff meetings. The delegation of infection control matters throughout the organization is clearly documented along with an infection control Co-ordinator job description. The infection control co-ordinator states the local DHB provides advice. Quality indicators are also presented to the governing body. Observation provides evidence staff provide infection management precautions.

ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control programme meets the needs of the organisation and provides information and resources to inform and guide staff. The IC Co-ordinators (Clinical Nurse Leader and senior RN are qualified health professionals with the relevant skills and resources necessary to achieve the requirements of this standard. RNs interviews report they are able to access lab personnel, GPs and other health care professionals for infection control matters, as required. Management and staff have access to relevant and current information, which is appropriate to the size and complexity of the organization. The IC Co-ordinators attended external education ('Starting out in Infection Control') on the 14 October 2013, provided by an infection control nurse educator.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

Policies and procedures on the prevention and control of infection include written material that is relevant to the organisation and reflects current accepted good practice and relevant legislative requirements. Policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel. Policies and procedures are developed and reviewed regularly in consultation with relevant service providers and identify links to other documentation in the organisation e.g. health & safety, quality and risk. The 'Bug Control NZ Infection Prevention and Control Manual 2013' is used. Staff interviewed confirm infection control policies and procedures are freely available for them.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control coordinators attended on going education provided by an infection control nurse educator on the 14 October 2013. Education is provided to new staff as part of their initial orientation. The Clinical Nurse Leader reports residents are educated in infection control matters on a as need basis. One resident in the rest home when interviewed reports they had had an infection in their wound and had been on antibiotics. Care staff interviewed state they receive one to one education from the RNs and have had hand washing competencies assessed. Infection control and prevention education last provided 30 May 2013.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

The Infection Control programme details surveillance processes, including surveillance objectives, priorities and methods at a level of detail relevant to the service setting and its complexity. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. The IC Co-ordinator (senior RN) completes an 'Infection Control Statistics Report' with relevant data that includes clinical indicators, and presents this to staff at the combined monthly quality and staff meetings, minutes sighted. Clinical indicators are also made available to the governing body. Care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, and daily handovers. Audits are undertaken on a regular basis, last completed May 2013.

**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:**