

Kamo Home & Village Charitable Trust

CURRENT STATUS: 22-Oct-13

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

GENERAL OVERVIEW

A partial provisional audit is undertaken at Kamo Home and Village to ensure the services preparedness to add hospital level of care beds to the service. The service plans to reconfigure the service to add a potential of 25 beds that can be used for either rest home or hospital level of care. The service has the available staff for the increased requirements of hospital level of care.

At the previous certification audit there were four areas required for improvement in the continuum of care standards. At this audit there is evidence that these have been addressed and have been areas of improvement implemented since the certification audit. There is one new area requiring improvement from this audit, to ensure the three monthly medicine reviews are consistently recorded on the medicine chart.

Kamo Home and Village

Kamo Home and Village Charitable Trust

Partial provisional audit - Audit Report

Audit Date: 22-Oct-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RN, B.Nursing, RABQSA lead auditor qualifications	4.00	4.00	22-Oct-13
Auditor 1					
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX	RN,MBA, NZQA 8086		1.00	

Total Audit Hours on site	4.00	Total Audit Hours off site <i>(system generated)</i>	5.00	Total Audit Hours	9.00
Staff Records Reviewed	7 of 75	Client Records Reviewed <i>(numeric)</i>	7 of 62	Number of Client Records Reviewed using Tracer	0 of 7

				Methodology	
Staff Interviewed	6 of 75	Management Interviewed <i>(numeric)</i>	1 of 4	Relatives Interviewed <i>(numeric)</i>	3
Consumers Interviewed	3 of 62	Number of Medication Records Reviewed	14 of 62	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	0

Declaration

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

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

Dated this 08 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

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified													
				Hospital Care							Rest Home Care		Residential Disability Care				
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability	
Kamo Home and Village	71	62	25	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

A partial provisional audit is undertaken at Kamo Home and Village to ensure the services preparedness to add hospital level of care beds to the service. The service plans to reconfigure the service to add a potential of 25 beds that can be used for either rest home or hospital level of care. The service has the available staff for the increased requirements of hospital level of care.

At the previous certification audit there were four areas required for improvement in the continuum of care standards. At this audit there is evidence that these have been addressed and have been areas of improvement implemented since the certification audit. There is one new area requiring improvement from this audit, to ensure the three monthly medicine reviews are consistently recorded on the medicine chart.

1.1 Consumer Rights

Not applicable to this audit.

1.2 Organisational Management

The service is managed to meet the needs of residents requiring rest home, specialist dementia care and the potential for hospital level of care. The service is suitably managed by the general manager who is a registered nurse. The general manager is supported by a clinical management team. The staffing for the proposed hospital level of care is based on safe staffing guidelines for aged care, with the service already commencing registered nurse coverage 24 hours a day. The service has commenced the training of staff for anticipated increased needs of residents at hospital level of care.

1.3 Continuum of Service Delivery

Staff are assessed as competent to perform medicine management. Safe medicine administration and storage of medicines is observed at the time of audit. The previous areas for improvement to ensure there is a consistent process for recording specimen signatures for the staff is now addressed and an improvement implemented since the last certification audit. There is one new area of required improvement to ensure the review of medicines is consistently recorded three monthly.

The kitchen does not need to make any changes to cater for the proposed increase needs of residents at hospital level of care. The kitchen service can meet the needs of residents with special and modified diets and access specialised feeding equipment to meet the residents' needs. The previous area for improvement identified to ensure the labelling of food is now addressed.

1.4 Safe and Appropriate Environment

Kamo Home is currently in the final stages of completing the refurbishment of the Sheila Mason House (previously named Alice Court) to meet the needs of the residents at either rest home or hospital level of care. The service also has 10 studio apartments, that are in the same building as the rest home, that are suitable for providing 'aging in place' services (hospital level of care) to the residents in the studio apartments.

There is a current building warrant of fitness and a certificate for public use for the refurbishment of Sheila Mason House. The evacuation plan remains current and is approved by the fire service.

There are documented processes for the management of waste and hazardous substances in place. Visual inspection evidences compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. A visual inspection evidences compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals.

The refurbished rooms in the Sheila Mason House wing of the facility are of a large size to have adequate access and space for the needs of the residents at hospital level of care. The studio apartments in Tuatara Court all have ensuite bathrooms and are of a suitable size for hospital level of care. Visual inspection evidences all buildings, plant and equipment complies with legislation. The previous area for improvement required in relation to safe hot water temperatures for residents is now addressed. There is a previous area for improvement related to the bathrooms in this wing, this is now addressed, with all bathrooms in the Sheila Mason House wing of the service being refurbished to provide additional space and hygiene services that can be easily cleaned to comply with infection control guidelines.

At the time of audit the refurbishment of the Sheila Mason House is yet to be fully furnished, decorated or landscaped. The studio apartments are currently of a suitable size and layout for the needs of residents, staff, equipment and furnishings for hospital level of care. Documented systems are in place for essential, emergency and security services including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Visual inspection of the refurbishment and extension evidences alternative energy and utility sources are maintained, an appropriate call bell system is available and security systems are in place.

2 Restraint Minimisation and Safe Practice

Not applicable to this audit.

3. Infection Prevention and Control

There are no additional changes required to the infection prevention and control policies and procedures for the reconfiguration of the service. The documented policies and procedures are in place for the prevention of infection and reflect current accepted good practice and legislative requirements to minimise the risk of infection to patients, staff and visitors.

Summary of Attainment

1.1 Consumer Rights

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

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

1.2 Organisational Management

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

Organisational Management Standards (of 7):	N/A:3	CI:0	FA: 4	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 34):	CI:0	FA:8	PA:0	UA:0	NA: 0		

1.3 Continuum of Service Delivery

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

Continuum of Service Delivery Standards (of 12):	N/A:9	CI:0	FA: 2	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:7	PA:1	UA:0	NA: 1		

1.4 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

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								

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	Not Applicable	0	0	0	0	0	6
Standard 2.2.1	Restraint approval and processes	Not Applicable	0	0	0	0	0	3
Standard 2.2.2	Assessment	Not Applicable	0	0	0	0	0	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	0	6
Standard 2.2.4	Evaluation	Not Applicable	0	0	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	0	1

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

3 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	Not Applicable	0	0	0	0	0	4
Standard 3.3	Policies and procedures	Not Applicable	0	0	0	0	0	3
Standard 3.4	Education	Not Applicable	0	0	0	0	0	5
Standard 3.5	Surveillance	Not Applicable	0	0	0	0	0	8

Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0
 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0

Criteria (of 29): CI:0 FA:3 PA:0 UA:0 NA: 0

Total Standards (of 50) N/A: 34 CI: 0 FA: 15 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
Total Criteria (of 219) CI: 0 FA: 35 PA: 1 UA: 0 N/A: 1

Corrective Action Requests (CAR) Report

Provider Name: Kamo Home and Village Charitable Trust

Type of Audit: Partial provisional audit

Date(s) of Audit Report: Start Date:22-Oct-13 End Date: 22-Oct-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.3.12	1.3.12.1	PA Low	Finding: Three of the 14 medicine charts sighted are overdue for GP review of medicines. Action: Ensure the GP review of the medicines is consistently recorded three monthly.	3 months.

Continuous Improvement (CI) Report

Provider Name: Kamo Home and Village Charitable Trust

Type of Audit: Partial provisional audit

Date(s) of Audit Report: Start Date:22-Oct-13 End Date: 22-Oct-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.2 ORGANISATIONAL MANAGEMENT

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

STANDARD 1.2.1 Governance

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The services are planned and coordinated to meet the needs of the residents requiring rest home, specialised dementia care and the addition of hospital level of care. The mission, vision, values, philosophy and purpose are clearly shown. The business plan, which shows short and medium term strategies, is in place to achieve set goals and mitigate known risk to all areas of service delivery. The focus for 2013 and 2014 sighted includes goals in service provision, human resources and the environment. The focus for service provision includes the implementation and integration of the interRAI assessments into the clinical care process. Organisational performance is monitored against identified values, goals and purpose through the Board of Trustees. Strengths, risks and opportunities are clearly identified. Key performance indicators are developed to match the business plan and reported and measured as identified on the balance score card and external benchmarking (results sighted).

The general manager is a registered nurse (RN) who has been in the role for over three years. The job description identifies the level of authority, accountability and responsibility for the provision of service (personnel file sighted). The general manager's role is supported by a management team of four (the accounts manager, the quality manager, the clinical manager and the support services manager). The general manager maintains both clinical and business management skills through on-going education which is well documented in the training file. Examples sighted for the past year include manual handling, cardio-pulmonary resuscitation, business excellence assessor training and holding the required level of expertise in the professional development recognition programme through the District Health Board (DHB). The general manager has in excess of eight hours education in the management of aged care service in the past 12 months. The general manager maintains a Professional Development and Recognition Programme (PDRP) with the Northland District Health Board (sighted).

The Aged Related Residential Care (ARRC) service agreement 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

The day to day operations of the service are managed in an effective manner to ensure the needs of the residents at current rest home level of care (which includes specialised dementia services) are met. The service has adequate planning and procedures in place to meet the needs of the potential residents at hospital level of care. As sighted in the organisation's focus for 2013/2014 the service has strengthened the provision of care with a 'comprehensive individualised care plan' by implementing tracer methodology to ensure the assessment outcomes are robust and linked to care plan outcomes.

During temporary absences of the general manager the clinical care manager performs the role of the general manager (job description sighted). The clinical care manager (RN) has extensive experience in generalist and aged care nursing (confirmed in review of personnel file). The staff records for the general manager, clinical nurse and RN who will provide the provision of services to the hospital level of residents, confirms the skills, knowledge and experience are maintained to meet the needs of residents at hospital level of care. The RN and senior caregiver interviewed report they feel confident that the service is able to meet the needs of residents at hospital level of care. One resident, who is a current rest home level of care resident in one of the studio apartments, reports that they receive excellent care, and states that if their condition deteriorates, they would wish to stay in the studio apartment. The ARRC requirements 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 1.2.7 Human Resource Management

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

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

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

How is achievement of this standard met or not met?	Attainment: FA
<p>The professional qualifications, including evidence of annual practising certificates and scope of practice are sighted for all staff that require them. A copy of the annual practising certificate (APC) is sighted in the three RNs files reviewed (including the general manager), with an electronic record maintained of when the APC requires renewing.</p> <p>The eight staff files reviewed (the general manager (RN), two other RNs, four caregivers and one cook) evidence appropriate recurrent and on-going performance reviews to ensure staff safety training meets the needs of the residents. The eight of eight staff files reviewed evidence an orientation to the essential components of the service, which is also confirmed at interview with two RNs, two caregivers and one cook. The induction process for the care staff include competency assessments. The competency assessment assesses the staff to varying levels, (eg, requires supervision with the task, can perform on their own or can perform and also support/guide others in the task). All the care staff personnel files (two RNs and four caregivers) reviewed indicated they</p>	

are able to perform their role independently or can perform the role and support others in their performance. The personal file reviewed of the kitchen assistant includes an induction checklist that covers the key components of the service and kitchen services.

The education calendar and individual staff members education records include the required education and training for the care staff. The education topics include manual handling, restraint minimisation, challenging behaviours, wound care, first aid and CPR, care planning and assessment skills, communication, falls management, specific medical conditions and caregiver and RN competencies. The service also accesses on-going education through the DHB. The two RNs and two caregivers report that they have had on-going training to prepare for the increased needs of residents at hospital level of care (eg, hoist, manual handling) and feel confident that they are prepared to meet the needs of residents at hospital level of care.

The ARRC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

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

Audit Evidence	Attainment: 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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
The roster reconciliation system is based on indicators for safe aged care. The general manager reports that this is reviewed weekly for the minimum staffing levels. The current roster sighted for the rest home services (including the specialist dementia unit) indicates a surplus of 120 care staffing hours. The	

manager reports that the current surplus of care hours is to prepare for the hospital level of care and have already introduced 24 hour a day RN coverage. The general manager reports they have already recruited for the extra hours and plan to increase the shift times for the current caregivers and RNs in preparation to ensure the increased needs of the residents at hospital level of care. The general manager reports that safe staffing guidelines will be used to ensure the recommended RN and caregiving hours are used as a basis for the staffing when hospital level of care is added to the scope of the service delivery. The general manager reports that these are minimum staffing levels and that the service has the flexibility and staff to increase staffing to meet any additional needs of the residents. The general manager reports that the plan is to gradually increase to hospital level of care beds/residents.

The current staffing levels sighted in the current rosters (for 19 residents in the dementia unit and 43 residents in the rest home section). A review of four weeks rosters identify that both the dementia unit and the rest home are staffed to ensure there is a skill mix and sufficient numbers of staff to meet residents' needs. All sick leave and annual leave is shown and replacement staff noted. The current staffing for the 43 residents in the rest home wings (which includes the studio apartments) is:

morning shift: one RN, one senior caregiver and six caregivers

afternoon shift: one RN, one senior caregiver and four caregivers

night shift: one RN and three caregivers.

In addition to the above rest home wing staffing the secure dementia unit has the following allocations:

morning shift : one RN five days a week and three caregivers seven days a week

afternoon shift: two caregivers in the dementia unit

night shift: one dedicated caregiver in the dementia unit.

The clinical management team are onsite during week days. There are adequate diversional therapy and housekeeping staff to meet the residents' needs. Interviews with two RNs and two caregivers confirm that they have sufficient time to complete all tasks to meet resident needs. Interviews with three of three residents and three of three family/whanau members confirm they are very happy with service provision and that staff always respond to the call bell within an appropriate time frame.

ARRC 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:

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 1.3.5 Planning

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The previous CAR at 1.3.5.2 is raised to provide evidence that the required support identified by the on-going assessment process is reflected within care planning documents. This is now addressed and an improvement implemented since the last audit.

The seven of seven residents' files reviewed (five rest home and two dementia) evidence care plans that reflect the resident's individual needs. The file sighted for the two residents living in the dementia unit, record behaviour assessments and interventions for the assessed needs over the 24 hour period. All seven of the seven care plans sight have care plans that contain the issue/need, summary of the assessment, preferred care goals and interventions, and the evaluation. One of the rest home resident's file reviewed has a temporary (short term) care plan for an infection.

The three of three residents and three of three family report that the residents receive services that meet their assessed needs. All spoke highly of the quality care they, or their relative, receives.

The ARRC 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:

STANDARD 1.3.12 Medicine Management

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

A previous CAR at 1.12.3 is raised to ensure all staff that are responsible for medicine management have a current competency recorded. There is also a previous CAR at 1.3.12.6 to provide evidence of specimen signatures for both GPs and staff are maintained in a consistent manner. Both of these are now addressed and improvements implemented since the last audit.

Medicines for residents are received from the pharmacy in the robotic sachet delivery system. The signing sheet that records the sachets are checked for accuracy against the resident's medicine chart. A safe system for medicine management is observed on the day of audit (RN with medicine competency administering medicines at the time of audit).

Medicines are stored in locked medicine treatment rooms. The temperature of the medicine fridge is monitored daily and is within recommended guidelines. Controlled drugs are stored in a safe in a locked cupboard in the locked treatment room. The controlled drugs are checked out by two staff and there is a weekly stocktake recorded in the controlled drug register.

The service does not currently use standing orders.

All 14 of the 14 medicine charts reviewed have all recorded medicines ordered containing the date, signature of the prescriber, medicine name, dose, time and route of administration. The 14 of 14 medicine signing sheets are fully completed on the administration of medicines for the past four weeks. Eleven of the 14 medicine charts record the three monthly GP review of the medicines. (Refer to CAR at 1.3.12.1).

There are documented competencies sighted for the staff designated as responsible for medicine management.

There is one resident assessed as competent to self-administer some of their medicines (inhalers). The resident has a self-administration competency in their file (reviewed by the RN and GP). The medicines are securely stored in the resident's room.

The ARRC requirements related to medicine management 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: PA

Risk level for PA/UA: Low

The 11 of 14 medicine charts reviewed are reviewed by the GP in the last three months, this is recorded on the medicine chart. The remaining three files have the last recorded medicine review in June 2013. These three residents are on the GP's list for review on 23 October 2013. A corrective action is required to ensure the GP review of medicines is consistently recorded three monthly.

Finding Statement

Three of the 14 medicine charts sighted are overdue for GP review of medicines.

Corrective Action Required:

Ensure the GP review of the medicines is consistently recorded three monthly.

Timeframe:

3 months.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There was a previous CAR to ensure all aspects of food legislation and guidelines are met. The previous certification audit identified that not all decanted food is dated or shows expiry dates. This is now addressed and an improvement implemented since the last certification audit.

The service has a four week rotating menu with summer and winter variations. The summer menu is reviewed in November 2011 using the NZ dietetics tool for the older person living in long term facilities. The cook and general manager report that the menu is currently under review by a dietitian and they have not yet received the review back from the dietitian at the time of audit.

A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. A copy of each resident's nutritional profile is kept in the kitchen. Until the kitchen staff get to know new resident's needs, the nutritional profile is kept on display before filing in a folder. As observed at the time of audit, residents are informed of the items on the menu for that day and asked what option they would prefer. The cook also has a copy of any dietitian review and gave an example of a resident who is on a high calorie and high protein diet to increase weight. The cook reports that there are a number of residents who currently require texture modified and specialist diets. The cook reports that the service is prepared to meet any additional nutritional needs of residents at hospital level of care.

Interviews with three of three residents and three of three family/whanau confirm they are happy overall with the food and fluids provided.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. The service has a Hazard Analysis Critical Control Points (HACCP) food safety plan. Fridge and freezer recordings are undertaken daily and meet requirements. The kitchen staff have undertaken food safety management education appropriate to service delivery. There was an area identified at the certification audit to ensuring all decanted food products have an expiry date. This is now addressed and an area of improvement since the last audit.

ARRC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

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

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

STANDARD 1.4.1 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

Hazardous substances are disposed of in an environmentally safe way in accordance with the safety data sheet instructions. Procedures, which are cross referenced to infection control, identify that all incidents are reported, recorded, investigated and reviewed. There is a documented procedure in place as part of the emergency plan that identifies the response to significant waste or hazardous substances. Service providers involved in the management of hazardous substances receive appropriate education to handle substances safely. Appropriate personal protective equipment (PPE) is sighted. Staff are observed using PPE appropriately at the time of audit.

ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
The certificate of public use for Sheila Mason House expires in November 2013. The current building warrant of fitness expires on 1 June 2014.	

The facility and all equipment is well maintained and a schedule of preventative maintenance, electrical safety checks and or calibration is maintained. The electrical safety checks undertaken in February 2013 includes medical equipment. Sanitizers and the washing machine are checked by the preferred external service provider for temperature accuracy and compliance with manufacturer's instructions, last conducted in February 2013.

Both Sheila Mason House (previously Alice Court) and Tuatara Court (the wing in which the studio apartments are located) have an appropriate environment for hospital level of care. The physical environment promotes safe mobility and resident independence by ensuring furnishings are in good condition and that clear walkways are maintained. The corridors have secure handrails. The refurbishment of two of the rooms and the disability bathroom in the Sheila Mason wing are not yet finalised at the time of audit. There are no renovations or refurbishments required to Tuatara Court to meet the needs of residents at hospital level of care.

The ARRC 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

There is a previous CAR at 1.4.3.1 to ensure all toilets and shower facilities are maintained to meet infection control requirements. All the bathrooms in the refurbishment include ensuring that the previous bathrooms have surfaces that comply with infection control cleaning requirements. This is an area of improvement since the last certification audit.

The Sheila Mason wing has three toilets and three showers for 15 residents, with one shared bathrooms that has enough space for a bath/shower trolley. All the 10 rooms in Tuatara Court have an ensuite shower, toilets and basins, with one additional disability access shared bathroom. The bathrooms and toilets have appropriate locks and systems to ensure privacy of use.

The sighted hot water temperatures are checked regularly, with the temperatures sighted for 2013 below 45 degree Celsius in resident areas.

ARRC 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

All the bedrooms in Sheila Mason House and Tuatara Court provide adequate space for residents at either rest home or hospital level of care. All bedroom areas are large and allow for adequate personal space for residents with mobility aids. The layout and proposed staffing for residents assessed at hospital level of care, in both the Sheila Mason House (the wing previously named Alice Court) and Tuatara Court, provide adequate space and facilities to meet the needs of the residents.

ARRC 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 manoeuvre 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

There is an adequately sized lounge area in Sheila Mason House. The separate dining area is located in the main rest home facility. All areas are spacious with natural light and easy flow of access. There is a library, several small rooms that can be used for quiet rooms, and a very large lounge area that is used for recreation. There is a separate indoor bowls area off one end of the lounge in the rest home section. All residents have access to the recreational facilities.

ARRC 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

The organisation has dedicated housekeeping staff. The facility has one laundry. Clean and dirty areas are clearly defined. The laundry uses a closed circuit chemical dispensing system. Cleaning and laundry chemicals are safely stored and labelled. Material data sheets are sighted. The general manager reports the methods, frequency and materials are monitored for effectiveness. Satisfaction with cleaning and laundry services is monitored through the annual satisfaction survey and informal feedback from residents and family/whanau.

The ARRC 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

Emergency flip charts are located at the entrance to the facility. Both the Sheila Mason House and Tuatara Court have fire smoke detectors, alarms, sprinkler system and smoke and fire doors which close automatically to form separate fire cells when the alarm goes off. A new fire cell/fire doors are still in the process of being installed in Sheila Mason House at the time of audit. The fire equipment is tested as required to meet building warrant of fitness requirements and annual testing of equipment occurred in May 2013. The service conducts six monthly trial evacuation drills.

The facility's emergency evacuation plan sighted was approved by the New Zealand Fire Service in 8 September 2008. The service has an email dated 8 July 2013 that indicates that the plan dated September 2008 remains current.

The service has procedures in place in case of either a gas, electric or both failures. As confirmed by the cook and the general manager, there is at least three days food stored on hand and water is collected in outdoor tanks that can be used in case of an emergency. There is emergency lighting for up to two hours if required. Staff have access to torches and backup batteries. There is an emergency call bell system for staff or residents to use which alerts an external security agency. Security procedures are clearly set out in policy.

There is a call bell system in both Sheila Mason House and Tuatara Court. There are call bell outlets in the four new bedrooms. The call bell system includes an audible call bell alarm and a visual display of the room number is shown at the nurses' station and on ceiling lighting.

ARRC 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

The facility has adequate natural light, heating and ventilation. The facility is at a comfortable temperature on the day of audit. All rooms are centrally heated and the resident can ask the maintenance officer to adjust their room temperature to meet their needs. All resident areas have at least one opening window to allow fresh air. All the rooms in Tuatara Court have sliding doors that allow for adequate natural light and ventilation.

ARRC 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:

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

STANDARD 3.1 Infection control management

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

The infection control co-ordinator has a current position description (sighted) which has clear guidelines for the accountability and responsibility in the infection control manual. The infection control co-ordinator monitors for infections, uses standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. There is a monthly infection control committee meeting, with the results communicated to staff through staff meeting and results posted on the notice board. Residents with infections are reported to staff at handover, on the alert sheet and documented in the progress notes. If there is an infectious outbreak this is reported immediately to staff, management, and where required, to the DHB and public health departments.

The infection control programme is reviewed monthly through the balance score card monitoring and monthly infection control committee. The review includes how the service has met the goals and objectives of the programme, the surveillance programme, education and training, internal audits, environmental inspection and policies and procedures. When the goals are not met, this is alerted through the balance score card results.

A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at entrances. Staff policy and notices in the staff room state not to come to work when suffering from infectious diseases. When outbreaks are identified in the community, notices are placed at the entrance not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are encouraged to stay in their rooms if required.

The two RNs and two caregivers interviewed are able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing.

The ARRC requirements are 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: