

Bethesda Care Limited

CURRENT STATUS: 22-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

Bethesda Care is a hospital and rest home community owned and operated by the Seventh-day Adventist Church. Bethesda Care is a not for profit organisation with 72 beds in 68 rooms. On the days of audit there are 34 rest home and 36 hospital level residents. All beds can be used for either rest home or hospital residents.

The Chief Executive Officer oversees all services, including a village area, which is not part of this audit. Care services are overseen by the Director of Nursing (PhD Nursing) and she is supported by a Clinical Charge Nurse (CCN) who is a registered nurse.

A number of improvement have been made to the service since the previous audit resulting in six areas being rated as continuous improvements (beyond that normally expected). These relate to management of quality and incident/accident data and assessment, planning, delivery and documentation of care.

There are no areas identified for improvement from this certification audit.

AUDIT SUMMARY AS AT 22-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

Indicator	Description	Definition
	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

Consumer Rights	Day of Audit 22-Oct-13	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained

Organisational Management	Day of Audit 22-Oct-13	Assessment
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained

Continuum of Service Delivery	Day of Audit 22-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.		All standards applicable to this service fully attained with some standards exceeded

Safe and Appropriate Environment	Day of Audit 22-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

Restraint Minimisation and Safe Practice	Day of Audit 22-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

Infection Prevention and Control	Day of Audit 22-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 22-OCT-13

Consumer Rights

The residents and families interviewed report that residents' rights are respected during service delivery. They express high praise for the friendliness and caring nature of the staff and that the residents' independence is maximised and encouraged, their personal privacy is maintained and they are treated with dignity and respect. The residents, family, staff and general practitioner interviewed have no concerns in relation to any forms of discrimination within the service. As observed at the onsite audit, residents receive services that uphold their rights. Information is provided on admission and displayed throughout the facility regarding residents' rights and access to advocacy services. Staff demonstrate understanding of their obligations regarding residents' rights and how to incorporate this knowledge into their day-to-day practices and interactions with residents and family.

The service has appropriate policies and procedures to ensure the recognition of Maori values and beliefs. The service provides care that recognises and respects the resident's individual culture, values and beliefs.

The service has an easily accessed and responsive complaints management system which is understood by staff, residents and family/whanau members. All complaints are documented and outcomes include corrective action management as appropriate to improve service delivery. There are no outstanding complaints at the time of audit.

Organisational Management

The organisation's purpose, values, and goals are clearly set out in the Business Management and Quality and Risk Management plans which are reviewed and updated annually. The plans identify strategies used to ensure that planning is co-ordinated to meet

the needs of residents. Planning incorporates the Eden Alternative principles which are embedded into everyday practice at the facility.

The day to day operation of the facility is undertaken by staff who are appropriately experienced and qualified. This allows residents' needs to be met in an effective, efficient and timely manner as confirmed during resident and family/whanau interviews and in the 2013 Eden resident satisfaction survey results.

Documented quality and risk management systems are implemented to assist residents, visitors and staff safety. Systems in place to measure the quality of service, include regular audits, benchmarking of collected data and ensuring corrective action planning is monitored for appropriate outcomes. Quality improvement data management and accident/incident reporting have gained a continuous improvement rating (above that normally expected) as the service can clearly demonstrate a review process which includes analysis and reporting of findings related to the actions taken that have improved service provision.

Human resources management processes implemented reflect current good practice and meet legislative requirements. Staff members knowledge and skills are maintained through on-going education which is appropriate to their role. The service implements safe staffing levels and skill mix to ensure contractual requirements and resident safety is maintained.

Resident information is uniquely identifiable, accurately recorded, up to date and securely stored. It is accessible to staff when required.

Continuum of Service Delivery

The residents` records reviewed provide evidence that all residents have been assessed appropriately prior to admission to the facility by the needs assessment service co-ordinators for the Counties Manukau District Health Board. The provider has comprehensive well implemented systems to assess, plan and evaluate the care needs of the residents. The residents` needs, outcomes and/or goals have been identified and these are reviewed on a regular basis with family input. A team approach to care delivery and continuity of service delivery is encouraged and promoted at all times. Continuous improvement ratings have been awarded for the comprehensive assessment processes adopted by this service provider and for the high level of care planning, documentation and timeliness of evaluations during all stages of service delivery.

Medication management is safely implemented. A visual inspection of the medication systems and the lunchtime medication round evidences compliance with respective legislative requirements, regulations and guidelines. There is evidence of the general practitioners reviewing medication records three monthly, or more often as required. The pharmacy audits, inclusive of controlled drug management, occurs six monthly and is conducted by the contracted pharmacist.

Food services are managed and contracted by Spotless Ltd. The service is managed by an experienced cook and Spotless supervisors are responsible for the training and performance monitoring of the staff. The menus are documented and displayed each day. The tables are decorated with colourful placemats made by the residents. The individual dietary needs, identified during the assessment process for each resident on admission, are addressed and

choices provided. Special diets can be arranged and dietitian input is clearly evidenced. Meals are provided at appropriate times of the day.

The activities programme is provided and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are meaningful and the programme is developed and implemented to ensure the interests of residents are included. The contracted occupational therapist develops the programme and the activities co-ordinator implements the programme. Outings in the community are arranged and entertainers from the community are very welcome to participate in the programme.

Safe and Appropriate Environment

The service has a documented emergency and pandemic response plan. These plans will be implemented as required. Processes are in place to prevent residents, visitors and staff from any harm as a result of exposure to waste or infectious substances generated during service delivery. Fire evacuations and education on managing in an emergency is undertaken as part of new staff orientation and ongoing education. The building has a current building warrant of fitness and the service has an approved fire evacuation plan. Regular checks are undertaken for environmental, electrical, hot water and ongoing maintenance, to ensure safety is maintained for all users of the service.

The facilities are fit for purpose and provide furnishings and equipment that are appropriately maintained to meet residents' needs. There are four double bedrooms for couples, two are currently occupied by couples and two are single occupancy. For this reason the service classifies itself as being full with 70 residents. All bedrooms are large enough to allow residents to move around safely with or without assistance. They all have double doors to allow ease of furniture and equipment movement. There is a chapel which is well used on a daily basis.

There are adequate numbers of toilet, hand washing facilities, and bathrooms to meet all residents' needs. Shower areas are centrally located. The dining and lounge areas meet residents' relaxation, activity and dining needs.

The facility is centrally heated and heat pumps are planned to be added. The facility is ventilated through opening doors and windows. There are appropriate outdoor areas that have seating and are sheltered for residents' use.

Restraint Minimisation and Safe Practice

The service has two bedside rails in use, which are enablers, and no restraint. The service can demonstrate how they are reducing enabler use by using alternative methods, such as low beds. Enablers have reduced from eight in April 2013 to two in October 2013. There are policies and procedures to guide staff actions should restraint be required. Information from a pre-audit document review has been left in the report although no restraint is in use. Appropriate staff education is undertaken annually to ensure they understand safe restraint use. Policy clearly describes enablers as voluntary and the least restrictive option.

Infection Prevention and Control

Bethesda Care has infection prevention and control policies and procedures relevant to the levels of care provided. The Director of Nursing, who is highly qualified to perform this role,

is responsible for the infection prevention and control programme, and is supported by the registered nurses. Surveillance is appropriate for this care setting and size of the organisation. Infection prevention and control benchmarking with other like organisations occurs through the service contracting to a service who collates all of the infection control data for this purpose. A summary of feedback is received and this is reported to the Bethesda Care Board. The infection control programme is integrated as part of the quality and risk system and staff receive feedback at their meetings. The in-service education and orientation programmes include training in infection prevention and control. There have been no reported infection outbreaks for this service. Outbreak management is well documented and would be managed in a professional way should this occur.

Bethesda Care
Bethesda Care Limited

Certification audit - Audit Report
Audit Date: 22-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Bethesda Care Limited
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Premise Name	Street Address	Suburb	City
Bethesda Care	743 Great South Road	Manukau	Auckland

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

Type of Audit	Certification audit and (<i>if applicable</i>)	
Date(s) of Audit	Start Date: 22-Oct-13	End Date: 23-Oct-13
Designated Auditing Agency	The DAA Group Limited	

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXX	RCN, BA, Lead Auditor 8086	16.00	8.00	22-Oct-13 to 23-Oct-13
Auditor 1	XXXXXXX	RN, RM Dip HSM, PG Cert Neurosurgical nursing, NZQA 8086	16.00	8.00	22-Oct-13 to 23-Oct-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXX	RN,MBA,NZQA US 8086		4.00	

Total Audit Hours on site	32	Total Audit Hours off site (system generated)	20	Total Audit Hours	52
Staff Records Reviewed	9 of 70	Client Records Reviewed (numeric)	9 of 70	Number of Client Records Reviewed using Tracer Methodology	2 of 9
Staff Interviewed	10 of 70	Management Interviewed (numeric)	6 of 6	Relatives Interviewed (numeric)	6
Consumers Interviewed	7 of 70	Number of Medication Records Reviewed	18 of 70	GP's Interviewed (aged residential care and residential)	1

				disability) (<i>numeric</i>)	
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Declaration

I, (full name of agent or employee of the company) XXXXXXXX (occupation) Managing 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 19th 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					Kinds of services certified										
	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care		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	
Bethesda Care	72	70	72	<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

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1.2 Organisational Management

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2 Restraint Minimisation and Safe Practice

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Summary of Attainment

1.1 Consumer Rights

		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 1.1.6	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

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

1.2 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	FA	1	7	0	0	0	9
Standard 1.2.4	Adverse event reporting	FA	1	1	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	FA	0	4	0	0	0	10

Organisational Management Standards (of 7): N/A:0 CI:0 FA: 7 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:2 FA:20 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	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	CI	3	0	0	0	0	6
Standard 1.3.4	Assessment	CI	1	0	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 1.3.12	Medicine management	FA	0	4	0	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:0 CI:2 FA: 10 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 51): CI:4 FA:17 PA:0 UA:0 NA: 0

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	FA	0	1	0	0	0	6
Standard 2.2.1	Restraint approval and processes	Not Applicable	0	0	0	0	0	3
Standard 2.2.2	Assessment	Not Applicable	0	0	0	0	0	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	0	6
Standard 2.2.4	Evaluation	Not Applicable	0	0	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	0	1

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

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: 5	CI: 2	FA: 43	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					
Total Criteria (of 219)	CI: 6	FA: 87	PA: 0	UA: 0	N/A: 0				

Corrective Action Requests (CAR) Report

Provider Name: Bethesda Care Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date: 22-Oct-13 End Date: 23-Oct-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

Continuous Improvement (CI) Report

Provider Name: Bethesda Care Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date: 22-Oct-13 End Date: 23-Oct-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

Std	Criteria	Evidence
1.2.3	1.2.3.6	<p>Finding:</p> <p>Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis process of all quality data which is gathered from key components of service which is benchmarked against previously collected data from both internal and by outside agencies. Corrective planning is monitored for effective outcomes. Many corrective actions are written up as ongoing projects, such as the laundry/linen project. Educational material includes written and pictorial evidence which was presented to staff so they gained a full understanding and allowed staff involvement in the purchase and use of new triple bag linen trolleys. (Blue for towels, red for sheets and white for personal clothing). The project included the contracted laundry staff. Following the introduction of the linen trolleys, staff completed evaluation about how well the new trolleys were working and the results are written up and shared with management and the Board. This has improved the service provision for residents and assists both care and laundry staff in the management of soiled linen.</p>
1.2.4	1.2.4.3	<p>Finding:</p> <p>Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis process of incidents and accidents to ensure appropriate corrective action planning has been undertaken to improve the safety and care delivery of residents. One example relates to a resident who had a fall in the garden area resulting in a fracture. (Appropriate notification was made). Follow up includes involvement of care staff and maintenance staff. The resident's dietary requirements were reviewed by a dietitian to ensure a high protein diet was put in place to assist the healing process, the physiotherapist developed a full rehabilitation plan which is implemented by staff and the external environment was reviewed and reported on. An environment check of the residents room was undertaken with family/whanau member involvement.</p>
1.3.3	1.3.3.1	<p>Finding:</p> <p>A continuous improvement rating is made for achievement beyond the expected full attainment for the high standard of documentation for each stage of service delivery. The clinical medical and nursing records were audited in March 2013 and after being analysed, the outcomes recorded evidenced a very high standard being maintained. The new assessment and care plans introduced as part of the quality improvement programme and implemented by the registered nurses is a significant improvement on the previous records sighted. Education is provided to staff at all levels to ensure a high standard is achieved and service provision is managed competently and promotes safety at all times for residents. Education is provided by a contracted educator and/or the director of nursing who are both highly qualified and experienced in aged care nursing.</p>
1.3.3	1.3.3.3	<p>Finding:</p>

		A continuous improvement rating is made for achievement beyond the expected for each stage of service provision, evaluation and review that safely meets the needs of the residents. The high standard of documentation into the individual care plans and checklists sighted ensures timeframes are effectively met. During the staff interviews input was acknowledged from all staff involved in the personalised care and management of the individual residents at this rest home and hospital. Staff interviewed stated they discuss with the resident any goals the individual resident wishes to strive for during their recovery and care and decide together how best to achieve this.
1.3.3	1.3.3.4	<p>Finding:</p> <p>A continuous improvement rating is made beyond the expected full attainment for an excellent service that is co-ordinated in a manner that promotes continuity of care and promotes a team approach to service delivery. A resident/family satisfaction survey performed in March 2013 evidenced feedback from residents and families regarding the level of care provided. This service is led by the director of nursing who is very qualified and has a doctorate in nursing. The service is effectively co-ordinated to a high standard with the best interests of the residents ensuring that set goals can be met safely or alternatively goals are reviewed by the multidisciplinary team to ensure the best outcomes for each resident occurs. Resident and family/whanau input is always sought to continually ensure the needs of the individual residents are met.</p>
1.3.4	1.3.4.2	<p>Finding:</p> <p>A continuous improvement rating is awarded as the comprehensive assessment process exceeds expectations and incorporates the nursing assessments and tools of the multidisciplinary team completed on admission to ensure all needs are clearly identified to serve as the basis for the goal setting and care planning development and implementation for each individual resident, both in the rest home and the hospital. The goals are reviewed six monthly or more often as required with a multidisciplinary approach. There is evidence in the care planning of input from all of the team involved as well as the resident and family input.</p>

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policy and procedures identifies staff education related to consumer rights is offered as part of orientation and bi-annually. The policies and procedures reference legislative requirements to be effectively met. Staff received additional training in May 2013 with fifteen staff attending. Eight staff files sighted evidence staff received orientation on the Code. Ten staff are interviewed, including three health care assistants, one activities officer, three registered nurses, one occupational therapist, one physiotherapist and one cleaner. All staff demonstrate knowledge and understanding of consumer rights, obligations and how to incorporate them as part of their everyday practice. As observed on site in the rest home and hospital, staff are seen addressing residents with respect and providing residents with choices. Maintaining privacy and confidentiality is also understood clearly by staff.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policy and procedures identify that a discussion and clarification about the Code is undertaken as part of the admission process. The policy available is in place to guide staff. The residents' rights are discussed with the resident or family/whanau on admission with the registered nurse. The Code of Health and Disability Services Consumers' Rights (the Code) is framed and displayed throughout the facility (eg, at reception, in the hospital lounge and in the rest home). The six of six family members interviewed report they are provided with information on the Code on admission, the information is in the admission pack, information brochure and the service agreement. Four of four residents in the rest home interviewed clearly understood the Code. Three of three residents in the hospital understood their rights during interview. The receptionist and the registered staff provide information about the Code. Pamphlets are displayed in the entrance lounge area and in the hospital and rest home.

Choices are available for residents and a residents' meeting is held regularly and the meeting minutes are available and sighted. The Code is discussed at the meetings to ensure the residents are well informed of their individual rights at all times.

The Nationwide Health and Disability Advocacy Service brochures are accessible. The contact numbers are on the reverse of the Health and Disability Consumers' Rights brochure. The resident advocate contact number is clearly displayed on the notice board near the reception desk. Advocacy service information is included in policy to guide staff.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policy identifies that staff must uphold all aspects of the Code. Guidance is clearly shown in policies. The privacy policy was reviewed in March 2013 and the abuse and neglect policy, developed and implemented in March 2013, covers varying types of abuse and identifies expected staff response should abuse occur. Ten of ten staff interviewed have a good understanding of abuse and neglect and know who they should report to, if necessary. The director of nursing is the privacy officer for this organisation. The spiritual advisor/chaplain ensures residents are aware of maintaining their rights and visits most residents on a daily basis.

All residents' individual rooms are single rooms except for four double rooms. Presently there are two couples in two of these rooms and one resident in each of the other shared rooms. The seven of seven residents and six of six family interviewed express a high level of satisfaction with the way they are treated by all staff (healthcare assistants, registered nurses, allied health, medical, domestic services and the activities officer) and report that the resident's dignity, privacy and independence is promoted at all times and respected. The general practitioner (GP) interviewed expressed no concerns with abuse, neglect or culturally unsafe practice.

Information on the Nationwide Health and Disability Advocacy Services is provided in the admission information and Code brochures which are readily available. The spiritual advisor is a resident advocate for the rest home and hospital. There is also one rest home resident (the 'resident ambassador') who visits fellow residents and is present for the resident meetings held regularly.

The service acknowledges in the Bethesda Care strategic, risk and quality plan, a commitment to mutual respect, dignity and consideration of individual needs to maintain health and wellbeing in a Seventh Day Adventist Christian environment. The service recognises each person, partnership and teamwork, religious beliefs, cultural needs and the Treaty of Waitangi. The Eden Alternative has been adopted for this service. The service strives to make a difference in the way the staff deliver care to residents while maintaining independence and the wishes of each resident.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has a Maori Health Plan which includes a Cultural Safety policy which recognises Maori values and beliefs. The holistic framework of Te Whare Tapa Wha is recognised as being central to the residents' wellbeing. Policy states the organisation will ensure that the cultural values and beliefs of residents, their whanau and staff are respected, recognising the Treaty of Waitangi in the day-to-day practices.

There are three staff and three residents who identify as Maori. Access for Maori has no barriers as the service works closely with the church, local iwi and Maori communities in South Auckland. The spiritual advisor interviewed identifies as Maori and works closely with these groups. The service actively promotes Maori participation in planning service delivery and promotes matauranga (knowledge) of Maori and staff through education and the principles of the Treaty of Waitangi, pukenga (skills) in understanding of communication during service delivery, te reo Maori and whakawhanaungatanga (relationships), especially with iwi, hapu, whanau. Whanau are welcome to visit anytime. The spiritual advisor interviewed provides training for staff to understand the philosophy of Te Whare Tapu Wha by recognising cultural differences and respect of cultural difference.

The service has access to an interpreter service which provides a service in the community acknowledging eighty languages. The service can be accessed by email or telephone. The contact details are readily available and sighted on a poster on the noticeboard located by the reception desk. Whanau are always welcome to visit.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policy identifies that resident and family/whanau are included in all care planning to ensure values and beliefs are recognised and met by the service. The service policy recognises that every individual is inherently influenced by the cultural environment with which they relate and that influence remains with the individual despite any change in living environment. The spiritual advisor and the director of nursing interviewed explained that the registered nurses when developing the initial and long term care plans, ensure all residents' cultures values and beliefs are recognised. Residents are treated as an individual and provided the support required to practice the beliefs that they have identified as important to them. The cultural values and beliefs are actively recognised and integrated into daily life as reflected in their respective care plans sighted. All residents have a right to follow their individual beliefs and faith and to receive services in a manner that recognises their individual values and beliefs.

The three registered nurses interviewed ensure information is obtained during the admission process for each resident. Any values and beliefs observed and acknowledged are clearly documented during the assessment and on the nine of nine resident records reviewed. The spiritual advisor is available for the three Maori residents if needed.

The ARRC agreements 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:

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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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policy reviewed (dated as developed and implemented March 2013) states that sexuality is managed in a manner that ensures the rights of the individual are protected and intervention only occurs to ensure balance between personal rights of the individual and others living and working in the facility. Staff interviewed (three healthcare assistants and three registered nurses) stated that they have received training recently September 2013 and 11 October 2013, due to a situation that arose with a resident where staff felt compromised. The training proved to be very valuable and staff are now able to manage this resident more effectively. Staff are signing when they read the appropriate policy which has been placed in the nurses' station for review and is available to guide staff at all times.

The director of nursing and registered nurses interviewed are fully informed and aware of professional boundaries. All registered nurses have to complete a (Professional Boundaries Workshop) over the next two years to meet New Zealand Nursing Council requirements for scope of practice requirements. The organisation has house rules and staff interviewed (clinical and non-clinical) ensure they abide by these rules as part of the employment agreement and human resources management protocol.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policies and procedures are reflective of evidence based practice and have all been reviewed this year to ensure they are up to date. There are many examples of good practice observed such as the standard of the staff and residents individual records sighted, the comprehensive assessment process undertaken and the subsequent care plan development and implementation for each resident, and the care plan review system. Clinical record reviews, care audits by the registered nurses, and medication system audits completed by the pharmacist also evidenced good practice.

Implementation of the quality improvement and quality management strategies are reflected across all services. The internal quality system and internal audits, especially those that are care related, evidence outcomes, and these outcomes are fed back to the staff at the staff meetings (minutes sighted). There is a communication diary which staff interviewed stated 'works well'. This diary is updated with residents' appointments, staff messages and rostering changes to alert staff. Another example of good practice is the infection control and laboratory results being monitored closely by the director of nursing and available for the doctors' rounds. The GP interviewed commented on the expertise of the director of nursing and the registered nurses and that communication was very good.

The ARRC 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

Policy fully describes that open disclosure is part of everyday practice. Residents have a right to full and frank information and open disclosure from staff. The manager interviewed is aware of using interpreter services if and when required. The three registered nurses interviewed had a good understanding of how to access interpreter services. The use of interpreter services is identified in policy reviewed. The details of the interpreter service is displayed on the notice board near reception. The service offers translation for eighty different languages.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Written consent processes and advanced directives are fully described in policy. The policy sighted relates to informed choice and consent and this information is compliant with the Code requirements. The organisation has specific advanced directive documentation which identifies residents' advanced directives prior to admission and other documentation which identifies resident and/or family/whanau involvement in this process. The three of three registered nurses and one GP interviewed has a good understanding of informed choice and consent. Any decisions are reviewed during the multidisciplinary reviews or earlier if required. Written consent is obtained during the admission process in respect to transportation consent, residents record management and sharing of residents' information with other health providers (eg, pharmacist, geriatrician, GP, service agreement obligations and for the referral process).

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has a simplified document which is given to all residents and their family/whanau members upon admission. Advocacy and support services are clearly documented through policy. Policy identifies that advocacy services are an essential provision allowing appropriate access to independent advice and support, cultural responsiveness and prompt access to a culturally and spiritually appropriate advocate whenever possible. The spiritual advisor was interviewed and is passionate about the role. Advocacy information is made available for residents and potential residents and is displayed throughout the rest home and hospital. The contact number for the resident advocate is displayed. The spiritual advisor is available at all times and is present in the rest home and hospital each day. Staff interviewed three registered nurses are aware of how to arrange an advocate for a resident if required. Pamphlets are available and the contact numbers for the Nationwide Health and Disability Advocacy Service is documented on the reverse of the pamphlet and on the reverse of the Code brochure.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
There are no set visiting hours and family/whanau are welcome to visit. The six of six families interviewed confirm unrestricted visiting hours and this is appreciated. Links with family/whanau is encouraged. Residents are supported and encouraged to access community services independently, with visitors/family or as part of the planned activities programme. The activities programme sighted verifies outings are organised on a regular basis. The spiritual advisor interviewed is responsible for taking individual residents to hospital appointments as required. The drivers' licences were verified for those staff who transport residents and the facility van has a current vehicle registration and warrant of fitness maintained and recorded by management.	
The ARRC 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 Mal V CQ SQ STQ Ma L

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

Stage one: There is a comprehensive complaints management process which is clearly documented in policy.

Stage two: The Director of Nursing (DON) and the Clinical Charge Nurse (CCN) confirm that complaints management is discussed as part of the admission process. A copy of the complaints form is available at the entrance of the facility and is included in the pack given to all family/whanau upon their relative's entry to the facility. Interviews with six of six family/whanau members and seven of seven residents (four rest home and three hospital level) confirm their understanding of the right to make a complaint and that a member of management is available to listen to any concerns or issues they may have. This is supported by the Eden Resident Survey results (October 2013).

Interviews with 10 of 10 staff (three RNs, three health care assistants (HCAs), the activities officer, the physiotherapist, the occupational therapist, and one cleaner and six members of the management team (the Chief Executive Officer (CEO), the Director on Nursing (DON), Clinical Charge Nurse (CCN), the maintenance manager, the Cultural/Spiritual Advisor and the administrator) confirm they all implement complaints management processes to meet policy requirements.

The complaints register identifies that all complaints and concerns are responded to by the DON and that the person who makes the complaint is kept fully informed of the investigation results and follow-up corrective actions as appropriate. One example relates to a resident who does not want a male caregiver. This has been followed up and is clearly recorded on the resident's care plan.

The majority of complaints are related to food services and each complaint is used to identify opportunities for improvement. All concerns about food are forwarded to the kitchen, regular management meetings are held with the food supervisor from the company who contracts the food services. The complainant is revisited post corrective actions to ensure their needs are being met. During interview, one family/whanau member stated that his father had requested fresh salad instead of vegetables and this is now given to the resident at least three times a week. Both the resident and the family/whanau are very happy with this response. There were no concerns about food voiced by residents on the days of audit. Family/whanau confirmed food services have improved over the past few months.

All complaints sighted have been resolved and signed off by the DON. There are no outstanding complaints at the time of audit. Documentation identifies that all complaints are discussed at staff and management meetings and the CEO is kept fully informed.

Residents have regular monthly meetings and minutes identify any issues or concerns as well as things they like. Resident interviews confirm they can bring up anything they wish up at the meetings and they are always responded to by management.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage one: The service has a Leadership, Management, Quality and Risk Management Manual (2013) which clearly describes organisational management. Documentation identifies the core purpose, vision, goals and values of the organisation.

Stage two: The overall governance of the organisation is managed by a Board of Directors (the Board) consisting of six members. One member is the Chief Executive Officer (CEO) who works full time in the service and oversees all service delivery. The day to day responsibility for clinical management is delegated to the Director of Nursing (DON). Both of these managers are very well qualified for the role they undertake. The CEO has over 15 years senior management experience in various industries. The DON worked as a consultant to Bethesda Care until April 2013 when she took up full time position at the facility. She has completed a PhD in nursing and is actively involved in many area of aged care management including a professional teaching fellowship at Auckland University. She is very skilled in evidence based practice, leadership and quality systems. She is an Eden Alternative Guide. The DON is a member of the Health Care Acquired Infection Governance Group. Accountability, responsibility and authority is clearly described in their role descriptions. They are supported by an experienced management team consisting of the administrator, the cultural/spiritual advisor, the maintenance manager and the Clinical Charge Nurse.

The service uses the 10 principles of the Eden Alternative and goals are set to reflect how each principle will be met. The 2013/2014 business management plan identifies how each Eden principle is embedded into practice and includes general operations, environment, financial, residents and families, clinical outcomes and staff. A strength, weakness, opportunity, threats (SWOT) analysis informs each section of the plan.

The quality plan identifies how the key principles of the Eden Alternative form the basis for all quality actions. Quality actions and projects are linked to the key activity relationships shown in the quality plan. The business and quality plans are reviewed monthly by the quality team and a full SWOT analysis is undertaken at Board level annually to ensure services are meeting residents' needs.

The results of the 2013 Eden Resident satisfaction survey identify services are delivered in a manner to meet residents' needs. This is confirmed during resident and family/whanau interviews. Very positive comments were made by everyone spoken to, including the GP about the overall management of the facility.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage two: During a temporary absence of the CEO the DON undertakes the role with oversight from the Board. During an absence of the DON the Clinical Charge Nurse (CCN) undertakes clinical oversight and is supported by other members of the management team. There is always a Board member available for advice and support. The CCN has been coached and mentored by the DON to ensure she is able to cover the role as required.

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 Mal V CQ SQ STQ Ma L

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

Stage one: Documentation identifies that the service actively encourages the accurate and timely reporting and recording and investigation of all accidents, incidents and unsafe conditions. Clinical risk management processes include a risk management plan which is reviewed annually. This is informed by information gathered from incidents, accidents, adverse events, infection control, complaints, and data reporting. Risks are categorised via a risk matrix and risk management is prioritised in the risk plan.

The quality plan covers all aspects of service provision, both clinical and non-clinical. Policy states trends will be considered in depth looking at the following issues:

- number of incidents/number of total residents;
- times of day;
- days of week/employees on duty;
- residents - same resident- high risk;
- procedures;
- equipment

Stage two: The DON has an in depth knowledge in the management of risk and ensures quality controls are implemented by the service to meet resident needs. The service operates using the principles of the Eden Alternative philosophy. The DON has completed Eden Associate training and is a registered Eden Guide. Staff also have the opportunity to undertake the Eden Alternative education.

Staff interviews confirm that they understand the quality and risk management systems and that they are involved in reporting, audits and undertaking corrective actions that are put in place. Staff understand that Eden Alternative principles are the cornerstones used for the development of the quality plan (2013) and that the focus is on continuous quality improvement that includes physical, therapeutic and the psychosocial environment.

Quality data is collected and collated for all key components of service (complaints, incidents and accidents, health and safety, restraint and infection control). Improvements are documented on specific corrective action forms and this information is shared with staff and management. Meeting minutes identify that a set agenda covers all quality issues. As observed, all benchmarked and trended data results are posted in the staff room. Proactive quality improvements are also undertaken and written up as projects. Projects sighted include, but are not limited to, roster management, reducing absenteeism, laundry/linen quality, staff orientation and review of pharmacy services.

A report is presented to the CEO who then takes this information to the Board every two months or sooner if there are any concerns. Monthly quality committee meetings cover all key components of service delivery, audit results, project data and quality improvements and all data is analysed and evaluated. A percentage rating is given to show if an issue is fully completed or not. The outcome of corrective actions are monitored and reported on. If it is found that a corrective action is not working it is revisited, with staff input, and a new action is developed. Quality improvement data management has fully attained the criterion 1.2.3.6 and has gained a continued improvement rating as the service can, in addition, clearly demonstrate a review process which includes analysis and reporting of findings related to the actions taken that have improved service provision. One example relates to the completion of the resident laundry project resulting in safer process for staff handling of soiled linen.

All policies and procedures sighted are up to date. They evidence how legislative and current best practice is reflected via detailed referencing on each policy. Special input is acknowledged such as in the infection control policy update. Policy manuals are available to all staff and content is monitored by the DON to ensure it current. Staff are informed when a policy or procedure is either introduced or updated.

Monthly resident meetings are held and used as a forum at which any concerns can be discussed. During interviews, residents confirm that any issues raised are addressed in a manner that responds to their needs.

Actual and potential risks are identified and documented in the hazard register. They are communicated to staff and residents as appropriate. Hazards are reviewed at the monthly quality group and any newly identified hazards that cannot be eliminated are added to the register. Staff confirm during interview that they understand and implement documented hazard identification processes.

The 2013 Eden resident survey results show that residents are satisfied with services provided at Bethesda Care and documentation identifies that any highlighted issues have been followed up by the DON or the CCN.

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:		

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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: CI	Risk level for PA/UA:
Quality improvement data is analysed and evaluated and the results are communicated to staff, management and the Board on at least a monthly basis. Residents are kept informed as appropriate. Results of all quality data is also printed off in hardcopy and placed on the staff notice board. Quality data covers all aspects of service delivery including adverse events, complaints, infection control, health and safety and restraint.		
Finding Statement		
Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis process of all quality data which is gathered from key components of service which is benchmarked against previously collected data from both internal and by outside agencies. Corrective planning is monitored for effective outcomes. Many corrective actions are written up as ongoing projects, such as the laundry/linen project. Educational material includes written and pictorial evidence which was presented to staff so they gained a full understanding and allowed staff involvement in the purchase and use of new triple bag linen trolleys. (Blue for towels, red for sheets and white for personal clothing). The project included the contracted laundry staff. Following the introduction of the linen trolleys, staff completed evaluation about how well the new trolleys were working and the results are written up and shared with management and the Board. This has improved the service provision for residents and assists both care and laundry staff in the management of soiled linen.		
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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
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Stage one: Policies and procedures are in place which identify that all adverse, unplanned or untoward events are recorded and followed up by the service. There is an open disclosure policy to identify family/whanau are informed. Policy states that serious accidents will be reported to the Labour Department and where required the Ministry of Health and the DHB. This process is documented where required. Corrective action planning is put in place to prevent the reoccurrence of an incident where possible. All incident and accident reports are analysed and trended via the quality team.

Stage two: The DON and CCN verbalise their knowledge and understanding of statutory and regulatory obligations in relation to essential notification reporting.

All incidents and accidents are recorded on a specific form. Adverse event data is collated, trended and benchmarked against previously collected data. Incident and accident information is used to identify areas for improvement and data is identified under specific sections to assist in the identification of cause of accident or incident. This includes the time of day, type of incident such as falls, injury or medication error, and any corrective actions put in place. Staff are informed at handover, during monthly staff meetings and in toolbox educational sessions. All information is evaluated and informs monthly management and staff reports. This is supported in meeting minutes and management reports sighted. Having fully attained the requirements of criterion 1.2.4.3 the service can in addition clearly demonstrate a review process which is inclusive of analysis, reporting of findings, evidence of corrective actions taken based on the investigation review for each incident or accident. Follow up undertaken shows how the actions put in place are outcome focused to assist in improvement to safety and care delivery of residents. This criterion has gained a continued improvement rating.

Staff interviews identify knowledge and understanding of the need to document all incidents and accidents. The incident and accident form clearly shows that family/whanau are informed and if the GP is notified. Family/whanau interviews confirm there is good communication and that they are informed of all incidents, accidents or concerns the service may have related to their relative.

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

All incidents are recorded on incident and accident forms which include detailed information about the type of incident/accident, the time of day and a risk analysis rated from low to high. If a moderate or high risk is raised corrective actions are put in place accordingly. One example traced shows that a full investigation occurred, nominated staff were accountable for follow up actions and an outcomes review occurred before the DON signed off to say the incident/accident was completed. All forms identify that family/whanau notification was undertaken. All data is reported per 1000 occupied bed days and benchmarked against previously collected data. The data is used to identify service deficits. One example relates to identification that most falls occurred between the hours of 3am and 7am. This has resulted in one additional staff member being rostered on night duty. Preliminary trended data identifies a decrease in falls during the night but full results are not yet benchmarked as the period runs from January to September and this is in progress.

Finding Statement

Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis process of incidents and accidents to ensure appropriate corrective action planning has been undertaken to improve the safety and care delivery of residents. One example relates to a resident who had a fall in the garden area resulting in a fracture. (Appropriate notification was made). Follow up includes involvement of care staff and maintenance staff. The resident's dietary requirements were reviewed by a dietitian to ensure a high protein diet was put in place to assist the healing process, the physiotherapist developed a full rehabilitation plan which is implemented by staff and the external environment was reviewed and reported on. An environment check of the resident's room was undertaken with family/whanau member involvement.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage one: The organisation has documented process related to human resources management to ensure good employment practice is undertaken and that all legislative requirements are met.

Stage two: There is a system in place to record annual practising certificates for staff who require them. Annual practising certificates are sighted for two GPs, the pharmacy and six pharmacists, one podiatrist, one physiotherapist, ten RNs (one is the DON), one dietitian.

A review of nine of nine staff files (the CCN, three RNs, the activities officer, one cleaner, and two HCAs (one newly appointed and one experienced), and the maintenance manager), and interviews with 10 of 10 staff confirm that the orientation process prepares staff for the roles they undertake. Documented orientation covers all aspects of service relevant to the role the employee undertakes. All files contain signed employment agreements, job descriptions, orientation workbooks covering all essential aspects of service delivery, up to date annual staff appraisals, and clinical staff medication competencies.

Staff members' education is individualised and interviews with 10 of 10 staff confirm they are satisfied with the amount and type of education offered. Education is offered on site and off site and staff are encouraged to attend related to the role they undertake. All 47 HCAs hold at least a stage two New Zealand recognised aged care qualifications or higher. A newly developed HCA performance reward system has been introduced by the service (August 2013). It is a graduated level career pathway linked to New Zealand Qualifications Authority certificate levels and identifies the relevant experience and knowledge of the HCA. Two HCAs stated during interview that they are very excited about commencing level four of the pathway.

Interviews with residents and family/whanau confirm they are very happy with the care delivery and that staff perform their roles in professional, competent manner. This is supported by the Eden Resident Survey results sighted for 2013 where there are no negative comments related to "staff being well trained and know what they are doing".

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

How is achievement of this standard met or not met?

Attainment: FA

Stage two: A review of six weeks rosters identify that staffing numbers meet DHB contractual requirements. Planned and unexpected leave is covered and replacement staff are shown on the rosters sighted. Interviews with 10 of 10 staff confirm they have adequate numbers of staff to complete all required tasks. One RN has to have her first aid update but the night shifts she works are covered by other staff members who hold a current first aid certificate.

Rosters show the following staffing numbers:

Monday to Friday morning duty - The CCN and on call as required.

Monday to Thursday morning duty - The DON and on call as required.

The CEO works 40 hours per week and is on call as required.

Dedicated cleaning staff are rostered 96 hours per week to cover seven days. The laundry staff are contracted and work seven days a week. The maintenance manager and cultural/spiritual advisor work 40 hours per week Monday to Friday and are on call as required. The activities officer works 40 hours per week, the physiotherapist works six hours per week and comes in on call as required. The occupational therapist works four hours per week and oversees activities planning. A receptionist works 40 hours per week.

All shifts are covered by a registered nurse. RNs work 12 hours shifts which are 6.30am to 7pm, 8am to 8.30pm and 7pm to 7am seven days a week.

Health Care Workers (HCAs) shifts are:

Morning duty- seven days a week

-three 6.45am to 3.13pm

-four 6.45am to 2.30pm

-two 6.45am to 1pm

-one 6.45am to 1030am

Afternoon duty - seven days a week

Health Care Workers (HCAs) shifts are:

-two 3pm to 11pm

-one 3pm to 10.30pm

-two 3pm to 10pm

-one 3pm to 9.30pm

-one 4pm to 9.30pm

-one 4.30pm to 8pm

Night duty - seven days a week

Health Care Workers (HCAs) shifts are:

- three 11pm to 7am

- one 12 midnight to 8am

Interviews with seven of seven residents (four rest home and three hospital), and six of six family/whanau members confirm all their needs are met and staff are always available when required.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The document control policy identifies how health information meets legislative requirements and relevant professional and sector standards. The nine on nine residents records reviewed demonstrate they are legible and show the date, time, name and designation of the staff member entering the information. Only the registered nurses write in the progress notes each shift. All residents' records have coloured dividers between each section and are integrated. Staff interviewed ensure confidentiality is maintained and records are stored appropriately in the nurse stations in the rest home and the hospital and are accessible to staff. The nurse station door is locked and accessed by swipe card only. Information resident boards are out of sight of the public. The resident register is maintained by the receptionist.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policy identifies entry processes which are communicated to residents, family/whanau and referral agencies. A care facility enquiry form is to be completed for each enquiry and this clearly details enquiry details, potential resident details, care type, general comments and a check list of referral information. The reception staff member is the first point of contact for enquires, as confirmed during interview. The director of nursing (DoN) or the clinical charge nurse (CCN), manage all enquires and spend time with the prospective residents and/or their families. An information pack is available and sighted. As this facility is owned and operated by the Seventh Day Adventist, often enquiries come from members of the church, who reside out of the CMDHB area, for example

Whanganui (which is a large Adventist area). Intra-NASC transfers are often arranged for appropriate placement of residents if required. There is a waiting list at the moment for rest home and hospital level residents.

Nine of nine residents' records reviewed, consisting of five hospital and four rest home residents, evidence that all residents have had their assessments by the needs assessment and service co-ordination assessors (CMDHB) prior to admission. A copy is retained in each individual resident's record. The report has two parts. Part 1: initial contact information (eg, in their own home, needs identified, disability if any, diagnosis, enduring power of attorney (EPOA) if established and available). Part 2: Background information if recorded and the reason for admission is recorded. There is a comprehensive report with all support needs being identified and summarised with options for meeting the needs and goals established, plus the outcome of the nursing assessment documented, and the resident agreement. The resident agreements were also verified in the individual records.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policy describes processes undertaken should entry to service be declined. This includes notification to appropriate persons and agencies. If a potential resident does not have the appropriate assessment for rest home or hospital care, or is declined entry to this service, the admission form and notes record the communication with the referrer or the alternative service. The resident agreement has a statement that indicates when a resident is required to leave the

service. If a resident requires a higher level of care, for example, from rest home to hospital level care or a secure dementia environment, a referral is sent by the GP or the clinical charge nurse for a reassessment to be completed by the geriatrician or by the NASC service. The geriatrician from CMDHB was present during the onsite audit reassessing a resident.

The ARRC requirements are met.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: CI

There are policies and procedures in place to identify how residents receive timely, competent and appropriate services to meet their needs as identified by the assessment processes. The registered nurses and the clinical charge nurse interviewed separately identified that the development of the long term care plan is to be a transparent partnership process. Bethesda Care registered nurses work collaboratively with the resident and the resident's family/whānau, advocate or other healthcare providers to complete the comprehensive care plans sighted. The initial care plan is documented within twenty four hours of admission taking into consideration the NASC assessment and the comprehensive admission assessment which has been developed and implemented by the director of nursing for this service. The full long term care plan is developed within three weeks of admission. The nine of nine resident records sighted (five hospital level and four rest home level) have all been reviewed six monthly or more often if required. There is clear involvement and evidence of the

consultation sought with the resident, the multidisciplinary team, resident's family/whanau and/or advocate. Six of six family members interviewed verified that they are always invited to participate in the evaluations.

Handovers are provided by the registered nurses between each shift. The registered nurses work twelve hour shifts to promote continuity of care.

Each stage of service delivery is undertaken by qualified and suitably skilled staff. The annual practising certificates (APCs) for the eight registered nurses employed are available and sighted. A system is in place managed by the director of nursing to verify APCs (Refer Standard 1.2.7). There is an appropriate education programme for staff that covers the essential components of the organisation and service delivery. A record of all participants is maintained for all in-service provided by the contracted registered nurse educator.

The registered nurses are responsible for the comprehensive nursing assessment for each individual resident on admission, develop the initial and long term care plans, evaluate and review care plans in consultation with the health care assistants, referral information, the resident and the family/whanau. The GP conducts the medical assessments and reviews the resident's condition. The healthcare assistants provide the majority of the personal cares for the residents. Three health care assistants interviewed confirm that team work is encouraged and continuity of care is promoted at all times. One general practitioner, who is interviewed, cares for all but four of the residents at this facility. The GP visits regularly and is on call seven days per week twenty four hours a day. The GP stated that he does not visit after hours however, strategies to manage after hours services are in place and there is a twenty four hour direct line to CMDHB Middlemore Hospital for advice for the GPs and nursing staff.

The nine of nine resident records reviewed evidence the comprehensive assessment process, set goals for the resident that identifies the physical, psychosocial and cultural aspects for each resident. The service uses a set of assessment tools which are incorporated presently into the adopted assessment document developed and implemented by the director of nursing in February 2013, which is very similar and more explicit than InterRAI (a comprehensive clinical assessment for people living in aged residential care). The director of nursing and the clinical charge nurse are enrolled in the InterRAI training for the beginning of 2014 as this will be compulsory by 2015.

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.*

The ARRC requirements are met.

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

The service is managed by an experienced nurse who has developed and implemented a comprehensive assessment process and care planning system inclusive of evaluation, review and discharge documentation. Nine of nine staff records were sighted and reviewed. The eight registered nurses are all trained to perform these comprehensive assessments and care planning which is observed to be of a very high standard and understood by the three registered nurses and the three healthcare assistants interviewed. Associated documents are also understood by the healthcare assistants to guide them when performing the personal cares for each individual resident. The multidisciplinary team, some of whom were interviewed, such as the occupational therapist, the physiotherapist and the GP, are all involved in each stage of service delivery.

Attainment: C1

Risk level for PA/UA:

Finding Statement

A continuous improvement rating is made for achievement beyond the expected full attainment for the high standard of documentation for each stage of service delivery. The clinical medical and nursing records were audited in March 2013 and after being analysed, the outcomes recorded evidenced a very high standard being maintained. The new assessment and care plans introduced as part of the quality improvement programme and implemented by the registered nurses is a significant improvement on the previous records sighted. Education is provided to staff at all levels to ensure a high standard is achieved and service provision is managed competently and promotes safety at all times for residents. Education is provided by a contracted educator and/or the director of nursing who are both highly qualified and experienced in aged care nursing.

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

The nine of nine long term care plans five hospital and four rest home are documented to a high standard, initially taking into consideration the NASC assessment prior to admission and subsequently the comprehensive assessment performed by the registered nurses on admission to the service. The multidisciplinary team members, for example the occupational therapist and the physiotherapists (both interviewed during the audit), also incorporate their individual assessments and assessment tools into the records and include respective plans into the main long term care plans for each individual resident.

Re-evaluations occur regularly to ensure interventions are appropriate and that the goals set by and for the individual residents can be effectively met. The staff, inclusive of the healthcare assistants, activities co-ordinator, registered nurses and contracted staff, such as the physiotherapist and occupational therapist all have significant input into the review of each care plan developed and implemented and during the review process. The GP, family/whanau and the resident are also involved in each stage of service delivery and time frames are appropriately met.

Finding Statement

A continuous improvement rating is made for achievement beyond the expected for each stage of service provision, evaluation and review that safely meets the needs of the residents. The high standard of documentation into the individual care plans and checklists sighted ensures timeframes are effectively met. During the staff interviews input was acknowledged from all staff involved in the personalised care and management of the individual residents at this rest home and hospital. Staff interviewed stated they discuss with the resident any goals the individual resident wishes to strive for during their recovery and care and decide together how best to achieve this.

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

The service is co-ordinated in a manner that promotes continuity in service delivery and promotes a team approach. This is clearly evident when interviewing the clinical and non-clinical staff during this audit. A team approach and continuity of care is encouraged at every opportunity and this is verified in the nine of nine individual residents' records reviewed. The GP interviewed reported that the registered nurses work collaboratively with the multidisciplinary team for the best outcomes for the residents across the services provided, being rest home and hospital level care. The staffing is adequate for both the rest home and the hospital and this was explained by the clinical charge nurse and the rosters were sighted. Additional staff can be arranged if and when required. All staff interviewed felt the staff cover was adequate to meet the needs of the residents.

Finding Statement

A continuous improvement rating is made beyond the expected full attainment for an excellent service that is co-ordinated in a manner that promotes continuity of care and promotes a team approach to service delivery. A resident/family satisfaction survey performed in March 2013 evidenced feedback from residents and families regarding the level of care provided. This service is led by the director of nursing who is very qualified and has a doctorate in nursing. The service is effectively co-ordinated to a high standard with the best interests of the residents ensuring that set goals can be met safely or alternatively goals are reviewed by the multidisciplinary team to ensure the best outcomes for each resident occurs. Resident and family/whanau input is always sought to continually ensure the needs of the individual residents are met.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: CI

Required assessments are integrated and use the SOAP framework (subjective, objective, assessment and plan). The assessments also include the 'FRAT' screen for falls, depression, pressure area care, mini mental, nutrition, medications, cognitive status, psychological, functional and continence as well as the comprehensive assessment tool utilised. All needs and support requirements, preferences, likes and dislikes, lifestyle information from the past, and more recent, is gathered on admission and within the time frames required.

The needs, outcomes and goals of residents are identified during the pre-admission NASC assessment and from the comprehensive assessment performed by the registered nurse on admission for each resident. The nine of nine residents' records reviewed (five hospital and four rest home level care residents files) assessments are clearly documented. The assessments serve as the basis for the initial and short term care plans reviewed being developed and implemented. Six of six family interviewed stated that they are highly satisfied with the care their family member received at this care facility. Seven of seven residents interviewed, inclusive of four rest home and three hospital level resident, report they receive care that meets their needs adequately.

The ARRC 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

Nine of nine resident records reviewed evidence that the goals of residents are realistic and are identified through the comprehensive assessment process on admission to this service. Additional assessments are used as required for individual residents such as depression, pressure area risk analysis, nutritional, mini mental, falls, gait, physical function and balance assessments. A pain management and compliance audit performed August 2013 evidenced 80% full compliance that residents` pain management was effectively managed by the registered nurses. The physiotherapist and the occupational therapists interviewed both explained the extensive assessments of all residents on admission using highly recognised professional tools. The three registered nurses interviewed stated that the pre-admission assessments are considered and used as the basis of service delivery planning as well as the comprehensive assessment sighted in all nine of nine residents` records five hospital and four rest home reviewed.

Finding Statement

A continuous improvement rating is awarded as the comprehensive assessment process exceeds expectations and incorporates the nursing assessments and tools of the multidisciplinary team completed on admission to ensure all needs are clearly identified to serve as the basis for the goal setting and care planning development and implementation for each individual resident, both in the rest home and the hospital. The goals are reviewed six monthly or more often as required with a multidisciplinary approach. There is evidence in the care planning of input from all of the team involved as well as the resident and family input.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Resident care planning is put in place from the findings of the assessment process. The initial care plan must be in place within twenty four hours of the resident's admission. The nine of nine care plans reviewed have a standardised format that is individualised to the resident`s assessed needs. The records of the residents (one hospital level and one rest home level) have appropriate long term care plans that clearly identifies the individual resident`s needs and care requirements, with specific plans to respond to reducing falls, increasing mobility and increasing weight. The nine of nine records reviewed (five hospital and four rest home) demonstrate integration inclusive of input from care, activities, medical and allied health services. The three of three healthcare assistants interviewed report they receive adequate information to assist the continuity of care. The handover observed was presented by the registered nurse and

included updates on residents, diabetic monitoring, specimens sent to the laboratory and results provided. Healthcare assistant input is encouraged at handover time.

The six of six family; seven of seven residents and the GP interviewed, report a high level of satisfaction with the quality of care provided at this service. 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:		

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Short term care plans are used for problems that can be resolved within four weeks. The nine of nine long term care plans reviewed record interventions that are consistent with the residents' assessed needs and desired goals. The family is notified if there is any changes to the care plan and this is recorded on the resident/family/whanau communication and education record sheet in the individual resident's record. Observations on the day of audit indicate residents receiving care that is appropriate and consistent with the individual resident's needs. All seven residents and all six family members interviewed report that the service meets the needs of the resident. The three healthcare assistants interviewed report that the care plans are up to date and do reflect the individual resident's needs and are able to be followed easily.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The individual comprehensive assessment and checklist is completed by the contracted occupational therapist. The pool activity level (PAL) assessment is completed. A key is defined and appropriate plan developed and implemented for each individual resident. The key consists of: (P) - planned level of ability, (E) - exploratory level of ability, (S) -

sensory level of ability and (R) - reflex level of ability. The occupational therapist oversees the activities programme for all residents in the rest home and hospital and develops all activities plans and the programme. The activities coordinator implements the programme ensuring the strengths, skills and interests of residents are maintained. The activities coordinator has completed Eden Alternative training. The Bethesda Care Board has adopted the Eden Alternative model to support residents to live in a human habitat where variety and spontaneity is part of everyday life. This is documented in the strategic, risk business and quality plan 2013 to 2014 and is considered when implementing the activities programme by the co-ordinator, who was interviewed. Nine of nine randomly selected resident's records sighted five hospital and four rest home each have activities plans that are current and up to date.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policy identifies that care plans are evaluated if there is a change in the resident's condition and that they are reviewed three monthly and updated every six months. Care plan review timeframes shown in policy range from weekly to six monthly, depending on the resident's condition. Multidisciplinary input is considered for all residents for the six monthly reviews. Reviews occur earlier if there is a change in the resident's status. Interventions are changed if required to ensure all needs and goals set can be effectively met. All evaluations are recorded, dated and signed by the registered nurse undertaking the review.

If a resident is not responding to the services interventions being delivered, or their health status changes, then this is discussed with their GP and the GP interviewed validated this information. Short term care plans are sighted for wound care, infections, changes in mobility and changes in food and fluid intake, and/or skin care and pressure area risk. These processes are clearly documented on the short term care plan, medical and nursing assessments and in the

residents` progress records. The resident/family/whanau communication and education record sheet is completed in the front of the record if the family are notified, if progress is different from expected, or for information provided or communicated to the family.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The residents are provided with options if required to access other health and disability services. There is one GP who is responsible for all but four residents in the hospital and rest home although residents are able to maintain their own GP if they wish. The GP can arrange a referral to specialist medical/surgical services when it is necessary. The GP interviewed reports that referral services at CMDHB respond to referrals quite promptly. Records of the process being maintained is confirmed in some of the nine records sighted when residents have been referred, for example, to orthopaedics, radiology and cardiology services, and the DHB. Referrals to the contracted dietitian are also responded to and onsite visits are arranged by staff for a resident if required. The GP interviewed reports that appropriate referrals to other health and disability services (eg, the geriatrician) is managed well for this service. The geriatrician was visiting the service on the day of the audit to undertake multidisciplinary care reviews with the GP and the director of nursing.

Transportation can be arranged to take residents to an appointment if family are unable to take them.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Transition, exit, discharge or transfer are all covered in policies and procedures. If a resident's condition or health status changes the GP is notified. Should a resident require higher level of care, being hospital or secure dementia care, a referral is sent to the NASC service for a re-assessment to be performed.

When approved, assistance is provided to families in the event of this occurring, to find a suitable alternative service provider. If a resident is to be transferred to CMDHB Middlemore Hospital the GP contacts the service required or GP contact number available to arrange the admission. The nursing staff arrange the transportation and complete the required DHB transfer yellow envelope information required. The resident register is maintained and a record noted in the individual resident's record of the transfer and/or admission.

The admission/discharge summary is fully completed when a resident is transferred to another service (eg, to another aged care facility) if this has been authorised and arranged by the NASC service. The admission information details are already completed in the yellow envelope of relevant clinical history and a full assessment of usual daily living abilities. A copy of the medication record is sent. The family are notified and a record of this is clearly documented on the resident/family/whānau communication and education record sheet in the front of the resident's individual record.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is a detailed medicine management policy that is reflective of current safe practice guideline. The policy identifies that staff who administer medicines must be competent. Procedures comply with current legislative requirements. Medication reconciliation processes are clearly described. Pharmacy reconciliation of each resident's medication record is undertaken at least six monthly. The pharmacy also audits the medication onsite six monthly, inclusive of the imprest system and the controlled drugs, and this was able to be evidenced when reviewing the controlled drug system. A stamp is used by the pharmacist with the name of the pharmacy and ('checked and correct') is stamped onto the controlled drug record books and initialled by the pharmacist. The controlled drugs for regular administration are blister packed by the pharmacist and bright pink alert stickers (controlled drugs) are visible on the top of the packs. The controlled drugs are stored in a locked cupboard in a locked room. The lock is swipe card access only into the medication room.

The imprest system and the hospital bulk supply order forms were sighted. The cupboards storing medication are well organised and shelves are labelled clearly. Safe practices are maintained by the three registered nurses interviewed. The registered nurses current APCs and training records are available and sighted. Medication competency records for the eight registered nurses was sighted. Ten senior healthcare assistants have completed medication competencies with the registered nurse educator. The recently appointed clinical charge nurse ensures that the registered nurses on all shifts administer the medications. The lunch time medication round was observed and performed safely.

The robotic medication system is utilised and storage in the medication room is very appropriate and well organised. The temperature of the medication room is monitored. There are two medication trolleys available, one for the rest home and one for the hospital. The GP and the clinical charge nurse (CCN) interviewed report safe practice is identified and good communication exists between the pharmacist, the GP and the CCN. The emergency box and emergency medication is stored in the locked medication room and is available in the event of an emergency.

Policy describes the processes if a resident wishes to self-administer medicines. Only one resident is self-medication presently. The medication is made up in the robotic pack system and delivered to the facility. The registered nurses check all medication on arrival to the facility. Eighteen medication records reviewed evidenced three monthly reviews are completed by the GPs and this is recorded on the medication record. The medication records have photo identification on the front record sheet and on the signing of medication record. Staff signatures can be verified.

The staff can ring the contracted pharmacy anytime with any queries.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are details related to nutritional and safe food and fluid management policies in place. They cover all aspects of this standard including additional or modified nutritional needs, weight loss management and gaining dietitian input. A contracted food service provider provides the food service. The cook interviewed has been working in this facility for sixteen years. The cook orders all the required food stuffs and produce to provide healthy nutritious meals for the residents. All food is produced in accordance with the menus and recipes provided. The service is provided under hygienic conditions free from potential food safety hazards (chemical, physical and or microbiological). All food preparation is undertaken within designated areas in the kitchen sighted using appropriate staff and equipment.

A nutrition assessment form - non-acute is utilised and completed by the registered nurses or the contracted dietitian when a resident is admitted to the service. A copy stays in the resident's own record and the cook gets a copy. If the dietitian is visiting to follow up on a resident referred by the nursing staff, on a referral basis, this comprehensive form is completed with the reason for the referral, date of birth, date of admission, relevant medications, weight, body mass index (BMI), appearance, height, appetite and/or any feeding issues, self-feeding/independent/dependent status. The dietitian can order nutritional supplements as required for a resident. Special diets can be arranged, for example, puree, fortified fluids, vegetarian diets or gluten free, or any other types of food requirements can be effectively met. Nutritional guidelines for the elderly are available and considered when the menu plans are developed and reviewed by the dietitian. A dietitian audit is performed six monthly and was last performed on 11 September 2013. Education was provided by the registered nurse on fluid requirements and weight management in the elderly 8 August 2013 and safe swallowing was provided to staff 4 October 2013.

At lunchtime the meal is served from a portable bain-marie trolley by the kitchen staff. This is plugged into a power source and kept hot for the duration of the meal time. All staff are employed by the contracted food service provider. The cook interviewed demonstrates and explains the day-to-day responsibilities for managing the kitchen and meal service, inclusive of the staff training records. All staff have completed relevant food safety certificates and each staff member has their own personal record maintained by the cook and supervisors.

The 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage one: Management of waste and hazardous substance identifies how staff and residents are protected from exposure to waste products. All rubbish bags are placed in green wheelie bins and collected by Waste Care collections three times a week. The service has a yellow wheelie bin for infectious waste products should it be required. There are approved containers for sharps.

Part two: The service uses approved cleaning chemicals and safety data sheets which are visible in all areas where chemicals are stored. Staff education related to safe chemical handling occurs annually and as part of the induction process as appropriate.

Personal protective equipment/clothing (PPE) sighted includes disposable gloves and aprons, goggles and masks. Interviews with 10 of 10 staff confirm they can access PPE at any time and they can verbalise appropriate use. Staff are observed wearing disposal gloves and aprons as required.

Approved yellow sharp bins are sighted in locked areas for the correct disposal of sharps.

The service undertakes appropriate storage and disposal of waste, infectious and/or hazardous substances to comply with current legislation. The maintenance manager confirms there are no specific territorial authority requirements related to waste care management.

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

Stage one: Regular audits are undertaken to ensure the physical environment and facilities remain safe and fit for their purpose.

Stage two: All processes are undertaken as required to maintain the service building warrant of fitness. The current warrant of fitness expires on 26 September 2014. There is long term maintenance schedule in place and regular preventative schedules are kept up to date by the maintenance manager. There is a documented reactive maintenance process implemented by the service.

Electrical testing occurred in August 2013. Biomedical and medical equipment which includes beds, hoists, sphygmomanometers, and stethoscopes are checked annually by an approved provider. This occurred in May 2013. Regular checks also sighted for washing machines, dryer and the dishwasher. Equipment is safely stored such as the oxygen being correctly secured in appropriate holders.

The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, the correct use of mobility aids and walking areas not being cluttered. The facility has good storage space available. Corridors have safety handrails to assist residents to mobilise safely. Residents who have mobility difficulties are assessed by a physiotherapist and appropriate walking aids are obtained as required.

Residents have access to secure outdoor areas with seating and shaded areas. Interviews with seven of seven residents (four rest home and three hospital level) and six of six family/whanau members confirm the environment is suitable to meet their needs.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage two: There are 23 bedrooms with full ensuite facilities, 14 with toilet and hand basins and 31 with hand basins only. Each wing has centrally located toilet and shower areas which have appropriate locks to allow resident privacy when undertaking personal cares. This includes two full size baths, one of which is a spa bath. Sanitising hand gel is available in all staff service areas and throughout the facility.

Hot water temperatures are monitored and recorded. The maintenance manager is aware of the safe hot water level (below 45oC) and if an area goes above this level the tempering valves are adjusted and the temperature is rechecked.

There are separate staff and visitor toilets.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage one: Bethesda operates all 72 beds as swing beds. Bethesda has four 'couples" suites.

Stage two: There are four double bedrooms which are used for couples. Currently there are two rooms with couples in them and the other two double rooms are single occupancy. All other 64 rooms are single occupancy. The facility counts itself as full when all rooms are occupied. Bedrooms are personalised to meet residents' wants and needs and are large enough to allow residents with or without mobility aids to move around safely. Every bedroom has double doors to allow for ease of furniture or equipment movement. All rooms are appropriate for either rest home or hospital level care.

The Eden resident survey results (2013) show that 15% of responses disagree that their bedrooms "looks like home". However, interviews with seven of seven (four rest home and three hospital) residents and six of six family/whanau confirm they are happy with their bedrooms.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
Stage one: There are six lounges, two dining rooms, a chapel and meeting room.	
Stage two: The physical environment provides safe, age appropriate and accessible areas to meet residents' needs. The lounge areas range in size and some are used as quiet rooms. Most lounge areas are used for activities as observed on the days of audit. There are two separate dining areas which accommodate all residents. All areas are appropriately furnished. Residents relax and sit in any area they choose as observed during the days of audit. There is a large chapel which is used daily by residents.	
Family/whanau and resident interviews confirm their high level of satisfaction with the facilities provided. They stated that there have been improvements in the environment over the past year which includes new furnishing. The environment meets their current needs.	

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
Stage two: Cleaning processes are undertaken as described in policy and according to the job description sighted. This covers required daily tasks and cleaning staff interviews confirm they have the appropriate equipment and time to complete all tasks. Laundry services are contracted. Laundry and cleaning	

staff are able to verbalise their understanding of isolation techniques and knowledge of documented laundry and cleaning process related to outbreak management.

Laundry chemicals are pre-mixed and on automatic feed as appropriate. They are closely monitored by the supplier and by monthly laundry checks undertaken by the maintenance manager to ensure products and washing cycles are being used for the job they are intended. This is confirmed by documentation sighted. Staff education is confirmed during interview and in the staff file reviews undertaken for the laundry and cleaning staff members. All chemicals sighted are appropriately labelled.

The laundry has a clean/dirty flow, with adequate equipment for the size of the facility. Newly purchased linen trolleys are colour coded for use and have lids attached. Cleaning trolleys are securely stored when not in use. The September 2013 laundry audit gained a 93% rating and the October 2013 cleaning audit gained a 95.8% rating. All audit ratings are notified to the CEO in a monthly report.

Interviews family/whanau and residents confirm they are satisfied with laundry and cleaning services. The facility looks and smells clean.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage one: Essential emergency and security systems are described in the Health and Safety policies and procedures and include evacuation processes.

Stage two: The approved emergency evacuation plan signed off by the New Zealand Fire Service is dated 24 July 2012. There have been no changes to the facility foot print since this time. Six monthly trial fire evacuations are conducted; last undertaken on 17 October 2013 with no corrective actions required.

Documentation identifies that 40 staff have attended fire safety education to date in 2013.

Fire equipment was checked by an approved provider in June 2013. Records are kept for monthly sprinkler, fire doors, emergency lighting and exit sign checks. The fire alarms were activated on the night following the first day of audit in response to toast burning. The emergency response worked accordingly. One resident asked to speak to the auditor the next day and she reported she is very happy with the response and the fact that the emergency lighting works very well and the emergency light in her bedroom made her feel safe. She said staff handled the situation very well.

Civil defence and emergency supplies are checked regularly. Observation and interview with the DON and the maintenance manager confirm there are emergency food and water supplies - at least three days food and there are three 1000 litre water storage cylinders. There are two gas BBQs that can be used for cooking in case of an emergency. Documentation identifies that 32 staff have attended emergency response education to date in 2013. There is an updated (2013) pandemic/emergency plan in place.

Staff confirm that are required to ensure doors and windows are securely closed at night. The main doors are on an electronic swipe card/key code exit which is clearly displayed. (This is not environmental restraint as the code is available to everyone and side door exits are only locked after 7pm for security reasons). After 7pm visitors ring a bell and staff respond.

Call bells are sighted in all resident areas. When the bell is activated a LED ceiling display shows where the bell has been activated from and staff pagers are activated. Call bells are on an escalating call system which if they are not answered within a set time the CCNs pager is activated and if there is still no response the DONs pager is activated. The call bells also have an emergency alarm system which alerts all senior staff as well as an outside security firm. All residents interviewed stated they feel safe. This is supported by the results sighted in the Eden resident survey results 2013.

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

Stage two: All resident areas have at least one opening window and/or door which provides natural light and ventilation. The facility is heated by use of gas heated water system which generates an electric thermostatically controlled central heating system. Each residents bedroom has an individual thermostat so they can control the temperature of their bedrooms. The facility was warm on the days of audit.

The facility and grounds are smoke free.

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**

Stage one: Policy states enablers are the use of equipment, devices or furniture, voluntarily used by the resident following appropriate assessment, that limits normal freedom of movement, with the intent of promoting independence. The use of enablers shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting resident independence and safety.

Stage two: There are no restraints in use. There are two bedside rail enablers in use at the time of audit. Interviews with clinical staff confirm their knowledge and understanding related to restraint versus enablers and how they are managed. Staff can verbalise the alternatives methods put in place to keep the environment restraint free. They talked about the use of low beds, 'lipped edge' mattresses, and close visual monitoring of residents and sensor mats. Staff education covers de-escalation techniques, such as calming, re-direction, activities, ensuring regular toileting and understanding 'cue signs' of residents' needs.

The restraint coordinator stated that the service actively works at keeping the environment restraint free by talking to family/whanau and residents about the use of alternatives and they explain the benefits of using restraint versus not using restraint.

There are appropriate policies and procedures in place to guide staff actions related to restraint and enabler use.

The Restraint Advisory Committee meet monthly to review restraint use. The committee held an annually quality review meeting on the 9 October 2013. Minutes identify no restraint is used. It shows that enabler use had been reduced from eight in April 2013 to five in July 2013 with the introduction of new low bed. This number was further reduced to two in August with the introduction of new lipped mattresses. Enabler use is discussed at multidisciplinary meetings as confirmed in two file reviews sighted. Both residents with enablers are able to make their own decisions and use bedside rails for safety and to assist them to maintain independence when moving around their bed at night.

Documentation identifies that 52 staff have attended restraint education to date in 2013 and eight RNs have attended a specific session on the use of de-escalation techniques.

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

Audit Evidence**Attainment: FA****Risk level for PA/UA:****Finding Statement****Corrective Action Required:****Timeframe:****3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

STANDARD 3.1 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The infection control manual identifies clear lines of accountability for infection control matters which includes senior management and all staff. The aim of the infection prevention and control policy and procedures is stated as ensuring the provision of a service which is consistently safe for residents, staff and visitors to the facility. An interview with the director of nursing provided insight into infection control management for this service. The director of nursing is the infection control co-ordinator. The infection control co-ordinator role is clearly defined and is clearly documented with functional relationship and who to be accountable to. Key responsibilities are documented to guide staff. The director of nursing is supported by the registered nurses. Strategies are in place for outbreak management, defined as when the threshold is two or more cases in the same rest home or hospital. The director of nursing interviewed explained the objectives of the infection control programme for 2013 and how the infection control programme is linked to the quality and risk management programme. There is a flow chart available to guide staff on the infection control responsibilities.

The infection control programme is developed and implemented dated March 2013. The programme for 2013 sighted states the activity required, details, action, timeframe and date of when completed. Audits are performed six monthly on hand hygiene (last completed March 2013) and standard precautions April 2013. Additional precautions and outbreak management are next to be audited. There have been no outbreaks reported at this facility since the last audit. A process is identified in policy for the prevention of exposing providers, residents and visitors from infection. Staff and visitors suffering from infectious diseases are advised not to enter the facility and notices are evident at the reception. Staff interviewed understand about staff illness and when not to come to work and when to return to work. Sanitising and gel dispensers are observed throughout the facility and there is adequate hand washing facilities for staff and residents.

There are criteria for sending specimens to the laboratory (based on evidence and advice from the laboratory microbiologist) and if a resident is asymptomatic a specimen is not sent. Infections are reported on as to being rest home or hospital level care and reported in the type of infections per 1000 occupied bed days. The total infections for the hospital so far this year is 2.1 and rest home 1.5 which is a substantial reduction since 2012. Attributed to education, marked decline in lower respiratory tract infections with a good uptake for influenza vaccinations and pneumococcal virus having been offered which was free to residents from June 2012. Extensive education has been provided to staff on transmission precautions. Laboratory summaries are provided monthly and this information is used to review infections reported and treated. The director of nursing reviews all laboratory results for all residents before the GP sees them and signs them off. Outcomes are reported in the quality report sighted for 30 September 2013. The information is sent to the contracted infection control consultant to be analysed and benchmarking occurs with other like organisations. A summary is sent to the director of nursing from this contracted infection control service. Information is fed back to staff at the staff meetings and to the Board of Directors for Bethesda Care.

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:

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policies and procedures identify how the service implements the infection control programme which covers all requirements of the Health and Disability Service Standards. The Quality Management Committee has the responsibilities for infection control. The director of nursing is very experienced and has expertise and resources available to meet the standard requirements. The director of nursing has been appointed onto the Healthcare Acquired Infection Governance Group as the representative for residential care. The director of nursing is well supported by the registered nurses, one of whom has completed a post graduate certificate in infection control. The service receives summaries monthly from the laboratory and all laboratory results are reviewed prior to the doctor's visit by the director of nursing. The service participates in the Simple Solutions Consultancy Ltd benchmarking programme.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is a full set of up to date policies and procedures related to all required aspects of infection control as appropriate for this aged care setting. They reflect current accepted good practice and meets relevant legislative requirements. There are clear guidelines on how to manage infections and outbreaks.

Observations at the onsite audit identify implementation of infection prevention and control procedures. Staff demonstrate safe and appropriate infection prevention and control practices.

The ARRC 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Infection control education is provided in the orientation programme and is part of the ongoing education schedule for 2013. The education programme sighted evidences infection prevention and control education was provided on the 22 February 2013 with eighteen staff attending and on the 24 March 2013 with twenty two participants. Educational topic related to infection control management have included catheterisation procedures, management of urinary tract infections, wound care management and specimens to the laboratory.

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 Mal V CQ SQ STQ Ma L

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

Policy identifies that surveillance data is used to identify trends and corrective planning is put in place as appropriate. The organisation has a system in place to ensure infection control is managed by a qualified infection control officer. Expert advice can be sought from the general practitioner (who was interviewed and reports to be pleased to participate or provide advice whenever needed), and/or the laboratory clinical microbiologist or the infection control nurse specialists at Counties Manukau District Health Board Middlemore Hospital if required. The contracted pharmacist to the service is also available for consultation.

The director of nursing is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (eg, facility acquired infections) are documented to guide staff. Information is collated on a monthly basis for respiratory, influenza, urinary tract infections, skin and soft tissue, multi-resistant infections (MRI), diarrhoea, eye, nosocomial infections. Information gathered is analysed three monthly and linked to the quality and risk programme. The information is sent to the contracted consultancy and a summary is forwarded back to the service. Benchmarking is valuable for quality improvement if required and to ensure the service is managing infection prevention and control to a high standard to ensure the risk is minimised and this is clearly evident in the summary results sighted.

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: