

Benhaven Care Limited

CURRENT STATUS: 14-May-13

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

GENERAL OVERVIEW

This audit is undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and the conformity of the service prior to a facility being purchased.

Benhaven rest home provides rest home and residential disability level care for up to 19 residents. On the day of the audit there were 19 residents, (14 rest home residents and three young people with disabilities).

This audit identified that the following improvements are required around: aspects of medication management, advance directive documentation, availability of appropriate weighing scales, and maintenance checks are required for the rest home hoist.

The new owners are experienced in business management, however have not had any experiences in aged care. The current owner advises that he will be providing four weeks orientation for the new owners and will be available in a consultancy role after the orientation period for as long as required. The potential owners interviewed stated that the facilities current business plan and quality and risk management plan will remain in place. Staff will remain in their current roles.

Benhaven Care

Benhaven Care Limited

Provisional audit - Audit Report

Audit Date: 14-May-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RN, auditor certificate	8.00	6.00	14-May-13
Auditor 1	XXXXXXXX	RN, auditor certificate	8.00	5.00	14-May-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX			2.00	

Total Audit Hours on site	16.00	Total Audit Hours off site <i>(system generated)</i>	13.00	Total Audit Hours	29.00
Staff Records Reviewed	5 of 17	Client Records Reviewed <i>(numeric)</i>	5 of 19	Number of Client Records Reviewed using Tracer Methodology	2 of 5

Staff Interviewed	8 of 17	Management Interviewed <i>(numeric)</i>	2 of 2	Relatives Interviewed <i>(numeric)</i>	2
Consumers Interviewed	5 of 19	Number of Medication Records Reviewed	10 of 19	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	1

Declaration

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

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

Dated this 28 day of May 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit:

The audit summary has been developed in consultation with the provider:

Electronic Sign Off from a DAA delegated authority (*click here*):

Services and Capacity

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Benhaven Rest Home	19	19		<input 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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

This audit is undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and the conformity of the service prior to a facility being purchased.

Benhaven rest home provides rest home and residential disability level care for up to 19 residents. On the day of the audit there were 19 residents, (14 rest home residents and three young people with disabilities).

This audit identified that the following improvements are required around: aspects of medication management, advance directive documentation, availability of appropriate weighing scales, and maintenance checks are required for the rest home hoist.

The new owners are experienced in business management, however have not had any experiences in aged care. The current owner advises that he will be providing four weeks orientation for the new owners and will be available in a consultancy role after the orientation period for as long as required. The potential owners interviewed stated that the facilities current business plan and quality and risk management plan will remain in place. Staff will remain in their current roles.

1.1 Consumer Rights

The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives/whanau/advocates. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Care plans accommodate the choices of residents and/or their family/ EPOA. Complaints and concerns are actively managed and well documented.

1.2 Organisational Management

Benhaven rest home has a quality and risk management system in place that is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to the monthly quality and monthly staff meetings.

The service is active in analysing data. Corrective actions are identified and implemented. Resident/family satisfaction surveys are completed annually and regular resident meetings are held. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is an orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Consumer information is relevant and appropriate.

1.3 Continuum of Service Delivery

Residents have a needs assessment completed prior to entry to the service. Residents' initial assessment, care planning and reviews are completed by the registered nurse. There is evidence of resident, family or advocate participation in the development and review of care planning as appropriate. Risk assessment tools are utilised effectively with timely and safe nursing interventions. Evaluations of care plans are completed within stated timeframes and reviewed more frequently if a resident's condition changes. Short term care plans are utilised. The activities team offer a stimulating and interesting programme to meet the social, recreational, spiritual and cultural needs of residents.

The cook provides nutritious home cooked meals and baking. Residents and family interviewed were complimentary about staff and the services provided. An appropriate medicine management system is in place. There are improvements required around aspects of medication management.

1.4 Safe and Appropriate Environment

There is a current building warrant of fitness. There are documented processes for waste management. The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. There is a requirement for all chemical bottles to have a manufacturers label. This audit identified that there is an improvement required around a planned maintenance programme for the rest home hoist.

The residents have access to communal areas for entertainment, recreation and dining. The service provides adequate space allowing residents to move safely around in their rooms and the facility. Residents are provided with hygienic cleaning and laundry services, which are appropriate to the setting. Residents are provided with adequate natural light, safe ventilation, and a safe environment with comfortable temperature throughout the communal areas and bedrooms.

There are outside paved areas with wheelchair access, hand rails, suitable furniture and shading. There is a designated outdoor smoking area for residents.

2 Restraint Minimisation and Safe Practice

Documented systems are in place to ensure the use of restraint is actively minimized. The registered nurse is the restraint coordinator. There are currently three residents using enablers, two bedrails and one lap belt. Staff interviews and staff records evidence guidance has been given on restraint minimisation and enabler usage. Policies and procedures include definition of restraint and enablers. Staff education on challenging behaviour management and restraint minimisation has been provided.

3. *Infection Prevention and Control*

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers.

Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	PA Moderate	0	2	1	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: 11	PA Neg: 0	PA Low: 0	PA Mod: 1	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Criteria (of 48):	CI:0	FA:22	PA:1	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	0	8	0	0	0	9
Standard 1.2.4	Adverse event reporting	FA	0	2	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:0	FA:22	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	PA Low	0	2	1	0	0	6
Standard 1.3.4	Assessment	FA	0	1	0	0	0	5
Standard 1.3.5	Planning	FA	0	2	0	0	0	5
Standard 1.3.6	Service delivery / interventions	FA	0	1	0	0	0	5
Standard 1.3.7	Planned activities	FA	0	1	0	0	0	3
Standard 1.3.8	Evaluation	FA	0	2	0	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	FA	0	1	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	FA	0	1	0	0	0	2
Standard 1.3.12	Medicine management	PA Low	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	FA	0	3	0	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 10	PA Neg: 0	PA Low: 2	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:19	PA:2	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	PA Low	0	2	1	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: 7	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0
		PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 36):	CI:0	FA:16	PA:1	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	1	3
Standard 2.2.2	Assessment	Not Applicable	0	0	0	0	1	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	3	6
Standard 2.2.4	Evaluation	Not Applicable	0	0	0	0	2	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	1	1

Restraint Minimisation and Safe Practice Standards (of 6):	N/A: 5 PA High: 0 UA Crit: 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
Criteria (of 21):	CI:0	FA:1	PA:0	UA:0	NA: 8	

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: 0	FA: 41	PA Neg: 0	PA Low: 3	PA Mod: 1	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Total Criteria (of 219)	CI: 0	FA: 89	PA: 4	UA: 0	N/A: 8			

Corrective Action Requests (CAR) Report

Provider Name: Benhaven Care Limited

Type of Audit: Provisional audit

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

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.1.10	1.1.10.7	PA Moderate	<p>Finding: Two advance directive forms were evidenced signed by the GP and EPOA.</p> <p>Action: Ensure that resuscitation/advance directive forms are correctly completed</p>	3 months
1.3.3	1.3.3.3	PA Low	<p>Finding: Suitable weigh scales were not available to weigh two residents monthly. There is no documentation in the medical notes to determine the frequency of weight recording. However three monthly GP medical reviews have occurred.</p> <p>Action: Access suitable scales to monitor residents weight. Ensure GP documents the frequency of weight monitoring to occur. Since the draft report the new owner advised that they will rent a hoist scale from Rehab Rentals to ensure the recordings are made (as per GP recommendations)</p>	3 months
1.3.12	1.3.12.1	PA Low	<p>Finding: Two medication competent staff sign the controlled drug register when medications are removed from the controlled drug safe for administration. However only one person signs the medication signing sheet.</p> <p>Action: Ensure the administration of controlled drugs is witnessed and signed by two medication competent staff on the signing sheet as per the MOH Medication guide 2011 immediately</p>	3 months

1.4.2	1.4.2.1	PA Low	<p>Finding: The lifting hoist has not had a functional test or check since October 2010.</p> <p>Action: Ensure resident lifting hoist is checked and safe for use. (advised since the draft report, the hoist is checked for functionality on a regular basis, but these have not been recorded. They will institute a new form to reflect these checks).</p>	3 months
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Continuous Improvement (CI) Report

Provider Name: Benhaven Care Limited

Type of Audit: Provisional audit

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

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

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

How is achievement of this standard met or not met?

Attainment: FA

Benhaven rest home has information available on the Code of Health and Disability Services Consumers' Rights. There is a code of rights policy in place that describes the code and the responsibilities of staff. Caregivers (three), manager who is an enrolled nurse and registered nurse interviewed are familiar with the policy. They could describe ways in which residents rights are acknowledged and incorporated in their day to day work such as obtaining informed consent, resident choice and complaints procedure. Code of rights training was conducted in April 2012. Code of Rights posters were observed displayed in the hallway and dining room of the rest home. At interview on the day of audit while present at the facility, the new owners were able to demonstrate an understanding of the Code of Rights.

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

The service has available information on the Code of Health and Disability Services Consumers' Rights. The Code was observed displayed in the foyer of the service and posters are on the wall in hallways and dining room. Information in relation to the service is in a format that suits the needs of residents. The service has a copy of the Code of Rights in the foyer. Residents interviewed (five) state they are well informed about the Code of Rights. D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, COR pamphlet and information on Advocacy and H&D Commission.

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

The facility provides for physical, visual, auditory and personal privacy. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Caregivers interviewed (3) could describe the procedures for maintaining confidentiality of resident records. Discussions with five residents and two telephone interviews conducted with family members identified that personal belongings are not used as communal property.

D14.4 Privacy and Dignity (May 2012) and work instructions: Resident Welfare - Care of Resident Property provide guidelines for staff. Three caregivers confirmed on interview that personal belongings are not used as communal property or lent to others and were able to discuss ways in which resident privacy is maintained. The staff were respectful on entering a resident's room and gained permission before doing so.

There are four double rooms, two of which are used as single rooms. In the two shared rooms, the residents had agreed to share the room and curtains were in place around each bed space that can be drawn to allow for privacy.

D4.1a Five resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified,

Information about the client's spiritual needs and values is collected on admission and documented. The admission form includes the religious affiliation of the resident.

There is a values and beliefs section in the assessment and care plan. The registered nurse and manager advised that discussion on values and beliefs including cultural and spiritual needs takes place at assessment and planning with discussion around the resident needs.

The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support the needs of residents. Resident choice is part of the client code of rights policy and this promotes the right of clients to independence. Discussions with residents and family members confirmed that residents are able to choose to participate in activities and can access community resources.

Caregivers interviewed (three) could describe examples of giving residents choice including: what time they would prefer a shower or breakfast, choices on food, what time they would like to get up, what clothes they would like to wear and what activities they would like to attend/participate in. This was confirmed on discussion with residents.

The Detection and Removal of Abuse and Neglect Policy (October 2012), includes behaviours of abuse and neglect, and associated indicators. Policy links to a Work Instructions Resident Welfare: Reporting Abuse, and Care of Resident Property describing actions for staff. Discussions with manager, registered nurse and three caregivers identified that there were no incidents of abuse or neglect. There have been no identified complaints around abuse or neglect and five residents interviewed (two YPD, one LTCS and two rest home residents) were very positive about the quality of care and support provided.

Education on abuse and neglect occurred 27-Sept-12 with seven staff attending.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

A3.2 The Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

The service has policies to support practice i.e. Maori health plan and Culturally Appropriate Services. Both policies evidence review October 2012. Maori health plan and Culturally Appropriate Services policies includes health definitions, concepts and ideology, Maori models of health - te whare tapa wha, cultural safety, treaty of Waitangi, protocol for mourning and care of Maori before and after death. Education on cultural safety occurred March 2013 with seven staff attending.

D20.1i: The plan includes contact details for local Maori, Maori health services and local Marae. Discussions with three caregivers, manager, and registered nurse confirms that they are aware of the need to respond appropriately to individual cultural difference. There is currently one resident who identifies as Maori but states he has no specific cultural needs. The Code of Consumer Rights is displayed in Maori and English.

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

D3.1g The service provides a culturally appropriate service by assessing resident needs on admission, a social profile is gathered as is psycho-social needs, spiritual requirements and family/significant other links. Cultural awareness training conducted in March 2013.

D4.1c five care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

The Culturally Appropriate Services and Individual Values and Beliefs policies support and guide staff to provide. There is a values and beliefs section in the care plan. Five residents interviewed stated that they felt the service did well to meet their individual values and beliefs and praised the service for support provided. Residents indicated that they are consulted and involved in the identification of spiritual religious and or cultural beliefs. Relatives interviewed (two) stated that they felt they were consulted and kept informed. Residents and family confirm that residents are able to access the spiritual leaders (ministers/pastors/priests) of their choice and any specific issues are addressed in plans.

Church services occur weekly and two residents interviewed also described attending church services in the community each Sunday. Involvement and attendance at local church services for these two residents is documented in their care plans including contact numbers for Church members who transport one of the residents to church each Sunday.

One resident file reviewed identified that the resident was of a particular faith. The care plan for this resident included arrangements for the resident to attend services each week and also included how the resident's faith and beliefs related to other relevant areas of the care plan.

The resident interviewed felt that his beliefs and faith were respected by staff and that he was supported to maintain his spiritual practices.

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

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

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

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

How is achievement of this standard met or not met?	Attainment: FA
There are policies and procedures to ensure consumers are not subjected to discrimination, coercion, harassment or sexual harassment. These policies are supported by the code of resident's rights policy, complaints policy, abuse and neglect policy - all of which are implemented. The policies include support for the resident throughout their engagement with the service. Residents interviewed (five) described feeling "respected, well informed and able to make choices." Staff training provided around Code of Rights in April 2012.	

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

A2.2 Services are provided at Benhaven rest home that adhere to the health & disability services standards. There is an implemented quality improvement programme that includes performance monitoring. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Policies and procedures cross-reference other policies and appropriate standards. The Quality Manager attends informal bimonthly meetings with other providers in the region where sharing of knowledge and ideas occurs.

An internal audit schedule is managed within the quality system. Staff meetings occur three monthly and discuss all components of quality including incident reporting, audit outcomes, compliments, education, restraint and infection control.

D1.3 all approved service standards are adhered to.

D17.7c. There are implemented competencies for caregivers and the enrolled nurse/manager and registered nurse. There are clear ethical and professional standards and boundaries within job descriptions.

The service has a weekly GP clinic based at the facility.

Residents (five) interviewed spoke positively about the care and support provided.

Staff described a positive atmosphere and stated that they had access to resources that assisted them in providing care to residents.

Assessments and care plans have been documented in all resident files reviewed (five).

Caregivers (three), manager and registered nurse interviewed have a sound understanding of principles of aged care and state that they have been supported by the service for on-going education.

Interview with the new owners advised that the current quality system and plan would remain in place.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Residents stated they were welcomed on entry and were given time and explanation about services, and procedures. There is an open disclosure policy. The service has access to interpreter services and there is an interpreting policy. The service has a commitment to ensuring that the service is resident driven and focused. Family are welcome at any time and are encouraged to be involved in resident care review. Interpreter services are accessible via the DHB.

Resident who do not have family have the name and contact details of their advocate documented in the resident file and on the long term care plan.

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

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

D16.4b: Two relatives stated that they are always informed when their family member's health status changes.

D11.3: The information pack is available in large print for residents.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.10 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: PA Moderate

Interviews with caregivers (three) who have had experience working both morning, afternoon and night shifts, confirmed that they were familiar with the requirements to obtain informed consent. They described asking residents what clothing they wished to wear, choice of food on menu, and if they were ready for personal care requirements. The caregivers interviewed were aware of the residents' right to decline or refuse. There is a resuscitation policy and advance directive form. Resuscitation orders are completed for residents who are competent to make the decision. There is an improvement required around the documentation of advance directives and resuscitation.

D13.1 there were five admission agreements sighted and all five had been signed.

D3.1.d Discussion with two family identified that the service actively involves them in decisions that affect their relatives lives.

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:

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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: PA	Risk level for PA/UA: Moderate
A revised resuscitation/advance directive form was evidenced correctly completed in three of five resident files reviewed which had been signed by the resident and GP who deemed the resident was competent to make the decision. However two advance directive forms were evidenced signed by the GP and EPOA. The director and registered nurse discussed at audit that following attendance a recent education seminar on advance directives/ EPOA that the HVDHB had decided to create information and develop an advance directive form which will be available for use on their intranet site which can be accessed by aged care providers. This form will be available on 1st June 2012. The revised form currently in use evidenced completed in three resident files meets with the HDC Code and the facility's advanced directive and informed consent policy.		
Finding Statement		
Two advance directive forms were evidenced signed by the GP and EPOA.		
Corrective Action Required:		
Ensure that resuscitation/advance directive forms are correctly completed		
Timeframe:		

3 months

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Client right to access advocacy services is identified for residents. Leaflets are available at the entrance of the service. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information.

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed.

D4.1d; Discussion with five residents (two rest home two YPD and on LTCS) and two family members identified that the service provides opportunities for the residents, family/EPOA/advocate to be involved in decisions and they are aware of their access to advocacy services.

D4.1e: five of five resident files reviewed includes information on residents family/whanau and chosen social networks.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

D3.1h Discussion with the registered nurses, three caregivers, one enrolled nurse/manager, five residents and two family members identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e Interviews with two activity officers described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Residents are assisted to meet responsibilities and obligations as citizens e.g. voting / census. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping, trips to the cinema, social events in the community and education centres. Entertainers are included in the activities programme. The activities officers described how outings in the facility owned van are tailored to meet the interests of the residents and are flexible.

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

The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation. There has been one documented complaint dated march 2012. Documentation sighted evidences resolution of the complaint to the complainants satisfaction. There is a complaints register which is current. Five residents and two family members advised that they are aware of the complaints procedure and how to access forms.

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

Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement**Corrective Action Required:****Timeframe:****Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.****Audit Evidence****Attainment: FA****Risk level for PA/UA:****Finding Statement****Corrective Action Required:****Timeframe:****OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

STANDARD 1.2.1 Governance

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Benhaven has quality objectives that are monitored through monthly trending of incident reporting. There is a process for managing shortfalls through Corrective Action Request forms (sighted) that include evaluation for effectiveness and close out. Monitoring against objectives is discussed at staff meetings (held three monthly. Benhaven's organisational structure includes a (non-clinical) owner and quality manager, a manager who is an enrolled nurse (with current APC) and relevant registered nursing hours for size and complexity of services. The owner has owned Benhaven for ten years, and the manager has been in place for 10 years. In the absence of the manager the registered nurse (with support of the owner) provides cover. The owner and quality manager live on site.

Advised at interview with new owners that they will both be living on site. One of the new owners will immediately take on the administration duties and will be mentored into the role by the current owner. One of the new owners has a Master's degree in Business Administration and a BA in English Language and Literature the other owner has a law degree. The current owner advises that he will be providing four weeks orientation for the new owners and will be available in a consultancy role after the orientation period has been completed. It is planned that the new owners will take ownership the first week in June 2013.

The new owner advises that there will be no changes made to the organisational structure and the enrolled nurse manager and registered nurse will remain in their current roles and will provide cover in the absence of the owners.

In discussion with the current owner and new owner the service will continue with the existing strategic plan and quality plans with accompanying KPIs.

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
During a temporary absence of the manager who is an enrolled nurse, the facility is managed by a registered nurse. The service has well developed policies and procedures at a service level and a strategic plan and quality improvement plan that are structured to provide appropriate safe quality care to people who use the service including residents that require rest home level care.	
D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.	
The current systems and processes will remain in place with the new owners.	

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

The service has a strategic plan and quality risk management plan that are implemented. Progress with the quality plan is monitored through the monthly quality meetings, and monthly staff meetings. The new owner informs that this system will remain in place with the new ownership. The management meeting agenda and the staff meeting agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Minutes are maintained and easily available to staff. Quality meeting minutes sighted for March 2013 and staff meeting minutes for March 2013. Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Benhaven rest home's commitment to on-going quality improvement. Discussions with three registered nurses, one enrolled nurse and two care givers confirm their involvement in the quality programme. Resident/relative meetings take place monthly. There is an internal audit schedule 2013 and internal audits are completed for 2012. Audits include: cleaning, laundry, food service, admission procedures, infection control, care plans, complaints, medication management, personal privacy and safety, continence, cultural safety and spiritual beliefs, wound management, staff training and informed consent. The service has a health and safety management system and this includes

the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Annual review of the quality programme was conducted 21-Feb-2013.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

D5.4 The service has the following policies/ procedures to support service delivery; Policies and procedures align with the client care plans. The RN manager is responsible for policy review.

- 1) Contenance Policy. Contenance assessments were evident in six resident files.
- 2) Challenging behaviour policy. A Challenging behaviour assessment and management plan were being utilised for one resident with challenging behaviour.
- 3) Pain Management policy and procedure. There is an assessment tool being utilised for two residents with pain. There are currently two residents prescribed controlled drugs.
- 4) Personal grooming and hygiene policy
- 5) Skin integrity Management policy.
- 6) Wound care policy and procedures. There are no residents with wounds.
- 7) Transportation of subsidised residents policy and procedure includes costs, resident, and staff safety.

D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

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

D19.2g Falls prevention strategies such as falls risk assessment, walking aids, physiotherapy assessment, use of appropriate footwear, correct seating, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy.

Incident/accident forms are completed and given to the registered nurses who completes the follow up. All incident/accident forms are seen by the RN manager who completes any additional follow up and collates and analyses data to identify trends. Results are discussed with staff through the monthly quality meeting and monthly staff meeting. A resident/relative survey conducted in 2012 evidences that residents and families are over all very satisfied with the service.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

This shall include, but is not limited to:

- (a) Event reporting;
- (b) Complaints management;
- (c) Infection control;
- (d) Health and safety;
- (e) Restraint minimisation.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.4 Adverse Event Reporting

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There is an adverse events policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at monthly management meetings and monthly staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and three family members interviewed stated they are informed of changes in health status and incidents/accidents. Incident reports for March 2013 were reviewed (13) and include four falls, three residents found on floor, three skin tears, two medication errors (pharmacy packaging) and a fridge door not closed. Monthly incident/accident analysis occurs with subsequent annual summary and analysis. Family are notified of incidents and accidents and this is documented on resident records.

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

The new owners advise that the current processes will remain in place.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications and experience. A copy of practising certificates including the registered nurses, pharmacist, podiatrist and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one registered nurses, two caregivers, one activities officer and one cook). Advised that reference checks are completed before employment is offered, these were evidenced in five staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Three caregivers were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in five of five staff files reviewed. Discussion with the manager, registered nurse, cook, two activity officers and three caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Caregivers interviewed have either completed the national certificate in care of the elderly or have commenced the aged care education programme. There are 4 caregivers who have completed ACE core, advanced and ACE dementia training and four caregivers are currently enrolled on the ACE programme and have

completed up to module five of the programme to date. The registered nurse attends external training including conferences, seminars and sessions provided by the local DHB. The manager has attended education and training sessions from external providers in 2012. Education provided in 2012-present date included: pain management, open disclosure; continence; use of hoist, wound care; infection control; code of rights including advocacy, abuse and neglect, First aid, sexuality, catheter care, values and beliefs, Parkinson's; use of chemicals; Fire and emergency procedures; safe patient handling; food safety handling and medication management. Treaty of Waitangi training conducted in March 2011. Documentation on education session content, evaluations conducted following training were sighted and the manager advised that those staff who do not attend training are given opportunity to access training session content.

On review of the five staff files, performance appraisals have been conducted in 2012, all five files had signed position descriptions and reference checks are documented.

The current owner and the new owner both agreed that there would be a good orientation in place. The current owner will stay on for four weeks to ensure a smooth transition. Following this initial orientation the current owner will be available on a consultancy basis to assist the new owners.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Staffing levels and skill mix policy in place. Sufficient staff are rostered on to manage the care requirements of the rest home residents. RN manager provides on call cover. Advised that extra staff can be called on for increased resident requirements. Interviews with two caregivers, three registered nurses, five residents and three family members identify that staffing is adequate to meet the needs of residents. The new owners advise that there will be no change to the current staff/staffing levels. The manager and registered nurse are available on call. The new owners will be living on site and will be available to staff.

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 resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

D7.1 entries are legible, dates and signed by the relevant caregiver, manager who is an enrolled nurse or registered nurse including designation

Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is evidence of needs assessor service coordination assessments completed prior to entry. Admissions are timely and in consultation with the referrer, transferring provider, resident (if appropriate) family or advocate. There is evidence of resident advocacy involved in the entry process for the persons. An information pack includes provision of services for prospective residents.

One resident interviewed, recently admitted to the rest home stated he was fully informed on the admission process and received all relevant information on the services provided.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

D14.1 exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.2 Declining Referral/Entry To Services

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

ARHSS D4.2

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

How is achievement of this standard met or not met?

Attainment: FA

Advised by the manager and registered nurse that should a resident be declined the referrer would be informed and this will be communicated to the resident/family/whanau in a timely manner. Reasons for declining would be if the person has been assessed at a level of care not provided by Benhaven rest home or there are no beds available

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: PA Low

The registered nurse completes an initial assessment within 24 hours of admission. Information is gathered from the needs assessment, GP letters and medical history, discharge summaries from the district health board and other allied health professionals who have been involved in the care of the resident. The resident and their family/whanau or advocate are involved in the initial plan of care. All the information gathered forms the basis of the initial care plan to guide the care staff and support services in the delivery of a safe care. Residents (three rest home and two YPD) and relatives (one rest home and one YPD) interviewed confirmed they were involved in care planning. They were kept informed of health changes and any medical or nursing interventions required to meet the residents health needs.

A range of assessment tools were completed in resident files on admission and reviewed at least six monthly including (but not limited to); nutritional assessment, continence assessment, Morse falls risk and Norton pressure area assessment. The residents weight, blood pressure, pulse, respiration rate are recorded on admission and completed monthly. The risk tool assessments identify if residents require additional equipment, resources or other allied health professional involvement to meet their assessed needs.

Two residents had not been weighed for a year. There is an improvement required around this.

D16.2, 3, 4: Four of four rest home files reviewed identified that in all four files (or active archive files) an assessment was completed within 24 hours and all four files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by a registered nurse and amended when current health changes.

All five care plans evidenced evaluations completed at least six monthly. Short term care plans are used for short term needs.

D16.5e: Four of four rest home files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has examined the resident at least three monthly. The GP was interviewed and confirmed he visited weekly on Tuesday's for routine visits and will see any resident the registered nurse has concerns about. There is GP cover over the weekends and a locum is provided to

cover annual leave. He also meets with the families to discuss care and treatment options, discuss end of life care and resuscitation status. The GP states he is notified in a timely manner for unwell residents by phone or fax. The hospice provide palliative care and pain management support for his patients in consultation with the registered nurse. The GP has a current practicing certificate and holds a contract for service with the facility.

Tracer Methodology: Rest Home

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

Tracer YPD

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Two residents files reviewed did not document any weight recordings had been completed for a year. At interview one resident stated that she had been weighed when she had attended physiotherapy sessions at the hospital which had then ceased approximately 12 months ago. The staff use a hoist to

transfer this resident with a history of MS. The service has only stand on weighing scales available which are not suitable to weigh this resident. The other resident has difficulty with balance and therefore the stand on scales are not suitable. Registered nurse advised that one resident was attending a nutritionist privately who specialises in nutrition for patients with MS. The resident set a goal to lose some weight which she had achieved and was now maintaining. The other resident has had no notable weight gain/loss observed by staff and has been reviewed by the GP three monthly.

Finding Statement

Suitable weigh scales were not available to weigh two residents monthly. There is no documentation in the medical notes to determine the frequency of weight recording. However three monthly GP medical reviews have occurred.

Corrective Action Required:

Access suitable scales to monitor resident's weight. Ensure GP documents the frequency of weight monitoring to occur. Since the draft report the new owner advised that they will rent a hoist scale from Rehab Rentals to ensure the recordings are made (as per GP recommendations)

Timeframe:

3 months

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.4 Assessment

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The registered nurse develops an initial assessment within 24 hours of the resident's admission. All available information is gathered including NASC assessments, GP medical history and medications, allied health professional records/letters, discharge summaries, Specialist letters and information. The resident (if appropriate) and their next of kin or advocate provide personal information and other details to assist with the initial assessment. The information is used to develop activities of daily living and identify any cultural/spiritual or social needs.

The use of assessment tools identify risk and interventions, equipment and resources required to ensure the safety of the resident. A range of assessment tools are completed on admission and reviewed at least six monthly. These include: a) nutritional assessment b) continence assessment c) Norton pressure area assessment d) Morse falls risk e) pain assessment f) challenging behaviour assessment. There are wound assessments available.

Advance directives and resuscitation is discussed with the GP and registered nurse soon after admission.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.5 Planning

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Long term care plans are developed from assessment information, on going collection of information, progress notes, monitoring and observations over a three week period. The long term care plan is resident focused with interventions and goals for each category of care to promote wellbeing and independence. The long-term care plan report includes: cognitive ability; hygiene needs; communication; continence; nutrition; sleep; skin; comfort (including pain management); other needs identify spiritual, emotional and special instructions; safety (mobility aids); medical, medicines use and side effects. The care plans are dated on completion and have a review date. The registered nurse signs the care plan and where able and appropriate the resident and their family. Residents with no family have advocates.

Short term care plans are used to document any changes in health needs such as infections, reduced mobility, changes in behaviour, pain management with interventions and management. These are kept with the long term care plan in the resident file until resolved or included into the long term care plan report as an on going need. The activity plan is included in the integrated files.

The resident file also contains the care progress notes; medical notes; risk assessment tools; observation recordings form; advance directive; laboratory results. Allied health professionals record their visits in progress notes in the integrated resident file.

Caregivers interviewed (three) were kept informed of residents care and health changes and read the care plans. There was good communication channels between all staff and a handover period at the beginning of each shift. Staff meetings are held three monthly.

Residents (two YPD and three rest home) and family members interviewed (one rest home and one YPD) confirmed they were involved in all aspects of care planning.

D16.3k, Short term care plans are in use for changes in health status.

D16.3f; Four rest home files reviewed identified that family/resident or advocate were involved in care planning as signed on the care plan

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

The use of clinical risk assessment tools identified the need for interventions, equipment, products and referrals to meet the needs, goals and outcomes for the resident. The GP (interviewed) confirmed that notifications were timely when his patient's health status changed.

Mobility aids required to meet the mobility needs and safety of residents are available. For residents under YPD contract equipment and resources are provided through Rehab rental.

Caregivers interviewed (four) confirmed they had adequate resources to meet the assessed needs of the residents. D18.3 and 4 There are adequate dressing supplies and a range of products available.

Continence products are available and resident files include a urinary continence assessment which includes product use.

Specialist continence advice is available as needed.

Continence management in-services and wound management in-service have been provided.

Wound assessment forms are available. Currently there are no wounds or skin tears.

Residents are weighed monthly with the exception of two residents (Link #1.3.3.3).

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.7 Planned Activities

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There is a Diversional Therapy policy. An activities assessment is undertaken soon after a resident's admission. This includes religious/social/cultural needs and interests and hobbies including past and current links with the community. There are goals and a programme developed to meet the individual recreational, spiritual and cultural needs and preferences. The activity care plans are reviewed two monthly.

Participation is voluntary and confirmed by five residents interviewed (two YPD and three rest home).

There are two activity officers who cover the mornings and afternoon activity programme. They work a total of 34 hours per week. There are networking opportunities at the DT meetings held three monthly and workshops attended. One activity officer is re-commencing the ACE Health Education Trust programme. There is access to internet and library resources. The residents have three monthly meetings and provide feedback on the programme. The activity officers are kept informed on the resident's physical and emotional health status. A varied and fun exercise programme (as observed) is provided throughout the day with morning and afternoon activities which include exercises, crafts, puzzles, quizzes and dancing. Entertainment is provided and there are weekly van drives in the homes six seater van. The daily programme is on the dining room whiteboard. The activity officers ensure one on one time is spent with those who do not participate in group activities. Recreational needs of residents with disabilities such as visual or hearing impairments are also met. Both activity officers hold a current first aid certificate. There are suitable activities available for YPD residents with trips to the movies, cafes, concerts, social events and entertainment.

D16.5d Five of five resident files reviewed identified that the individual activity plan has not been reviewed within the last six months.

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

Long term care plans are evaluated by the registered nurse at least six monthly or earlier if the resident's health needs change. Caregivers (three) interviewed confirm the registered nurse involves the care staff in the review of care plans. Risk assessment tools are evaluated at the time of care plan review or earlier if there is a change in resident condition. Short term care plans are evaluated regularly with short term needs being resolved or included in the long term care plan as an on going need.

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

ARC: D16.3c: Four of four initial care plans for rest home residents were evaluated by the registered nurse within three weeks of admission

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: 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 registered nurse assessments identify the need for a referral to specialist or allied health professionals to meet the resident's needs and goals. The GP initiates referrals as required through the district health board or privately in consultation with his patients. There was evidence of referrals to dietician, physiotherapist, podiatrist, continence specialist, urology clinic, dental referral, radiology, breast screen central, mole map services.

D16.4c; The policy is to involve the needs assessment coordination team for re-assessment where a higher level of care is identified.

D 20.1 discussions with registered nurse identified that the service has access to allied health professionals as required. The Hospice provide support and advice for end of life care and management.

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

There is a procedure for safe, timely and co-ordinated transfer of residents. Documents are provided to include all information to assist medical teams in a full assessment. A resident file reviewed with a recent transfer to hospital January 2013 evidenced appropriate documentation sent to the DHB. There was a discharge summary in the resident file. All appropriate notifications are forwarded to the required departments on admission, transfer and discharge from the facility. Family contact informing of transfer to hospital is documented.

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: PA Low

There are policies and procedures in place for safe medicine management. The registered nurse and senior caregivers who administer medications are competency assessed annually and attend medication education. Three caregivers interviewed were able to describe the orientation for administering medications and the assessment process. The robotic rolls for resident medications are checked on delivery by the registered nurse who countersigns the pharmacy signature on the residents signing sheet. There is a pharmacy agreement in place. All medications are kept in a locked room and the medication trolley is kept under supervision during medication rounds. The medication drug charts are pharmacy generated with photo ID and document any known allergies. The GP has signed the medication charts correctly and three monthly reviews are evidenced. The standing orders are reviewed annually and meet the prescribing requirements. There are no self-medicating residents. Controlled drug register stocktake is carried out weekly and all medications in the controlled drug safe were correctly labelled for the resident. Two medication competent persons checked out controlled drugs. Only one person signed the administration form, therefore there is an improvement required. All returns were kept in locked cupboard until collection by pharmacy.

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

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

Two medication competent staff sign the controlled drug register when medications are removed from the controlled drug safe for administration. However only one person signs the medication signing sheet.

Finding Statement

Two medication competent staff sign the controlled drug register when medications are removed from the controlled drug safe for administration. However only one person signs the medication signing sheet.

Corrective Action Required:

Attainment: PA

Risk level for PA/UA: Low

Ensure the administration of controlled drugs is witnessed and signed by two medication competent staff on the signing sheet as per the MOH Medication guide 2011 immediately

Timeframe:
3 months

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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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
<p>Two cooks are employed to prepare, cook and serve meals. They hold certificates in food preparation and food hygiene. There is a three week summer and winter menu. All baking and meals are prepared and cooked on the premises. The main hot meal is at midday with a light nutritious meal for tea. Hot foods are served immediately. Snack foods are readily available. Special diets for diabetics and pureed meals are catered for as are resident likes and dislikes. The registered nurse provides the cook with a resident food instruction sheet on admission. This is reviewed at six monthly care plan review or updated when there have been changes to resident's dietary needs. The menu has recently been reviewed by the dietitian with an improvement required around the variety of puddings. Recommendations have been implemented. Residents may choose to have breakfast in their</p>	

rooms or the dining room. Residents have the opportunity to feed back on the food service at their three monthly meetings and raise any concerns they have at any other time with the manager. Five residents interviewed (two YPD and three rest home) gave positive feedback about the meals.

The kitchen is spacious with a separate pantry. All dried foods are stored in labelled containers. There is a gas operated stove top and electric oven. The dishwasher is auto fed with an approved chemical. Safety data sheets are available in the kitchen. The handyman checks and records monthly temperatures on the five freezers and three fridges. There is enough food held for at least three days in case of an emergency. There is a BBQ available as an alternative cooking source. Plastic cups, plates and utensils are utilised in an outbreak or equipment breakdown situation.

The kitchen has its own hand basin. Staff wear aprons and powder free blue gloves.

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

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

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

STANDARD 1.4.1 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

Chemicals are stored in locked storage area. Jaysol provide chemical use wall charts and safety data sheets which are in the kitchen and laundry areas. A chemical spills kit is located in the garage. All general waste is disposed of into wheelies bins for collection. There is an approved biohazard container for the disposal of sharps. There is appropriate protective equipment available.

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: PA Low

The current building WOF expires September 2013. All fire safety equipment is checked and current. ADT fire monitoring service is carried out as per fire safety regulations. The external buildings and grounds are well maintained. There are outdoor seating areas with shaded areas provided. The outdoor areas are flat with safe paved areas and footpaths. There is ramp access and handrails. A designated smoking area is provided for residents. The interior is well maintained and welcoming with furnishings selected to meet the consumer group needs and safety. The corridors in all areas are wide and spacious enough to allow residents the freedom to move around the facility with the use of mobility aids. There is adequate space for the use of wheelchairs and walking frames. Safety handrails are in place along the corridors. Staff amenities are available. The carpets and other floor surfaces are well maintained.

Two maintenance men are employed to carry out daily maintenance requests and contacts contractors such as electrician or plumber as required.

A younger person has the use of electric bed, hoist and electric wheelchair provided and checked by Rehab rental.

There is a second lifting hoist available for resident use in the event of an emergency or fall. The hoist has not had a functional or electrical check since October 2010, therefore is an improvement required.

D15.3d There are two lounge areas designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; The following equipment is available, pressure relieving resources as assessed, shower chairs, high rise toilet seats, walking frames, lifting hoist.

The new owners advise that the maintenance persons will continue to be employed and the current maintenance plan will remain in place.

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

Audit Evidence

A lifting hoist is available for resident use in the event of an emergency or fall.

Attainment: PA**Risk level for PA/UA:** Low**Finding Statement**

The lifting hoist has not had a functional test or check since October 2010.

Corrective Action Required:

Ensure resident lifting hoist is checked and safe for use. (Advised since the draft report, the hoist is checked for functionality on a regular basis, but these have not been recorded. They will institute a new form to reflect these checks).

Timeframe:

3 months

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

There are nine bedrooms with a toilet and hand basin and three rooms with hand basin only. Residents in single rooms without hand basins or toilets share the communal facilities. There are two large wheelchair access toilets with hand basins and three shower rooms. Residents are assured privacy when attending to personal hygiene needs. The staff knock on doors before entering and there is a vacant/occupied system for communal toilets and showers. Five residents interviewed (two YPD and three rest home) confirmed staff respect their right to privacy.

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

There are four double rooms. Two of these rooms are shared the two others have single occupancy. All other rooms are single. There is an in-built wardrobe in each room. The rooms are personalized. There is adequate space for residents who use mobility aids to safely move about in their rooms. Residents interviewed (two YPD and three rest home) stated they were content with their bedroom space, the communal areas and the environment.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

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

ARC E3.4b ARHSS D15.3d

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

How is achievement of this standard met or not met?

Attainment: FA

There is a large lounge which is readily accessible for social interaction, activities and entertainment. There is also a lounge/dining area. A separate conservatory is available as a quiet area for privacy or time with visitors. All seating is suitable and appropriate to the needs of the consumer group. The dining area is large and spacious to safely accommodate the residents at meal times. The dining room is suitable to utilize as an additional activity area. Residents were observed moving safely about the communal areas with their mobility aids (includes the use of an electric wheelchair). D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

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

The Manager oversees the housekeeping and laundry area. There are written procedures (Bugs control manual) for all aspects of the cleaning and laundry service. Weekly cleaning schedules are in place. Internal audits are carried out monthly.

A cleaner is employed. On the day of audit staff were observed to be compliant in infection control practice. Protective apparel such as gloves, plastic aprons and cloth aprons worn. Goggles were also available in the sluice/laundry room. There is large washing machine in the laundry/sluice room and a dryer in a separate clean linen room. Chemicals are provided by Jaysol and chemical wall charts are in place with safety data sheets readily accessible. The chemicals are stored in a locked cupboard. There is a locked gate at the top of the three steps which lead down to the nurses office and laundry. Wet floor signs were in use.

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

The service has an approved fire evacuation plan from NZFS dated 1995 and 2001. Fire drill carried out 11-Dec-12. Emergency plans include a disaster plan and a very in-depth evacuation plan documented. There is 125 litres of bottled water stored in the shed to supply the residents in the event of an emergency. The facility is part of the Upper Hutt Emergency Preparedness Network (Readynet).

There are ample contingency plans and equipment in place for civil emergencies. There is a gas BBQ for alternative heating and cooking.

Emergency food supplies sufficient for more than three days are kept in an external store room and extra blankets are also available. There are also civil defence kits, and least seven days stock products such as incontinence products and PPE for staff to access in an emergency.

There are is a working call bell system that connects to nurse call boards During the tour of the facility residents were observed to have easy access to the call bells. Residents interviewed stated their bells were answered in a timely manner.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

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:

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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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The communal areas have large windows and are well designed to allow natural light and sunshine into the rooms. There are doors opening out onto the external courtyards. Each bedroom is situated with an outlook onto gardens. The bedrooms all have an external window to allow adequate natural light into the rooms.

The environment is warm and comfortable. There is under floor heating which circulates into the individual bedrooms. The heating is thermostat controlled. There are heating units in the bathrooms. The Vulcan heating unit is also a ventilation unit. Residents (two YPD and three rest home) and two relatives interviewed (1 rest home and 1 YPD) confirmed the environment was warm and comfortable.

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 Mal V CQ SQ STQ Ma L

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

Documented systems are in place to ensure the use of restraint is actively minimized. The registered nurse is the restraint coordinator. There are currently three residents using enablers, two bedrails and one lap belt. Staff interviews and staff records evidence guidance has been given on restraint minimisation and enabler usage. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on challenging behaviour management and restraint minimisation was conducted on 07-Mar-13 with seven staff attending.

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

Benhaven rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. There is a staff meeting which incorporates infection control and health and safety and includes discussion and reporting of infection control matters and consequent review of the programme. Minutes are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff.

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**

The registered nurse designated the role of infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurses maintain their practice by attending annual infection control updates. The IC nurses and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse consultant. The infection control team is representative of the facility.

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 an infection control policy and procedures appropriate to for the size and complexity of the service.

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed, reviewed and updated annually. Last review conducted October 2012. Behaven rest home's infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment., personal protective equipment, medical waste disposal and sharps and spills management. The facility uses the Bug Control IC manuals.

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

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurses with expert support from external providers who provide the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. The IC nurse attends training annually. Education for staff last conducted in January 2013. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Evidence of documentation of education sessions for staff on use of PPE and hand washing was sighted.

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
<p>Infection surveillance is an integral part of the infection control programme and is described in Benhaven rest home's infection control and surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the registered nurse.</p>	

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: