Sandringham House Limited

CURRENT STATUS: 04-Mar-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

Sandringham House in Oamaru is owned by a husband and wife team with one owner as manager and the other owner provides maintenance and resident support. Sandringham House is certified to provide rest home level care for up to 21 rest home residents. On the day of the audit, there were 19 residents. The service continues to implement a quality and risk management system and continues to apply the principles of continuous improvement. The owners are supported by a registered nurse with experience in aged care who provides clinical oversight to the facility. There is an implemented quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided. Improvements are required whereby: complaints and concerns are documented on a complaints register, corrective actions are developed around audit outcomes, initial care plans are completed by the registered nurse and within expected timeframes, aspects of medication management comply with best practice, decanted foods are dated and food temperatures are recorded, hot water temperatures are within expected limits and chemicals are stored securely.

The prospective new owners (husband and wife) are planning to manage the facility following transition into the service by the current owners/managers. One of the new owners is a registered nurse who has worked as a registered nurse at Sandringham for four years with many years' experience in community nursing. The other will work as a handyman and provide administration support. The new owners advised that they intend to run the home as a very family orientated rest home like the current owners. There is a plan to maintain current staffing, policies, procedures, quality systems and no environmental changes are envisaged at this time.

Sandringham House Rest Home

Sandringham House Ltd

Provisional audit - Audit Report

Audit Date: 04-Mar-13

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Sandringham House Ltd

Premise Name	**Street Address**	**Suburb**	**City**
Sandringham House Rest Home	12 Sandringham Street		Oamaru

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

Type of Audit	Provisional audit and (*if applicable*)	
Date(s) of Audit	**Start Date:** 04-Mar-13	**End Date:** 04-Mar-13
Designated Auditing Agency	Health and Disability Auditing New Zealand Limited	

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXXX	RCpN; Health Auditor; AdDipBusMan	8.00	6.00	4-Mar-13
Auditor 1	XXXXXXXXX	RN; Lead Auditor, BHSc	8.00	4.00	4-Mar-14
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXXX			2.00	

Total Audit Hours on site	16.00	**Total Audit Hours off site** *(system generated)*	12.00	**Total Audit Hours**	28.00
Staff Records Reviewed	4 of 16	**Client Records Reviewed** *(numeric)*	4 of 19	**Number of Client Records Reviewed using Tracer**	1 of 4

				Methodology	
Staff Interviewed	8 of 16	**Management Interviewed** *(numeric)*	2 of 2	**Relatives Interviewed** *(numeric)*	3
Consumers Interviewed	5 of 19	**Number of Medication Records Reviewed**	10 of 19	**GP's Interviewed (aged residential care and residential disability)** *(numeric)*	1

Declaration

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

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

Dated this 10 day of June 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

				Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
Premise Name	**Total Number of Beds**	**Number of Beds Occupied on Day of Audit**	**Number of Swing Beds for Aged Residential 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
Sandringham House Rest Home	21	19		☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐

Executive Summary of Audit

General Overview

Sandringham House in Oamaru is owned by a husband and wife team with one owner as manager and the other owner provides maintenance and resident support. Sandringham House is certified to provide rest home level care for up to 21 rest home residents. On the day of the audit, there were 19 residents. The service continues to implement a quality and risk management system and continues to apply the principles of continuous improvement. The owners are supported by a registered nurse with experience in aged care who provides clinical oversight to the facility. There is an implemented quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided. Improvements are required whereby: complaints and concerns are documented on a complaints register, corrective actions are developed around audit outcomes, initial care plans are completed by the registered nurse and within expected timeframes, aspects of medication management comply with best practice, decanted foods are dated and food temperatures are recorded, hot water temperatures are within expected limits and chemicals are stored securely.

The prospective new owners (husband and wife) are planning to manage the facility following transition into the service by the current owners/managers. One of the new owners is a registered nurse who has worked as a registered nurse at Sandringham for four years with many years' experience in community nursing. The other will work as a handyman and provide administration support. The new owners advised that they intend to run the home as a very family orientated rest home like the current owners. There is a plan to maintain current staffing, policies, procedures, quality systems and no environmental changes are envisaged at this time.

1.1 Consumer Rights

Sandringham House rest home strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are actively managed and well documented. An improvement is required whereby all complaints are documented on a complaints register.

1.2 Organisational Management

Sandringham is owned by a husband and wife team with clinical oversight provided by a part time registered nurse. Day to day management is provided by one owner/manager. The owner/manager and registered nurse are responsible for the implementation of the quality and risk management programme. The quality and risk management programme includes service philosophy , goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly management

meetings and monthly staff meetings. Residents are surveyed at two monthly meetings and family satisfaction surveys are completed annually. 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 a comprehensive 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. Improvement required whereby corrective actions are identified, implemented and followed through following audits.

1.3 Continuum of Service Delivery

Sandringham House has documented entry criteria, which is communicated to residents, family and referral agencies. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Resident and family interviews confirm their input into care planning, care evaluations and access to a typical range of life experiences and choices. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services and residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs. Sampling of residents' clinical files validates the service delivery to residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes and this is noted on a short term care plan. Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. An appropriate medicine management system is implemented. Policies and procedures record service provider responsibilities. Staff responsible for medicine management have attended in-service education on medication management and have current medication competencies. Policy on residents who wish to self- administer medicines is recorded. A central kitchen and on site staff provide the food service for the home. Kitchen staff have completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis.

Improvements are required whereby the initial care plan is conducted by a registered nurse and timeframes are adhered to; aspects of medication management system comply with legislation, protocols and guidelines including residents who self-administer medicines; decanted foods are dated and food temperatures monitored.

1.4 Safe and Appropriate Environment

There are documented processes for waste management. The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemical safety training is provided to staff. There is a current building warrant of fitness. The maintenance role entails checks for safety of the facility and implementing requests from the maintenance book. The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. General living areas and resident rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. There are outside paved areas with suitable furniture and natural shading. The service provides adequate space allowing residents to move safely around in their rooms and the facility. Residents are being provided with safe and 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.

There are two areas requiring improvement that relate to safe storage and labelling of chemicals and providing hot water at a safe temperature.

2 Restraint Minimisation and Safe Practice

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There were no residents requiring restraint or enabler use at the facility on audit day.

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 service providers 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	FA	0	3	0	0	0	9
Standard 1.1.11	Advocacy and support	FA	0	1	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	FA	0	2	0	0	0	2
Standard 1.1.13	Complaints management	PA Low	0	1	1	0	0	3

Consumer Rights Standards (of 12):	N/A:0	CI:0	FA: 11	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Criteria (of 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	PA Low	0	7	1	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 PA Crit: 0	CI:0 UA Neg: 0	FA: 6 UA Low: 0	PA Neg: 0 UA Mod: 0	PA Low: 1 UA High: 0	PA Mod: 0 UA Crit: 0	PA High: 0
Criteria (of 34):	CI:0	FA:21	PA:1	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 Moderate	0	1	2	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 Moderate	0	2	2	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	PA Low	0	2	1	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 9	PA Neg: 0	PA Low: 1	PA Mod: 2	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:16	PA:5	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	PA Moderate	0	1	1	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: 6	PA Neg: 0	PA Low: 1	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 36):	CI:0	FA:15	PA:2	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:** 38	**PA Neg:** 0	**PA Low:** 4	**PA Mod:** 3	**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:** 84	**PA:** 9	**UA:** 0	**N/A:** 8			

Corrective Action Requests (CAR) Report

Provider Name: Sandringham House Ltd
Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:04-Mar-13 End Date: 04-Mar-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.1.13	1.1.13.3	PA Low	**Finding:** The complaints register has not been maintained to document a record of complaints and concerns. **Action:** Maintain the complaints register with all complaints and concerns.	3 months
1.2.3	1.2.3.8	PA Low	**Finding:** Finding statements and corrective actions have not been developed for audits conducted in 2012 and for family survey conducted in January 2013 **Action:** Ensure that all audits and surveys have evaluations completed and identified issues are managed through corrective actions.	3 months
1.3.3	1.3.3.1	PA Moderate	**Finding:** Two of four residents' files evidence the initial care plan is completed by the owner/ manager. There is no recorded evidence of RN input into initial care plans, as per ARC D16.2b. **Action:** Provide evidence resident's initial care plan is conducted by RN, as per ARC D16.2b.	3 Months

1.3.3	1.3.3.3	PA Moderate	**Finding:** Two of three newly admitted residents' files evidence the initial nursing history assessments are not completed within 24 hours of admission to the facility and the long term care plans are not completed within the three week timeframe of admission to the facility. Three of three residents' files (all three residents' were admitted in last four months) evidence risk assessments, such as falls, pressure injury, pain, are not conducted on admission. **Action:** Provide evidence timeframes are adhered to, as per ARC contract.	3 months
1.3.12	1.3.12.1	PA Moderate	**Finding:** a) The controlled drug register does not evidence weekly CD checks or six monthly CD physical stock takes; b) One of ten medicine charts did not have resident photo identification. This was discussed with the RN and resident's photo ID was placed in the medicine chart on audit day; c) Nine of ten medicine charts evidence no recorded allergies. Discussion was held with the RN, all of the nine residents had no known allergies and this was entered on the medicine charts on audit day; d) there is no recorded evidence of GP sample signature register. **Action:** a) Provide evidence of CD register weekly checks and six monthly stock takes of CD drugs; b) ensure all residents have photo ID on medicine charts; c) ensure patients' allergies and no known allergies are recorded on medicine charts; d) provide evidence of GP sample signature register.	1 month
1.3.12	1.3.12.5	PA Moderate	**Finding:** One resident is self- administering medicines at the facility. There is no evidence of GP's assessment of the resident's competency to self-administer medicines. Medicines are not securely stored in resident's room. Record of administration of medicines is not maintained. **Action:** Provide facilitation of safe self-administration and storage of medicines by residents.	1 month
1.3.13	1.3.13.5	PA Low	**Finding:** Decanted foods are not dated. Food temperatures are not monitored. **Action:** Date decanted foods and monitor food temperatures.	3 months

1.4.2	1.4.2.1	PA Moderate	**Finding:** Hot water temperatures show temperature recording at 46 degrees in one wing of the facility. All monthly recording for 2012 show this wing is consistently above 45 degrees Celsius. **Action:** Provide evidence hot water temperature is provided at 45 degrees Celsius.	3 Months
1.4.6	1.4.6.3	PA Moderate	**Finding:** Visual inspection evidences two chemical containers are not appropriately labelled and chemicals in laundry, kitchen and visitors toilet are not securely stored. **Action:** Provide evidence of safe storage of chemicals and appropriate labels are attached to chemical containers.	1 month

Continuous Improvement (CI) Report

Provider Name:	Sandringham House Ltd
Type of Audit:	Provisional audit
Date(s) of Audit Report:	Start Date:04-Mar-13 End Date: 04-Mar-13
DAA:	Health and Disability Auditing New Zealand Limited
Lead Auditor:	XXXXXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 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

The code of health and disability rights is incorporated into care. Discussions with three caregivers identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with five residents and three family members confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in November 2011.

The prospective owners are aware 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 ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

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

Code of rights leaflets are available at the front entrance of the facility. Code of rights posters are on the walls in the hallway of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. If necessary, staff will read and explain information to residents. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement as evidenced in four of four files reviewed.

D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, 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 ☒ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

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

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. The home's philosophy which states: 'to assist all residents to maintain their independence and involve them in all decision making regarding themselves (with inputs from families too)', is implemented in practice. There is a policy that covers abuse and neglect and staff have completed training in March 2012.

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

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

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

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

There are current policies and procedures for the provision of culturally safe care for Māori residents. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. Cultural safety training occurred as part of the annual in-service education programme in February 2012 with revision in November 2012.

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

D20.1i The service has developed links with local iwi. There are currently no Maori residents at Sandringham rest home.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

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

The service's philosophy focuses on residents' right to be accepted as an individual and being given the opportunity to enhance the values in their lives thereby enables residents to be individuals. This flows through into each person's care plan and could be described by three caregivers interviewed. During the admission process, the registered nurse along with the resident and family/whanau complete the documentation. Regular reviews are

evident and the involvement of family/whanau is recorded in the resident care plan. Three family members interviewed feel that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day.

D3.1g The service provides a culturally appropriate service by implementing the Sandringham rest home mission statement which is 'to provide a quality homely environment for the elderly whom we have the privilege of looking after in an atmosphere of respect and friendliness which enables them to have their care met regardless of culture, race or creed'.

D4.1c Four of four care plans reviewed included the residents social, spiritual, cultural and recreational needs.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

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

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

There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct. Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment.

Performance appraisals are conducted and staff receive supervision. Discussions with five residents identify that privacy is ensured. Discussions with three caregivers described how professional boundaries are maintained. Discussions with the manager and a review of complaints identified no complaints of this nature.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

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

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

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

A2.2 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. Policies and procedures are provided by an external consultant, who provides regular updates for the service to maintain best practice. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through residents meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.

There is an internal audit schedule. It includes (but is not limited to): admission procedures, cleaning, food service, laundry, infection control, medication competency, activities programme, use of restraint, safety, lifting and transferring, and staff education.

Five residents and three family members interviewed spoke very positively about the care provided.

D1.3 All approved service standards are adhered to.

D17.7c. There are implemented competencies for the care givers and registered nurse. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

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

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

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

There is an open disclosure policy, a complaints policy, an accident/incident policy and adverse events policy.

Five residents and three family members stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur two monthly and the owner/manager and registered nurse has an open-door policy.

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 The three family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.10 Informed Consent

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

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

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

The informed choice and consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process and at resident reviews. Caregivers interviewed (three) are familiar with the code of rights and informed consent and described the link between the rest home's philosophy and choice and consent on a daily basis. Informed consent forms are evident on four of four resident files reviewed. There is a resuscitation policy and resuscitation decision form that is completed appropriately. Resuscitation orders are completed for residents who are competent to make the decision. Education on informed consent was conducted by the RN in July 2012. The admission agreement records informed consent and this is signed by residents and/or family.

D13.1 There were four admission agreements sighted and evidence signing.

D3.1.d Discussion with three family members identifies 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:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11 Advocacy And Support

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

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

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

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

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. Advocacy training was provided in November 2011.

D4.1d; Discussion with five residents and three family members identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.

D4.1e: Four of four 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 nurse, three caregivers, five residents and three 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 the activity person 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. Entertainers are included in the rest home activities programme. The activities coordinator and owners described how outings in the facility owned van are tailored to meet the interests of the residents.

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.13 Complaints Management

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

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

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

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

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. Two verbal concerns from residents have been documented and managed. These demonstrate that both verbal and written complaints are actively managed. There is a complaints register, however, this has not been utilised for documenting complaints or concerns. Five residents and three 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:** PA **Risk level for PA/UA:** Low

A complaints/compliments folder is maintained with all documentation. These demonstrate that both verbal and written complaints are actively managed. There is a complaints register form, however, this has not been utilised for documenting complaints or concerns.

Finding Statement

The complaints register has not been maintained to document a record of complaints and concerns.

Corrective Action Required:
Maintain the complaints register with all complaints and concerns.

Timeframe:
3 months

OUTCOME 1.2 ORGANISATIONAL MANAGEMENT

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

STANDARD 1.2.1 Governance

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

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

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

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

Sandringham rest home is owned by a husband and wife team who have owned the service for 16 years. One owner is the designated manager who is supported by an experienced part time registered nurse. The rest home provides care for up to 21 rest home residents with 19 residents on the day of audit. The service has a current strategic plan and quality plan for 2013. The quality programme is managed by the owner/manager with assistance from the other owner and registered nurse. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The quality committee incorporates the owner/manager, the owner and the registered nurse. The committee meets monthly to assess, monitor and evaluate quality care at Sandringham rest home. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The mission statement sets out the vision and values of the service: 'to provide a quality homely environment for the elderly whom we have the privilege of looking after in an atmosphere of respect and friendliness which enables them to have their care met regardless of culture, race or creed'.

D15.3d: The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

The prospective new owners (husband and wife) are planning to manage the facility following transition into the service by the current owners/managers. One of the new owners is a registered nurse who has worked as a registered nurse at Sandringham for four years with many years' experience in community nursing. The other will work as a handyman and provide administration support. The new owners advised that they intend to run the home as a very family orientated rest home like the current owners. There is a plan to maintain current staffing, policies, procedures, quality systems and no environmental changes are envisaged at this time.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.2 Service Management

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

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

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

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

During a temporary absence of the owners, the facility is managed by the registered nurse. The registered nurse is experienced in aged care and management. 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.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

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

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

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

The service has a strategic plan and quality risk management plan that are implemented. There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through monthly management/quality meetings, and monthly staff meetings. 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. Management meeting minutes sighted for 28-Feb-2013 and staff meeting minutes for 27-Feb-2013. Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Sandringham rest home's commitment to on-going quality improvement. Discussions with the registered nurse and three care givers confirm their involvement in the quality programme. Resident/relative meetings take place two monthly. Audits are conducted and include: cleaning, laundry, food service, admission procedures, infection control, activities programme, use of restraint, safety audit, lifting and transferring and staff education. 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.

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.

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 nurse who completes the follow up. All incident/accident forms are seen by the owner/manager who completes any additional follow up and collates and analyses data to identify trends. Results are discussed with staff through the monthly staff meetings, the monthly management meeting. Audits for 2012 have been completed; however, there is a lack of documented management around non-compliance issues identified. Finding statements and corrective actions have not been documented. A family survey conducted in January 2013 evidences that families are over all very satisfied with the service. A survey evaluation has not been conducted for follow up and corrective actions required.

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

Audits for 2012 have been completed with overall compliance; however, there is a lack of documentation around the management of non-compliance issues identified. Finding statements and corrective actions have not been documented. A family survey conducted in January 2013 evidences that families are over all very satisfied with the service. However, a survey evaluation has not been conducted for follow up and corrective actions identified.

Finding Statement

Finding statements and corrective actions have not been developed for audits conducted in 2012 and for family survey conducted in January 2013

Corrective Action Required:
Ensure that all audits and surveys have evaluations completed and identified issues are managed through corrective actions.

Timeframe:
3 months

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.4 Adverse Event Reporting

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

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

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

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

There is 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 confirm 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 February 2013 were reviewed. All reports were completed and family notified as appropriate. Monthly incident/accident analysis occurs with subsequent annual summary and analysis.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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

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

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

The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurse and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Four staff files were reviewed (one registered nurse, two care givers/cooks, and one recently employed care giver). Advised that reference checks are completed before employment is offered as evidenced in one recently employed staff file 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 four of four staff files reviewed.

Discussion with the owner/manager, registered nurse 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. Three caregivers interviewed have either completed the national certificate in care of the elderly or have commenced the aged care education programme. The registered nurse attends external training including conferences, seminars and sessions provided by the local DHB. The owner/manager has attended education and training sessions from external providers in 2012. Education provided in 2012 included: cultural safety and Treaty of Waitangi; abuse/neglect prevention, complaints process and open disclosure; care hygiene, skin and wound care and pressure area prevention; restraint minimisation and challenging behaviour management; communication and reporting, quality and risk management, advanced directives and informed consent; manual handling; orientation and admission of residents; death and dying. Education in 2011 included: safe chemical handling; medication administration; health and safety, security and emergency management; advocacy and residents rights. Fire evacuation drill last conducted February 2013. On review of four staff files, performance appraisals for three of four staff have been conducted (one staff file reviewed has been employed within the past 12 months).

The prospective owners advised they will continue with the same education programme.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

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

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

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

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

Good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home residents. At least one staff rostered on at any one time with one staff on-call. Registered nurse or owner/manager provide first on call. Advised that extra staff can be called on for increased resident requirements. Roster includes: three care givers work 7 -1pm daily, cook/care giver works 7-3.30pm - from 1-3.30pm assists with cares. Care giver x 1 works 3 - 11pm and care giver x 1 11pm - 7am. Registered nurse works 10+ hours per week. Owner/manager and owner are on site 40 hours per week and on-call after hours. Interviews with three caregivers, five residents and three family members identify that staffing is adequate to meet the needs of residents.

The prospective new owners advised that staffing will remain the same. Advised that the current owners/managers will be available for a two week period, to transition the new owners. They will also be available as and when required after that.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

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

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

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 (with exceptions #1.3.3). Residents' files are protected from unauthorised access by being locked away in the manager's/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 or RN 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 ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

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

Documented systems and processes are implemented to ensure resident's entry into the service has been facilitated in a competent, equitable, timely and respectful manner. The service's philosophy is recorded and communicated to residents, family, relevant agencies and staff and displayed at the facility. The admission agreement defines scope of service and includes all the contractual requirements, sighted. The owner/ manager and the RN interviews confirm access and entry processes are followed. This facility operates 24/7. The service provides information to potential referral sources. Resident information booklet/welcome pack was sighted with all relevant information for the resident and family is recorded. Residents' files sampled demonstrate all needs assessments are completed for rest home level of care. Five of five resident interviews confirm their input into the admission process. Admission procedure audit was conducted in May 2012. Staff education in orientation and admission of residents was conducted in September 2012.

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

Systems to decline resident entry to the service are documented and the resident, and/or their family and agency are informed of the reason for this. The scope of the service provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, the reasons why the service has been declined will be implemented, if required, stated by the owner/ manager. The owner/ manager states resident will be declined entry if not within the scope of the service or if a bed is not available at the time and referred back to the NASC service.

Owner/manager interview confirms two residents were declined entry to the facility in last 12 months and this data and reasons for the declined entry is recorded.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.3 Service Provision Requirements

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

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

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

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

In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and the service is coordinated to promote continuity of service delivery.

Four of four clinical staff (one RN and three care staff) interviews confirm residents and/or family members are involved in all stages of service provision.

Five of five resident interviews confirm their input into service delivery planning and care evaluations.

Four of four residents' files sampled demonstrate the long term care plans are developed by the RN, in consultation with the resident and/or family member. Family communication sheets are maintained, sighted in all four residents' files sampled. There is a process to identify and respond to variances/trends e.g. accident / incident / unwanted events reporting system. RN interview confirms handovers between shifts occurs and communication book and handover sheets are maintained, sighted. The interview with the GP confirms that staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff. Staff competency assessments are current, sighted on staff competency register and staff records sampled. Staff education in care hygiene, pressure areas, skin management and wound cares was conducted in April 2012 by the RN and attended by 15 staff.

Residents' clinical files sampled evidence timeframes are not adhered to and the initial care plans are conducted by the owner/ manager who is not a RN.

There are two areas requiring improvement that relate to providing evidence the resident's initial care plan is conducted by a registered nurse and timeframes are adhered to.

Tracer Methodology Rest Home Resident.

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

D16.2, 3, 4: Two of four residents' files reviewed, identify nursing history assessment was not completed within 24 hours and the long term care plan was not completed within three weeks. There is no documented evidence that the initial care plan was reviewed by a RN in two of three files sampled.

D16.5e: All resident files reviewed identify that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly.

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

Two of four residents' files evidence the initial care plan is completed by the owner/ manager. There is no recorded evidence of RN input into initial care plans.

Finding Statement

Two of four residents' files evidence the initial care plan is completed by the owner/ manager. There is no recorded evidence of RN input into initial care plans, as per ARC D16.2b.

Corrective Action Required:
Provide evidence resident's initial care plan is conducted by RN, as per ARC D16.2b.

Timeframe:
3 Months

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:** Moderate

Four residents' clinical files were sampled. Three of the three newly admitted residents' files evidence the risk assessments are not conducted on admission. The variation in timeframe is from a week to a month post resident's admission. One of four residents' files is a file of a resident admitted to the facility in 2004 and the risk assessment were reviewed as part of a care plan review in January 2013.

Two of three newly admitted residents' files evidence the initial nursing history assessments are not completed within 24 hours of admission to the facility. The variation in timeframe is five days and four weeks post residents' admission.

Two of three newly admitted residents' files evidence the long term care plan is not completed within the three week timeframe of admission to the facility. The variation in timeframe is four week and five weeks post residents' admission.

Finding Statement

Two of three newly admitted residents' files evidence the initial nursing history assessments are not completed within 24 hours of admission to the facility and the long term care plans are not completed within the three week timeframe of admission to the facility. Three of three residents' files (all three residents' were admitted in last four months) evidence risk assessments, such as falls, pressure injury, pain, are not conducted on admission.

Corrective Action Required:
Provide evidence timeframes are adhered to, as per ARC contract.

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 ☒ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

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

Residents' needs, outcomes and goals are identified via the assessment process. The organisation has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer.

Four of four rest home residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider is available and appropriate resources and equipment are available. The RN interview confirms that assessments are conducted in a safe and appropriate setting including visits from the doctor. GP interview confirms GP visits are conducted in a safe and appropriate setting, frequently at the medical centre and less frequently at the facility.

Five of five residents interviewed confirm their involvement in their assessments, care planning, review, treatment and evaluations of care.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.5 Planning

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

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

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

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

All four residents' files sampled evidence residents' care plans are individualised and up-to-date. The long-term and short-term goals are identified by the residents and service providers and reviewed at regular intervals, at least three monthly or as needs change. Residents have input into their care planning and review, confirmed at all five resident interviews.

Four of four clinical staff interviewed confirm that care plans are accurate and up to date.

Four of four residents' files sampled evidence the care/treatment/support or interventions that is to be provided by the staff is current, the risk assessment findings are recorded on the care plans and there is evidence of discussions and sign off by residents and family members. The facility ensures access to regular GP care, confirmed at GP interview.

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

D16.3f; All four resident files reviewed identify that family were involved.

Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.6 Service Delivery/Interventions

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

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

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

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.

Four of four residents' files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement.

Five of five residents and three of three family members interviewed confirm their current care and treatments they and they family members are receiving meet their needs. Family communication sheets record family communications, sighted in all four residents' files sampled.

D18.3 and 4 Wound dressing supplies are available. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided (April 2012). Wound assessment and wound management plans are in place for two residents requiring wound care. The Registered Nurse interviewed describe the referral process and related form should they require assistance from a wound specialist or continence nurse.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.7 Planned Activities

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

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

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

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

Residents and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. Residents' meeting minutes evidence residents' discussion in relation to the activities programme - sighted minutes from monthly meetings.

Four of four residents' files sampled demonstrate the individual activities plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being. Residents' activities assessments were sighted in all four residents' files sampled.

Interviews with two activities coordinators confirm the activities programme meets the needs of the service group and the service has appropriate equipment. Activities are provided for seven hours per week. The week's daily list of activities is displayed on the whiteboard in the dining room. Five of five residents interviewed confirm their past activities are considered and their enjoyment of the activities they choose to participate in. Activities audit was conducted in October 2012.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

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

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

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

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

All four residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Evaluation are conducted by the RNs with input from the resident, family, care staff, activities coordinator and GPs. Family are notified of any changes in resident's condition, evidenced in all four residents' files sampled. Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. Residents' files evidence referral letters to specialists and other health professional.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

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

Service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services.

Residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services. Residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. Resident's progress notes detail relevant processes are implemented.

D16.4c; the service provided an example of where a resident condition had changed and the resident was reassessed for a higher level of care.

D 20.1 discussions with registered nurse identified that the service has access to GP services, other facilities with hospital level of care NASC assessors and DHB specialists.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

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

ARC D21 ARHSS D21

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

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

All four residents' files sampled evidence appropriate communications between family and other providers. Resident's transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

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

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

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

Visual inspection of the medication area evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Controlled drugs storage is secure and the controlled drug register is maintained, however, there is no evidence of weekly CD checks or six monthly physical stock takes of controlled drugs by pharmacist. Residents' medicines charts list all medications a resident is taking (including name, dose, frequency and route to be given). There is evidence staff are signing off, as the dose is administered. Lunch time medication round was observed on audit day.

There are eight of 16 care staff authorised to administer medicines. Staffs' competencies were sighted in staff files sampled and on staff competency register. Medication competency audit was conducted in November 2012. Staff education in medicine management was conducted in January 2013 and this was attended by 15 staff.

Ten of ten medicine charts were sampled and demonstrate documentation is legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. One of ten medicine charts did not have patient

photo identification. This was discussed with the RN and patient's photo ID was placed on the medicine chart on audit day. Nine of ten medicine charts evidence no recorded allergies. Discussion was held with the RN, all of the nine residents had no known allergies and this was entered on the medicine charts on audit day.

There is one resident who self-administers medicines. Interview was conducted with the resident and confirms the resident is aware of the medicines and self-administration timeframes. Patient consent for self-administration of medicines is recorded. There are three monthly competency assessments conducted by the RN, however there is no recorded evidence of the patient's competency assessment by the GP. Visual inspection of the resident's room evidences some medicines are located in an unlocked top draw of the bedside cabinet and larger supply (three months) of the medicines is located in the resident's unlocked wardrobe. There is no signing record of the medication taken.

D16.5.e.i.2; Ten of ten medication charts reviewed identified that the GP had reviewed the resident 3 monthly and the medication chart was signed.

There are two areas requiring improvement that relate to ensuring medication management systems comply with legislation, protocols and guidelines and facilitation of safe self-administration of medicines by residents is implemented.

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

Audit Evidence

Attainment: PA **Risk level for PA/UA:** Moderate

The controlled drug register does not evidence weekly CD checks by staff or six monthly physical stock takes of controlled drugs by pharmacist.

One of ten medicine charts did not have patient photo identification. This was discussed with the RN and patient's photo ID was placed in the medicine chart on day of audit.

Nine of ten medicine charts evidence no recorded allergies. Discussion was held with the RN, all of the nine residents had no known allergies and this was entered on the medicine charts on audit day. There is no recorded evidence of GP sample signature register.

Finding Statement

a) The controlled drug register does not evidence weekly CD checks or six monthly CD physical stock takes; b) One of ten medicine charts did not have resident photo identification. This was discussed with the RN and resident's photo ID was placed in the medicine chart on audit day; c) Nine of ten medicine charts evidence no recorded allergies. Discussion was held with the RN, all of the nine residents had no known allergies and this was entered on the medicine charts on audit day; d) there is no recorded evidence of GP sample signature register.

Corrective Action Required:
a) provide evidence of CD register weekly checks and six monthly stock takes of CD drugs; b) ensure all residents have photo ID on medicine charts; c) ensure patients' allergies and no known allergies are recorded on medicine charts; d) provide evidence of GP sample signature register.

Timeframe:
1 month

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

There is one resident who self-administers medicines. Interview was conducted with the resident and confirms the resident is aware of the medicines that are being self-administered and self-aware of the administration times. The patient consent for self-administration of medicines is recorded in the clinical file. There are three monthly competency assessments conducted by the RN, however there is no recorded evidence of the patient's competency assessment by the GP. Visual inspection of the resident's room evidences some medicines are located in an unlocked top draw of the bedside cabinet and larger supply (three months' supply) of the medicines is located in the resident's unlocked wardrobe. There is no signing record of the medications taken.

Finding Statement

One resident is self- administering medicines at the facility. There is no evidence of GP's assessment of the resident's competency to self-administer medicines. Medicines are not securely stored in resident's room. Record of administration of medicines is not maintained.

Corrective Action Required:

Provide facilitation of safe self-administration and storage of medicines by residents.

Timeframe:
1 month

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

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

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

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

Food services policies and procedures are appropriate to the service setting. The menu is being reviewed by a dietitian, evidence of correspondence with the dietitian was sighted. There are documented protocols for management of residents with unexplained weight loss or gain. Resident's individual dietary needs are identified, documented and reviewed on a regular basis as part of the care plan review. Kitchen staff are informed if resident's dietary requirements change, confirmed at kitchen staff interview. Copies of dietary profiles are located in the kitchen and in residents' files. Additional snacks are available for residents when required. Residents are offered fluids throughout the day. Residents' files sampled demonstrate regular monthly

monitoring of individual resident's weight. Residents' nutritional needs and interventions are identified and documented on the care plans. Residents interviewed were satisfied with the food service provided and report their individual preferences are well catered for and confirm adequate food and fluids are provided.

Food service audit was conducted in February 2012 with no corrective actions required.

Improvements are required whereby decanted foods are dated and food temperatures are monitored.

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

Visual inspection of the kitchen environment evidences decanted foods are not dated. Interview with the kitchen staff confirms food temperatures are not conducted as the food is prepared and directly served from the kitchen servery to the residents in the adjacent dining room. Food is purchased by the owner /manager in town and delivered immediately to the facility. Milk is brought in a chilled truck which has a temperature gauge on the outside.

Finding Statement

Decanted foods are not dated. Food temperatures are not monitored.

Corrective Action Required:
Date decanted foods and monitor food temperatures.

Timeframe:
3 months

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

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

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

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

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

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

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

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

There are documented processes for waste management. The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemical safety training is a component of training and orientation. Cleaners use gloves, aprons, and goggles which are available for all staff.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.2 Facility Specifications

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

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

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

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

The building warrant of fitness expires on 26 August 2013. The maintenance role involves regular building checks and implementation of reactive maintenance requests. Safety audit was conducted in December 2012.

There is one area requiring improvement that relates to providing hot water at a safe temperature.

ARC D15.3; Appropriate equipment is available for rest home residents. Interviews with three caregivers and one RN confirm there is adequate equipment at the facility.

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

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

Hot water temperatures at the facility are monitored monthly. Hot water temperatures show temperature recording at 46 degrees in one wing of the facility. All monthly recording for 2012 show this wing is consistently above 45 degrees Celsius at times reaching 48 degrees,

Finding Statement

Hot water temperatures show temperature recording at 46 degrees in one wing of the facility. All monthly recording for 2012 show this wing is consistently above 45 degrees Celsius.

Corrective Action Required:
Provide evidence hot water temperature is provided at 45 degrees Celsius.

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 ☒ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

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

The service has communal showers and toilets. Four bedrooms have full en-suits. The service has one visitors/ staff toilet with hand basin. Most of the resident's rooms at the facility have no hand basins. There are two double rooms, one of the double rooms is used by one resident and the second double room has a married couple residing in it. Resident interviews confirm sufficient bathroom facilities at the home.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.4 Personal Space/Bed Areas

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

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

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

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

The service provides adequate space allowing residents to move safely around in their rooms. Visual inspection evidences adequate personal space for residents. Resident interviews confirm satisfaction with bedrooms.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

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

ARC E3.4b ARHSS D15.3d

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

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

The residents have access to communal areas for entertainment, recreation and dining at the facility. There are two lounge areas and one dining room located next to the kitchen.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.6 Cleaning And Laundry Services

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

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

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

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

Residents are being provided with hygienic cleaning and laundry services, which are appropriate to the setting. Interview with a cleaner/ laundry staff member confirms cleaning is provided at the home from Monday to Friday each week and care staff conduct cleaning and laundry in the weekends. Chemical training is provided by the chemical supplier, confirmed at staff and management interview.

Monthly cleaning audits are conducted. Cleaning audit results for March and April 2012 were sighted, no corrective action was required. Laundry audit was conducted in January 2013, however this audit requires completion (refer #1.1.2.3).

There is one area requiring improvement that relates to correct labelling and safe storage of chemicals.

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

Visual inspection evidences two chemical containers are not labelled appropriately (one chemical container has no label, second chemical container's label is defaced) and chemicals in the laundry, the kitchen and the visitors' toilet are not securely stored.

Finding Statement

Visual inspection evidences two chemical containers are not appropriately labelled and chemicals in laundry, kitchen and visitors toilet are not securely stored.

Corrective Action Required:
Provide evidence of safe storage of chemicals and appropriate labels are attached to chemical containers.

Timeframe:
1 month

STANDARD 1.4.7 Essential, Emergency, And Security Systems

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

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

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

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

The service has a fire and emergency manual. There is currently a trained person with a first aid certificate on each shift. Sandringham House has a NZFS approved fire evacuation scheme, dated 5-Jun-2003. A call bell light alerts staff to the area in which residents require assistance. The home is

small and advised that most visitors are known to staff and/or management. Fire drill last conducted 20-Feb-2013. A civil defence kit is stocked and checked six monthly. Water is stored - sufficient for at least three days. Alternative heating and cooking facilities are available. Call bell system evident and in use in the resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure.

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:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.8 Natural Light, Ventilation, And Heating

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

ARC D15.2f ARHSS D15.2g

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

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

Residents are provided with adequate natural light, safe ventilation, and a safe environment with comfortable temperatures. There are no residents who smoke at the home. Staff who smoke do so at a designated area. Resident interviews confirm the facility is kept at a comfortable temperature.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

How is achievement of this standard met or not met?	**Attainment:** FA
Documented systems are in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint or enabler use on audit day. Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education programme on RMSP /Enabler and challenging behaviour management training/education was conducted in May 2012 and attended by 11 staff. Staff education was also conducted in January 2013 and attended by 15 staff. Use of restraint audit was conducted in May 2012 and indicated no restraint use at that time.	

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 ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

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

Sandringham House 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 management 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 ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

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

The registered nurse at Sandringham is the 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) nurse maintains her practice by attending annual infection control updates (last attended a training session on

outbreak management on 26-June-2012). The IC nurse 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 ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

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

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

D 19.2a: The infection control section of the nursing 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 by an external provider and reviewed and updated annually. Last review conducted January 2013. Sandringham'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 and sharps and spills management.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.4 Education

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse 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 - last session in June 2012. 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.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.5 **Surveillance**

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

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

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

Infection surveillance is an integral part of the infection control programme and is described in Sandringham's infection control and surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. 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 monthly management meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the owner/manager.

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: