**Bainlea House (2013) Limited**

**Current Status:** **10-Jun-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**

Wiltshire Lifecare includes Wiltshire Home and Hospital and Wiltshire House. Their service provides rest home, hospital, and dementia level care for up to 87 residents. On the day of audit there were 14 rest home and 35 hospital level residents at Wiltshire Home and Hospital, and 26 dementia level residents at Wiltshire House. Both facilities are located in Rangiora, Canterbury, and approximately one kilometre apart.

This audit identified further improvements required relating to communication with staff around audit outcomes, all staff have signed job descriptions, staff sign their designation when writing in progress notes, risk assessments completed in a timely manner, registered nurse input into progress notes in the dementia unit, care plans reflect all identified needs, food temperatures monitored and are at required temperatures, all staff with responsibilities with food preparation have safe food handling training, and equipment is calibrated and serviced within expected time frames.

The prospective owners/shareholders have an overall business plan and risk management plan. The intending manager (current owner/manager of Bainswood Home in Rangiora) is a diversional therapist and has been an owner/operator of rest homes for the past nine years. The new owners plan to maintain the current staffing, nursing management and service provision for Wiltshire facilities. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

Bainlea House

Bainlea House (2013) Ltd

Provisional audit - Audit Report

Audit Date: 10-Jun-13

**Audit Report**

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Bainlea House (2013) Ltd  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Wiltshire Home and Hospital | 28 Victoria Street |       | Rangiora |
| Wiltshire House | 29 Wiltshire Court |       | Rangiora |

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

|  |  |
| --- | --- |
| **Type of Audit** | Provisional audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 10-Jun-13 **End Date:** 11-Jun-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 | XXXXXXX | RCpN,HealthAuditor, AdDipBusMan, CertQA | 16.00 | 7.00 | 10-Jun-13 to 11-Jun-13 |
| Auditor 1 | XXXXXXX | RCpN,PGDipHSM,Health Auditor | 16.00 | 6.00 | 10-Jun-13 to 11-Jun-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 2.00 |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 32.00 | **Total Audit Hours off site** *(system generated)* | 15.00 | **Total Audit Hours** | 47.00 |
| **Staff Records Reviewed** | 10 of 75 | **Client Records Reviewed** *(numeric)* | 9 of 75 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 9 |
| **Staff Interviewed** | 19 of 75 | **Management Interviewed** *(numeric)* | 5 of 5 | **Relatives Interviewed** *(numeric)* | 9 |
| **Consumers Interviewed** | 9 of 75 | **Number of Medication Records Reviewed** | 18 of 75 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

**Declaration**

I, (full name of agent or employee of the company) XXXXXXX (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 19 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 Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Wiltshire Home and Hospital | 59 | 49 | 59 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Wiltshire House | 28 | 26 |       | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Executive Summary of Audit**

*General Overview*

Wiltshire Lifecare includes Wiltshire Home and Hospital and Wiltshire House. Their service provides rest home, hospital, and dementia level care for up to 87 residents. On the day of audit there were 14 rest home and 35 hospital level residents at Wiltshire Home and Hospital, and 26 dementia level residents at Wiltshire House. Both facilities are located in Rangiora, Canterbury, and approximately one kilometre apart.

This audit identified further improvements required relating to communication with staff around audit outcomes, all staff have signed job descriptions, staff sign their designation when writing in progress notes, risk assessments completed in a timely manner, registered nurse input into progress notes in the dementia unit, care plans reflect all identified needs, food temperatures monitored and are at required temperatures, all staff with responsibilities with food preparation have safe food handling training, and equipment is calibrated and serviced within expected time frames.

The prospective owners/shareholders have an overall business plan and risk management plan. The intending manager (current owner/manager of Bainswood Home in Rangiora) is a diversional therapist and has been an owner/operator of rest homes for the past nine years. The new owners plan to maintain the current staffing, nursing management and service provision for Wiltshire facilities. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

*1.1 Consumer Rights*

Residents and their families/whānau are informed of their rights as part of the resident information pack. Residents stated that care givers always respected their privacy. Initial and on-going assessment includes gaining details of people’s beliefs and values. Interventions to support these are identified and evaluated. Residents are encouraged to continue with their spiritual activities. Cultural awareness training occurred as part of the annual training programme. There is Maori Health Plan which is implemented.

Residents and relatives spoke positively about care provided at Wiltshire home and hospital and dementia unit. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

*1.2 Organisational Management*

Wiltshire Lifecare has an established quality and risk management system that supports the provision of clinical care and support Annual resident/relative satisfaction surveys are completed and there are regular resident/relative meetings. Quality and risk performance is reported to the organisation's management team. Improvements are required whereby staff at the dementia unit (Wiltshire House) are informed of internal audit outcomes and corrective actions required. There is an active health and safety committee. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Improvements are required whereby all staff have signed job descriptions on file.

There is a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. There is an improvement required around staff signing their designation when documenting in progress notes.

*1.3 Continuum of Service Delivery*

The service has assessment process and consumer’s needs are assessed prior to entry. There is a well-developed information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed or signed off by the registered nurses. Risk assessment tools and monitoring forms are available and implemented. Service delivery plans are individualised. Short term care plans are in use for most changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. There are improvements required around the timely reviewing of risk assessments, registered nurse input into progress notes at Wiltshire House and aspects of care planning.

There is an activities coordinator who provides an activities programme at the home and hospital and a diversional therapist who provides activities at Wiltshire House. There are programmes running at each facility that are meaningful and reflect ordinary patterns of life. There are also visits to and from community groups.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. There are competency assessments completed for residents who self-administer medicines and staff who administer medicines have a current competency assessment.

Food services policies and procedures are appropriate to the service setting. Consumer's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchens shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were very complimentary of the food service provided and report their individual preferences are well catered. Additional snacks are available if the kitchen is closed. There are improvements required around ensuring reheated food is reheated to a safe temperature and food safety training for staff at Wiltshire house who prepare food.

*1.4 Safe and Appropriate Environment*

The service is over two sites - one for the rest home and hospital and another site for the dementia unit. There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Service providers receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by staff

Staff documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. The facilities are well maintained. There are improvements required around calibrating and servicing of equipment.

Documented policies and procedures for the cleaning and laundry services are implemented. There is a laundry at each site. Staff have completed appropriate training in chemical safety. Visual inspection evidences compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals. There are emergency plans in place and emergency drills have been held annually. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

*2 Restraint Minimisation and Safe Practice*

Wiltshire Lifecare has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option. There are two hospital level residents requiring the use of an enabler (bedrails) and nine residents requiring the use of a restraint (bedrail, lap belt). Wiltshire House dementia unit remains restraint-free. Staff receive training on restraint minimisation and managing residents' behaviours that can be challenging. Review of restraint use is discussed at monthly management meetings and staff meetings. Evaluation and review of restraint use occurs monthly.

*3. Infection Prevention and Control*

The infection prevention and control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control co-ordinator is the clinical nurse manager at the home and hospital and the nurse manager at the dementia unit. They are both responsible for coordinating/providing education and training for staff at their respective units. The co-ordinators have attended external training and are well supported by an external infection control expert. Infection prevention and control training is provided at orientation and is on-going throughout the year. The infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines. The co-ordinators uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facilities. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

**Summary of Attainment**

* 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 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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

* 1. ***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 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | PA Low | 0 | 3 | 1 | 0 | 0 | 10 |

|  |
| --- |
| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 4 PA Neg: 0 PA Low: 3 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:19 PA:3 UA:0 NA: 0 |

* 1. ***Continuum of Service Delivery***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | PA Low | 0 | 1 | 2 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | PA Low | 0 | 1 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Moderate | 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: 2 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:17 PA:4 UA:0 NA: 0 |

* 1. ***Safe and Appropriate Environment***

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

|  |
| --- |
| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:16 PA:1 UA:0 NA: 0 |

1. ***Restraint Minimisation and Safe Practice***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

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

1. ***Infection Prevention and Control***

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

|  |
| --- |
| 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: 0Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

|  |
| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 43 **PA Neg:** 0 **PA Low:** 6 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 93 **PA:** 8 **UA:** 0 **N/A:** 0 |

**Corrective Action Requests (CAR) Report**

Provider Name: Bainlea House (2013) Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:10-Jun-13 End Date: 11-Jun-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.3 | 1.2.3.6 | PALow | **Finding:**Internal audit outcomes and related corrective actions are not communicated to staff in the Wiltshire house dementia unit.**Action:**Ensure that internal audit outcomes and corrective actions are implemented and communicated to staff in the Wiltshire dementia unit | 3 months |
| 1.2.7 | 1.2.7.3 | PALow | **Finding:**Of the 10 staff files reviewed, five staff files do not have signed job descriptions in their files.**Action:**Ensure all staff have signed job descriptions on file | 3 months |
| 1.2.9 | 1.2.9.9 | PALow | **Finding:**On review of progress notes of nine resident files, it is noted that designation of staff member is not always recorded.**Action:**Ensure that progress notes document the designation of the staff member making the entry. | 3 months |
| 1.3.3 | 1.3.3.3 | PALow | **Finding:**One of nine resident files sampled (from the hospital) has not had risk assessments completed within the last six months.**Action:**Ensure that all risk assessments are repeated at least six monthly. | 6 months |
| 1.3.3 | 1.3.3.4 | PALow | **Finding:**In the three files sampled at Wiltshire House there is no evidence of regular registered nurse input into and review of progress notes.**Action:**Ensure that there is regular evidence of registered nurse input into and review of progress notes. | 3 months |
| 1.3.5 | 1.3.5.2 | PALow | **Finding:**Two of nine care plans sampled do not have interventions that correlate to identified needs. Examples include depression and the use of a walking frame.**Action:**Ensure care plans describe interventions for all identified needs. | 3 months |
| 1.3.13 | 1.3.13.5 | PAModerate | **Finding:**(i)care staff who are responsible for reheating and serving meals in the dementia unit have not had safe food handling training; ii) the freezer in the main kitchen has had some recordings outside acceptable temperature ranges; iii) tea time meals is not routinely checked for temperature and three temperatures that were checked in Victoria wing in June 2013 were below required temperatures. **Action:**(i) Ensure that care staff who have food service responsibilities receive safe food handling training; ii) ensure all fridge and freezers are maintained at safe levels; iii) ensure all food that is reheated is heated to safe levels and monitor and record same. | 1 month |
| 1.4.2 | 1.4.2.1 | PALow | **Finding:**(i) The scales at Wiltshire House have not been calibrated. (ii) The service is not able to provide evidence that the two hoists that are more than one year old have been serviced.**Action:**Ensure that all equipment that requires calibration is calibrated. | 6 months |

**Continuous Improvement (CI) Report**

Provider Name: Bainlea House (2013) Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:10-Jun-13 End Date: 11-Jun-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

Wiltshire Lifecare policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumer Rights. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at orientation and through on-going in-service training and competency questionnaires. Interviews with 10 caregivers (seven rest home/hospital, three dementia) showed an understanding of the key principles of the code of rights. Resident rights/advocacy training was last provided in August 2011 and again in November 2012. Nine residents interviewed (four rest home and five hospital) and nine relatives (two rest home, four hospital, and three dementia care) confirmed that staff respected privacy, obtained daily consent and choice.

The new owners (Bainlea House 2013 Ltd) advise that residents will continue to be made aware of their rights through information offered on admission, made available within the facility and discussed with them at intervals during their admission.

Other relevant acts including privacy of information will be available via pamphlets and residents information brochure. Code of rights training is planned for August 2013. Advised that no changes are planned to Wiltshire Lifecare education programme by the new owners for the first few months of ownership.

**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

There is a 'Welcome to Wiltshire Lifecare' information booklet that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and as appropriate their legal representative. On-going opportunities occur via regular contact with family. Advocacy pamphlets are clearly displayed at the rest home and hospital entrances and the dementia unit entrance and on noticeboards throughout the facility. Large print posters are also displayed throughout the facility. Code of rights, advocacy information on complaints and compliments is brought to the attention of residents and families at admission, in the information booklet and via the two monthly resident/family rest home and hospital meetings and the three monthly dementia unit resident/family meetings. Nine residents interviewed (four rest home and five hospital) and nine relatives (two rest home, four hospital, and three dementia care) confirmed that information has been provided around the code of rights. The clinical manager and owner/operations manager has an open door policy for concerns or complaints.

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. The clinical manager and registered nurses described discussing the information pack with residents/relatives on admission.

D16.1bii. The families and residents 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.

**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 facility provides physical, visual, auditory and personal privacy for residents. During the audit, staff demonstrated gaining permission prior to entering resident rooms.

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. Ten caregivers (seven rest home/hospital and three dementia) interviewed described ensuring privacy by knocking on doors before entering.

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. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with 10 care givers described providing choice during daily cares. Interview with nine residents (four rest home and five hospital) and nine relatives (two rest home, four hospital, and three dementia care) all stated staff provided a respectful service and were very approachable and friendly. There is an abuse and neglect policy that is implemented and staff are required to complete education on abuse and neglect. Abuse and neglect training is included as part of the education programme - last conducted November 2012. Discussions with residents and family members were extremely positive about the care provided.

E4.1a Three family members interviewed state that their family member was welcomed into the dementia unit and personal pictures were put up and familiar items of furniture/bedding were placed in the room to make it more homely and more familiar to the resident.

D4.1a Nine resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and is integrated with the residents' long term care plan. This includes cultural, religious, social and ethnic needs. Interviews with nine residents confirmed that their values and beliefs were considered.

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.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. Cultural needs is addressed in sexuality/spirituality/intimacy heading of the care plan. There are currently one resident in the hospital area who identifies as Maori. Resident file records ethnicity and cultural aspects of care are documented.

D20.1i The service has developed a link with iwi. Cultural training was last provided for staff 15-May-2013. The Maori health plan identifies the importance of whānau. Interviews with one clinical manager, one nursing support manager, one nurse manager (dementia unit), ten caregivers, two registered nurses and one enrolled nurse discussed the importance of family involvement. Discussion with nine residents (four rest home and five hospital) and nine relatives (two rest home, four hospital, and three dementia care) confirm that they are regularly involved.

Owner/manager of Bainlea House Ltd advise that organisational policies including the Māori Health plan will be implemented.

**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

Wiltshire Lifecare has policies and procedures to guide staff practice. There is a Maori health plan, a culturally safe policy which includes guidelines for provision of culturally safe services for Maori, cultural awareness and cultural responsiveness, Treaty of Waitangi and a residents rights policy. The resident’s rights policy includes independence, spirituality and sexuality and intimacy. Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family involvement and is integrated into residents' long term care plans. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if any changes are required in delivery of service and care plans. Family are invited to attend. Interviews with nine family members (two rest home, four hospital, one dementia and one rest home) confirmed they are involved in the care planning process and review.

D3.1g The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Interviews with nine residents (four rest home and five hospital) and nine relatives (two rest home, four hospital, and three dementia care) confirmed that cultural values and beliefs were considered and discussed during preparation and review of the care plan.

D4.1c Care plans reviewed included the resident’s 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

The staff code of conduct is included in the staff employment documentation. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in 10 staff files reviewed. Enrolled nurses work under the direction and supervision of registered nurses. There are policies to guide staff practice including; staff code of conduct, discrimination, human resource management policies, residents safety, abuse prevention and security policy. Registered nurses meet two monthly and meetings include discussions on professional boundaries and concerns. Interviews with the clinical manager, the nursing support manager, the dementia unit nurse manager, two registered nurses and one enrolled nurse described professional boundaries.

D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with 10 caregivers (seven rest home/hospital and three dementia) could describe how they build a supportive relationship with each resident. Interviews with three family members from the dementia unit confirmed the staff assist to help residents manage their anxieties and distract from behaviours that may be challenging to other residents/visitors.

**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

Wiltshire Lifecare has quality and risk management systems which are implemented at both facilities (rest home/hospital and dementia unit). This is evidenced by meeting minutes sighted for staff, quality/management, registered nurses, residents/family, health and safety/infection control. Comprehensive policies and procedures are provided by an external consultant with regular updates and reviews to ensure best practice and currency. The quality and risk management system is also supported by a comprehensive education programme with competencies completed around medication, restraint minimisation, hand hygiene, wound care, comprehensive caregiver competencies and competencies specific for registered nurses (syringe driver and male catheterisation). Wiltshire provides the Aged Care Education programme for caregivers. Orientation programmes are implemented for new staff. There is a strong commitment to staff development by way of education and in-service training with support from external education providers including but not limited to: local Maori elder, Aged concern, National advocacy service, local DHB, nutrition expert, pharmacist, dietitian, NZ Fire service and the Chaplain. Education is supported for all staff. Ten caregivers interviewed have either completed the ACE programme or the National certificate or are in the process of completing the ACE programme. The three nurse managers are encouraged and supported to complete annual training and attend local and national conferences, education and training to maintain 'best practice'. Implementation of evidenced best practice and legislation requirements are reflected in clinical policies. Care planning is holistic and integrated. Quality improvements are identified and initiated via complaints, incidents/accidents, internal audits, staff and resident feedback. Corrective actions are identified to minimise potential risks occurring and correct identified gaps in service delivery. Action plans are followed through and signed off when completed. Services are provided at Wiltshire Lifecare that adhere to the health and disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for care givers, registered and enrolled nurses and household staff. 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

Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. The clinical manager, nursing support manager and nurse manager of the dementia unit demonstrated their responsibility to notify family/whānau of any incident/accident that occurs and contact with family/next of kin is recorded.

D16.4b Nine relatives (two rest home, four hospital, and three dementia care) stated that they are always informed when their family members health status changes. Access to interpreter services is identified through the local DHB.

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

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

D16.1bii; The information pack and admission agreement included payment for items not included in the services. There is a section in the Wiltshire Lifecare information booklet specific to Wiltshire House dementia unit, providing practical information for family, friends and visitors visiting the facility 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.

**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

Written informed consent is gained for do not resuscitate or resuscitation orders appropriately for nine of nine resident files sampled (two from the rest home, four from the hospital and three from the dementia unit). Nine files were reviewed and found to have valid consents. It was stated by two registered nurses (from the hospital and rest home), one enrolled nurse (from the hospital and rest home), one clinical manager, one nursing support manager and one nurse manager (from the dementia unit) that family involvement occurs with the consent of the resident. Other forms of written consent included consent to share information and consent for transportation. A review of five files found all consents were present and signed by the resident or their EPOA. EPOA documents are kept on the resident's file. Nine of nine residents (four from the rest home and five from the hospital) interviewed confirm that they are given good information to be able to make informed choices. Ten of 10 caregivers (seven from the hospital and rest home and three from the dementia unit) and one enrolled nurse (from the hospital and rest home) interviewed conform information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent. Staff received training around obtaining informed consent in 2012.

D13.1 There were nine admission agreements sighted and all had been signed on the day of admission

D3.1.d Discussion with nine of nine relatives (two from the rest home, four from the hospital and three from the dementia unit) identified that the service actively involves them in decisions that affect their relatives lives.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

The residents rights policy and procedure provides definitions of advocacy and states that information on advocacy is made available. Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the clinical manager, nursing support manager and dementia unit nurse manager, described how residents and family are informed about advocacy and support.

Interviews with nine residents (four rest home and five hospital) and nine relatives (two rest home, four hospital, and three dementia care) confirmed that they are aware of their right to access advocacy.

D4.1d: discussion with nine family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.

D4.1e: Nine residents files (two rest home, four hospital and three dementia) reviewed included 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

The service has a policy maintaining links with family and community, identifies assistance with the electoral process and visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported by activity staff to access the community as required and the service maintains key linkages with other community organisations.

D3.1h; Discussion with nine residents (four rest home and five hospital) and nine relatives (two rest home, four hospital, and three dementia care) confirm that they are encouraged to be involved with the service and care.

D3.1.e; Discussion with staff across the facilities and nine family members confirmed that residents are supported and encouraged to remain involved in the community and external groups such as church visits, RSA, own GP and shopping.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights .

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

The complaints register for 2012 and 2013 was reviewed. There were 21 complaints received at the Wiltshire home and hospital facility in 2012 and seven complaints for 2013. The Wiltshire House dementia unit received one complaint in 2012 and none for 2013. A sample of complaints received in 2012 and 2013 for the home and hospital were tracked, indicating that they had been actioned according to investigation/follow-up letter timeframes and resolution - with the exception of one (of three) complaints that have been investigated by the Health and Disability commissioner. Two complaints in 2012 were received anonymously via the DHB with subsequent inspection and investigation. Temporary management was instigated in July 2012 with progress monitoring provided to the DHB at regular intervals. The service has worked closely with the temporary manager and the DHB to improve care and services to residents and families. There is evidence that complaints and outcomes are discussed at staff and quality/management meetings. Discussion with nine residents (four rest home and five hospital) and nine relatives (two rest home, four hospital, and three dementia care) confirmed they were provided with information on complaints and complaints forms.

E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

Wiltshire Lifecare's mission statement aim is: "to provide a quality, home-like environment in which the frail elderly (and/or confused elderly) may live in a safe and relaxed atmosphere of respect and friendliness and have their physical and psychological needs met regardless of culture, race or creed." There are six goals associated with the philosophy of care and include maintaining residents independence, involving family, maintaining wellness, maintaining outside contacts, and supporting social, cultural and spiritual needs. There is a current business plan developed by the current owners. The quality and risk management plan has five goals which relate to consumer focus, provision of effective programmes, achievement of certification, risk management, and continuous improvement. The current owners provide operations management and administration support.

Wiltshire Lifecare operates two facilities - the Wiltshire home and hospital facility and the Wiltshire House dementia unit - situated approximately one kilometre apart in Rangiora. The home and hospital provides rest home and hospital level care for up to 59 residents with 48 residents on the days of audit - 14 rest home and 35 hospital. The Wiltshire House dementia unit is able to accommodate 28 dementia specific residents with 26 residents on the days of audit.

Wiltshire home and hospital is managed by a clinical manager (RN) who has been in the role for nine months. She is supported by a nursing support manager who has also been in the role for nine months. The Wiltshire House dementia unit is managed by a registered nurse who has been in the role for four years. There are job descriptions for all nursing leadership positions that include responsibilities and accountabilities. Registered nurse leaders managers are able to attend conferences, local education and training provided by the service and the DHB.

Policies and procedures are developed at by an external consultant who provides regular updates and reviews of policies and procedures.

D17.3di (rest home) & D17.4b (hospital), the managers have maintained at least eight hours annually of professional development activities related to managing a rest home and/or hospital.

ARC E2.1. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

Bainlea House (2013) Ltd is currently in negotiations to purchase Wiltshire Lifecare. There is an overall business plan and risk management plan. The provider's mission statement is to provide quality health care and services to North Canterbury and the wider district. The provider's philosophy of care states that "We believe that: an environment will be provided which allows a resident to live as a continuance of their life before admission within the limitations of their health needs. Each resident will have the choice and involvement in decision making concerning their care and in the environment around them. The ongoing involvement of family/whanau is integral to the resident’s wellbeing. A resident will feel at home within an atmosphere of security, tranquility and care."

Advised by the prospective owner/managers that the intention is to ensure a seamless transition of ownership. The prospective owners have owned/managed rest homes for the past nine years. One owner has a background in diversional therapy. Current policies and procedures and quality systems at Wiltshire will remain in place including annual audit schedule, incident & accident reporting processes and policies, annual education schedule, staff competencies, and formal orientation processes. The current nursing management and staff will continue. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided. The intention is to have one stream lined quality management system across all the Bainlea House (2013) Ltd owned facilities in the future. Advised by the prospective owners that the clinical manager and nursing support manager will remain in their roles at Wiltshire. The transition period is minimal in that no changes to services are planned for either dementia or rest home/hospital. The new owners will provide oversight to both Bainlea and Wiltshire with the clinical manager in charge at Wiltshire.

**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, the nursing support manager covers the clinical manager's role (rest home and hospital) and the unit manager's role (dementia unit). There is registered nurse cover 24/7 in the rest home/hospital facility as well as the clinical manager and nursing support manager. An enrolled nurse works in the rest home/hospital three days a week. The unit manager (RN) provides registered nurse input into the dementia unit. The service is supported by the owners.

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. There is a quality plan 2013 which includes five goals which relate to consumer focus, provision of effective programmes, achievement of certification, risk management, and continuous improvement. The senior management team meets weekly to admissions, staffing, and general care for residents.

**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

Wiltshire Lifecare has an established quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings with the exception of one improvement relating to communicating internal audit outcomes to staff at the dementia unit.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The facility have a master copy on computer of all policies and procedures provided by an external consultant. The consultant provides regular updates and reviews of policies which are then sent through to the service and manuals and folders are updated. There is a policy/procedure sign off sheet for staff to sign as having noted/read the new/reviewed policy. The policies and procedures have been developed in line with current accepted best and/or evidenced based practice. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. Discussion regarding policy development/revision also occurs at staff meetings. Key components of the quality management system link to the monthly quality/management meetings. There is a standing agenda for monthly quality/management meetings and two monthly staff meetings held in each facility. These include discussion of residents care issues, clinical updates, audit results (exception dementia unit staff meeting) and corrective action plans, improvement projects, complaints/compliments, policies and reviews, staff training, incidents/accidents, infection rates, and any other business. Weekly senior management meetings are held.

There are monthly accident/incident, infection rates, complaints, staff incidents, occupancy and rostering reports completed by the clinical manager in the rest home and hospital and by the nurse manager in the dementia unit. The infection control team and the health and safety committee meets monthly and health and safety is also an agenda item at the quality/management and staff meetings. Internal audits are completed. The nursing support manager is responsible for ensuring that the quality programme is implemented.

The internal audit planner is implemented in both the home and hospital and the dementia unit. The planner includes (but not limited to); clinical records, infection control and hand washing, complaints, care plan audit, restraint use, privacy of information, medication management, resident admission, food service, a general audit tool which includes resident rights, health care, environment, safety, nutrition, staffing; recreation, audit of contractors, resident hygiene, manager/charge person audit, behaviour management, staff education, lifting/transfering, building compliance, laundry and cleaning, Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the quality/management committee meetings and to the staff meetings in the home and hospital. Improvement is required whereby internal audit outcomes are reported to staff meetings in the dementia unit.

Quality initiatives are documented as identified via complaints, feedback from staff and residents, and audits. Current quality improvements relate to appointment of a new dietitian, flooring areas, linen, crockery, gardens, staff files, and continence products. Improvement forms are utilised and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.

D19.3: There is a comprehensive H&S and risk management programme in place.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Strategies and equipment available to minimise falls risk are hi low beds, floor sensor mats, walking frames, gutter frames, nurse call bells and mobility aids.

The Bainlea House Ltd organisational goals will be introduced at the facilities in the future. Advised by the prospective owner/manager that the rest home/hospital and dementia unit will continue to use the existing policies /procedures and forms until such time as the service introduces their own policies. The plan includes having a generic and streamlined system across all Bainlea owned facilities.

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

Internal audits are completed. The nursing support manager is responsible for ensuring that the quality programme is implemented.

The internal audit planner is implemented in both the home and hospital and the dementia unit. The planner includes (but not limited to); clinical records, infection control and hand washing, complaints, care plan audit, restraint use, privacy of information, medication management, resident admission, food service, a general audit tool which includes resident rights, health care, environment, safety, nutrition, staffing; recreation, audit of contractors, resident hygiene, manager/charge person audit, behaviour management, staff education, lifting/transfering, building compliance, laundry and cleaning, Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the quality/management committee meetings and to the staff meetings in the home and hospital. It was noted and confirmed by staff interviewed that audit outcomes are not reported to staff meetings in the dementia unit.

**Finding Statement**

Internal audit outcomes and related corrective actions are not communicated to staff in the Wiltshire house dementia unit.

**Corrective Action Required:**

Ensure that internal audit outcomes and corrective actions are implemented and communicated to staff in the Wiltshire dementia unit

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted, implemented by care staff and registered nurses and any follow up action required. Minutes of the quality/management meetings, staff meetings, and health and safety meeting reflect a discussion of results.

A sample of incident/accident forms were reviewed for May 2013 from both the rest home/hospital and the dementia unit. All identified that the next of kin were contacted or if family did not wish to be contacted. The incident forms reviewed for Wiltshire home and hospital related to three residents - two with multiple falls, and one resident with behaviours. Incident forms for Wiltshire house dementia unit were reviewed and the sample includes one resident with multiple falls and one with three incidents of challenging behaviours. In all forms reviewed there is evidence of assessment and first aid provided, registered nurse follow up including clinical observations, post fall assessment forms, development of short term care plans and review of risk assessments, review by GP and referral as appropriate. Contact is documented on either the progress notes or family contact sheet.

Two medication error incident forms were reviewed. Appropriate follow up with the staff members involved were actioned.

Discussions with management confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

D19.3b; there is an incident/accident 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:** PA Low

Evidence of registered nurses' practising certificates is maintained. Website links to the professional bodies of all health professionals have been established and are available on the computers and in training folder.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Ten staff files were reviewed (rest home and hospital - three care givers, one cook, one enrolled nurse, one registered nurse, one clinical manager; dementia unit - three care givers) and all had up to date performance appraisals. All staff files included a personal file checklist. It was noted that not all files had signed job descriptions in place. Improvements are required in this area.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. New staff are buddied for a minimum of two full shifts and for a longer period of time if required. Completed orientation booklets are on staff files. Staff interviewed (two registered nurses, one enrolled nurse, one clinical manager, one nursing support manager, one dementia unit nurse manager, seven rest home/hospital care givers and three dementia unit care givers) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. One dementia unit care giver and two rest home/hospital care givers had commenced employment at the facilities in the past six months and reported that the orientation process was thorough, with on-going support being provided by the staff including the clinical manager and other more senior care givers. There is an annual education schedule that is being implemented. External education is available via the senior staff, external providers and the DHB. There is evidence on RN and EN staff files of attendance at internal and external training days.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the staff meetings.

A competency programme is in place with different requirements according to work type (e.g. care givers, kitchen staff, cleaners and registered nurses). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.

D17.7d: RN competencies include: T34 syringe driver, medication administration, male catheterisation, wound care, and restraint.

E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

E4.5f There are 18 care giving staff working in Wiltshire House dementia unit - 14 staff have completed the required dementia standards and the remaining four caregivers are in the process of completing the unit standards.

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

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Ten staff files were reviewed (rest home and hospital - three care givers, one cook, one enrolled nurse, one registered nurse, one clinical manager; dementia unit - three care givers) and all had up to date performance appraisals. All staff files included a personal file checklist. It was noted that not all files had signed job descriptions in place for staff working in the rest home and hospital facility. Position descriptions were not on file for two care givers, one registered nurse, one cook, and one enrolled nurse. Signed job descriptions are on file for three care giver staff files reviewed in the Wiltshire House dementia unit.

**Finding Statement**

Of the 10 staff files reviewed, five staff files do not have signed job descriptions in their files.

**Corrective Action Required:**

Ensure all staff have signed job descriptions on file

**Timeframe:**

3 months

**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

There is good employer policy which includes staffing levels and skills mix. There is registered nurse cover 24/7 in the rest home and hospital. The dementia unit after hours on call cover is provided by the nurse manager and the nurse managers from the rest home/hospital.

There are two facilities - Wiltshire home and hospital has a full time clinical manager, a full time nursing support manager and 24/7 RN cover. The Wiltshire House dementia unit has a nurse manager who works 40 hours per week and provides shared on-call cover. There is an enrolled nurse who works in the rest home/hospital three days a week.

In the rest home and hospital. short and long shifts are covered by 10 caregivers in the morning, seven caregivers in the afternoon, and three care givers over night. The dementia unit is staffed by three caregivers in the morning, three in the afternoon and two over night.

Interviews with nine residents (four rest home and five hospital) and nine relatives (two rest home, four hospital, and three dementia care) all confirmed that staffing numbers are adequate to meet the resident’s needs. Caregivers (10) and one enrolled nurse interviewed stated that staffing ratio to residents is adequate, and that the introduction of a care giver 'float' shift has improved work systems in the rest home/hospital unit.

Advised by the prospective owners that there are no plans to change the current staffing and rosters.

**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:** PA Low

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 support plan is also developed in this time.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure locked filing cabinets at the nurses' station in each unit/department. Archived files are kept in a secure external storage area.

Long term care plans are dated and signed on completion. Policies contain service name. All resident records contain the name of resident and the person completing the entry.

Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.

D7.1 Entries are legible, dated and signed by the relevant care giver, registered or enrolled nurse. However, on review of progress notes it is noted that designation of staff member is not always recorded on written entry.

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

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 support plan is also developed in this time. Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. Entries are legible, dated and signed by the relevant care giver, registered or enrolled nurse. However, on review of progress notes of nine resident files, it is noted that designation of staff member is not always recorded.

**Finding Statement**

On review of progress notes of nine resident files, it is noted that designation of staff member is not always recorded.

**Corrective Action Required:**

Ensure that progress notes document the designation of the staff member making the entry.

**Timeframe:**

3 months

**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

The service has a comprehensive information pack that is given to all inquiring residents or their families. Entry criteria and access process are clearly defined in policy and the resident information pack. Interview with nine of nine residents (four from the rest home and five from the hospital) and nine of nine relatives (two from the rest home, four from the hospital and three from the dementia unit) indicate that entry criteria and access processes were made clear to them. Nine of nine resident files sampled (two from the rest home, four from the hospital and three from the dementia unit) have a current needs assessment indicating they have been assessed for rest home, hospital or dementia level care.

E4.1.b There is written information on the service philosophy and practices particular to Wiltshire House included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

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.

E3.1 Three of three resident files sampled from Wiltshire House were reviewed and all includes a needs assessment as requiring specialist dementia care.

**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

The service has policies around declining entry and processes to be followed when an entry is declined including communicating with the referrer and the potential consumer and/or their family. The service has not declined entry to any potential resident as reported by the clinical manager.

**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 Low

Admission procedures are carried out by the registered nurses. Assessments and care plans are developed by the registered nurses. Cares and support are primarily provided by caregivers under the supervision of enrolled nurses and registered nurses. There is a registered nurse on duty at all times in Wiltshire Home and Hospital (the rest home and hospital) and on duty or on call at all times at Wiltshire House (the dementia unit). There is an in-service programme for all staff.

D16.2, 3, 4: In nine of nine resident files sampled (two from the rest home, four from the hospital and three from the dementia unit), an assessment was completed within 24 hours and in nine files reviewed the long term care plan was completed within three weeks. Eight of nine care plans evidenced evaluations completed six monthly (the other resident is on short term respite care).

Three monthly medication reviews by a general practitioner are documented on 18 of 18 medication charts reviewed.

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); falls, nutrition, oral, pain, pressure areas, and continence for eight of nine resident files sampled (two from the rest home, four from the hospital and three from the dementia unit). This is an area requiring improvement. Weights are monitored monthly.

There is evidence in all nine files of continuity of service delivery including progress notes written at least daily. The two files sampled in the rest home and the four files sampled have evidence of regular registered nurse input in the progress notes. This has not occurred in the progress notes of the three files sampled in the dementia unit and this is an area requiring improvement. GP's and other health professionals including the podiatrist and the psychiatric service for the elderly document notes in the resident file. Ten of 10 caregivers (seven from the hospital and rest home and three from the dementia unit), two registered nurses (from the hospital and rest home), one enrolled nurse (from the hospital and rest home), one clinical manager, one nursing support manager and one nurse manager (from the dementia unit) interviewed report a thorough handover and use of the communication book to ensure service delivery continuity.

D16.5e: Nine of nine resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly.

Tracer methodology hospital:

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

Tracer methodology rest home:

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

Tracer methodology dementia unit:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

D16.2, 3, 4: In nine of nine resident files sampled (two from the rest home, four from the hospital and three from the dementia unit), an assessment was completed within 24 hours and in nine files reviewed the long term care plan was completed within three weeks. Eight of nine care plans evidenced evaluations completed six monthly (the other resident is on short term respite care).

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); falls, nutrition, oral, pain, pressure areas, and continence for eight of nine resident files sampled (two from the rest home, four from the hospital and three from the dementia unit). Weights are monitored monthly.

D16.5e: Nine of nine resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly.

**Finding Statement**

One of nine resident files sampled (from the hospital) has not had risk assessments completed within the last six months.

**Corrective Action Required:**

Ensure that all risk assessments are repeated at least six monthly.

**Timeframe:**

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

There is evidence in all nine files of continuity of service delivery including progress notes written at least daily. The two files sampled in the rest home and the four files sampled have evidence of regular registered nurse input in the progress notes. GP's and other health professionals including the podiatrist and the psychiatric service for the elderly document notes in the resident file. Ten of 10 caregivers (seven from the hospital and rest home and three from the dementia unit), two registered nurses (from the hospital and rest home), one enrolled nurse (from the hospital and rest home), one clinical manager, one nursing support manager and one nurse manager (from the dementia unit) interviewed report a thorough handover and use of the communication book to ensure service delivery continuity.

**Finding Statement**

In the three files sampled at Wiltshire House there is no evidence of regular registered nurse input into and review of progress notes.

**Corrective Action Required:**

Ensure that there is regular evidence of registered nurse input into and review of progress notes.

**Timeframe:**

3 months

**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

Nine of nine resident files sampled (two from the rest home, four from the hospital and three from the dementia unit) have evidence of an initial assessment that includes activity level, orientation, sleep patterns, mobility, nutrition, elimination, perception, mental ability, behaviour, depression, pain, social history, independence, skin integrity, sexuality, privacy and values and beliefs. This is an area requiring improvement. Nine of nine files sampled also have a falls, nutrition, oral, pain, pressure areas, and continence assessment. Information gained from these assessments is used to inform the initial and long term care plans. In eight of nine files the falls, nutrition, oral, pain, pressure areas, and continence assessment had been completed six monthly (see CAR 1.3.3.3) with information where the resident has been at the service for six months with some issues identified being transferred to the long term care plan (see CAR 1.3.5.2). Three of three residents who exhibit behaviours that challenge has on-going behaviour assessments and monitoring forms. Nine of nine residents (four from the rest home and five from the hospital) and nine of nine relatives (two from the rest home, four from the hospital and three from the dementia unit) interviewed report having input into assessment processes.

ARC E4.2; Three of three resident files reviewed from Wiltshire House included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed for residents at Wiltshire House.

**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:** PA Low

Assessments completed on admission are comprehensive. Care plans are a template document that include support needs, problem/goal, interventions and evaluation. In seven of nine residents files sampled all identified areas of need are well completed and individualised and reflect needs identified in the assessments. There are two files where all needs not identified in care plans. This is an area for improvement. Ten of 10 caregivers (seven from the hospital and rest home and three from the dementia unit) and one enrolled nurse interviewed report care plans are easy to follow. Nine of nine resident files sampled (two from the rest home, four from the hospital and three from the dementia unit) include input from GP's podiatrists, physiotherapists, mental health services and all staff from the facility.

E4.3 Three of three resident files reviewed from Wiltshire House identified current abilities, level of independence, identified needs and specific behavioural management strategies.

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

D16.3f: Nine of nine resident files reviewed identified 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:** PA **Risk level for PA/UA:** Low

Seven of nine residents whose files were sampled have an individualised long term care plan that covers all area of need identified. Areas covered in the nine files sampled include (but are not limited to) diabetes, toileting, falls risk, ADL's, nutrition and sensory needs.

Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health. There is evidence that residents are seen by their G.P. at least three monthly and within 48 hours of admission in nine of nine files sampled. The care plan format is comprehensive and goal oriented.

D16.3k: Short term care plans are in use for changes in health status. Residents’ files evidenced a short term care plan in use for pain, increased need for insulin, weight loss and decreased mobility.

**Finding Statement**

Two of nine care plans sampled do not have interventions that correlate to identified needs. Examples include depression and the use of a walking frame.

**Corrective Action Required:**

Ensure care plans describe interventions for all identified needs.

**Timeframe:**

3 months

**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

Residents care plans are completed by registered nurses. Care delivery is recorded and evaluated by caregivers at least daily (evidenced in all nine residents' progress notes sighted). When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. GP documentation is kept in the resident's file. Interviews with 10 of 10 caregivers (seven from the hospital and rest home and three from the dementia unit), two registered nurses (from the hospital and rest home), one enrolled nurse (from the hospital and rest home), one clinical manager, one nursing support manager and one nurse manager (from the dementia unit) indicate that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies, hoists and any miscellaneous items. Sighted on the day of the audit were thermometers, a sphygmomanometer, a stethoscope, scales and blood glucose testing equipment. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Nine of nine residents (four from the rest home and five from the hospital) interviewed and nine of nine relatives (two from the rest home, four from the hospital and three from the dementia unit)interviewed were complimentary of care received at the facility.

The care witnessed to be provided appears to meet the needs of residents and at all times was seen to be respectful.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

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.

Wound assessment and wound management plans are in place for 10 residents in the rest home and hospital including one pressure area. There are no current wounds in the dementia unit.

The registered Nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse and one current resident is under Nurse Maude for specialist wound nurse input.

Nine of nine residents interviewed and nine of nine family members interviewed reported that they were warmly welcomed to the service, shown around and introduced to staff and residents.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

There is an activities coordinator who works 26 hours per week in the rest home and hospital over four days. Volunteers provide activities on Fridays. There is a programme planned for that includes (but is not limited to) movies, reading, entertainers, , nails and beauty, board games and newspaper reading and visits from local schools.

Outings for rest home and hospital residents occur between monthly and three times monthly depending on activities available in the community. Outings include visits to the RSA, visits to the SPARKS museum and outings for coffee.

In Wiltshire House (the dementia unit) there is a diversional therapist who works 26 hours per week, from 10.30 am until 5 pm Monday to Thursday and from 1 pm until 5 pm every second Friday. Regular outings occur and include going out for coffee, visiting the RSA and community concerts. Regular visits are made to the dementia unit from school groups, a Sunday school, entertainers and the Lions group. There is a large cupboard with a variety of cards, puzzles, games and crafts that staff or families can access for residents at any time of the day or night.

Nine of nine residents (four from the rest home and five from the hospital) report having enough to do and being able to make requests of the activities included in the programme.

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

Evaluations are documented on the care plan template for eight of nine resident files sampled (two from the rest home, four from the hospital and three from the dementia unit). The other resident is on short term respite care. There are also six monthly multidisciplinary reviews undertaken in eight of nine files sampled (with the other resident being on respite care). Nine of nine residents files sampled show care plans are updated as changes occur in the residents condition.

D16.3k: Short term care plans are in use for changes in health status. Residents’ files evidenced a short term care plan in use for pain, increased need for insulin, weight loss and decreased mobility.

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

ARC: D16.3c: All initial care plans were evaluated by the registered nurses within three weeks of admission.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

There is a policy around referral to other health and disability services. Nine of nine residents (four from the rest home and five from the hospital) and nine of nine relatives (two from the rest home, four from the hospital and three from the dementia unit) interviewed are aware of their options to access other health and disability services and are provided with information and supported through this process. All confirm advice has been provided by the facility. The registered nurses interviewed (including the clinical manger and nursing support manager) report that possible options to which a consumer might be referred include (but are not limited to): NASC; hospital geriatricians and rehabilitation services; speech language therapists; dieticians, Medlab; radiological services; hospital specialists; cultural organisations or social workers. Advocacy information is available in the facility. When a resident requires a referral to another service, the GP takes responsibility for this task. An explanation is given to the resident and their family/whanau are informed as appropriate. Documentation relating to referrals and completed referral forms were sighted in eight of nine residents files sampled. The other resident is on short term respite care. Progress notes demonstrates staff contact family when referrals for specialist review or transfer is necessary. Residents and family members interviewed were satisfied that they were kept well informed in regard to referrals and/or transfer to hospital where this had occurred. The clinical manager and registered nurses interviewed described the referral and or transfer processes and demonstrated an understanding of residents right to be informed. Where residents have family locally they are contacted and wherever possible encouraged to accompany the consumer to outside appointments. When this is not possible the facility endeavours to provide a staff member to accompany the resident. (ARC D 20.4).

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

D 20.1 Discussions with the two registered nurses (from the hospital and rest home), one clinical manager, one nursing support manager and one nurse manager (from the dementia unit) identified that the service has access to NASC; hospital geriatricians and rehabilitation services; speech language therapists; dieticians, Medlab; radiological services; hospital specialists; cultural organisations or social workers.

**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

Nine of nine relatives (two from the rest home, four from the hospital and three from the dementia unit) interviewed stated they were well informed of the transfer process. The service has policies for transfer or exit of the service which describes guidelines for death, discharge, transfer, documentation and follow up. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities with a transfer letter from the facility photocopied with accompanying relevant documentation including medication charts (ARC D 21.1). When a resident wishes to leave the facility the NASC service is notified as reported by the clinical manager at Wiltshire Home and Hospital and the nurse manager at Wiltshire House (ARCD21.3). All relevant information is documented and communicated to the receiving health provider or service, notes are photocopied. A referral form and any other relevant documentation accompanies residents to receiving facilities. These were evident in five of nine resident files (other residents had not been transferred to another provider). Nine of nine residents (four from the rest home and five from the hospital) interviewed and nine of nine family members interviewed were satisfied that they were kept well informed in regard to referrals and/or transfer to hospital where this had occurred. Staff could describe the referral and or transfer processes and demonstrated an understanding of residents right to be informed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

18 medication charts were sampled and all medication was looked at in the locked cupboards, the medication fridges and the trolleys. The facility uses the medication management system of blister packs, that are delivered in a four week supply. Medication is checked on delivery and stored safely and all medication charts are legible and reviewed three monthly for 18 of 18 charts. Controlled drugs are stored in a locked cupboard in each of the rest home/hospital wings and there is a controlled drug safe in Wiltshire House but no current controlled drugs in that unit. Weekly stocktakes have occurred. There are appropriate medication policies and procedures including around residents who self-administer medicines. There are four residents who self-administer inhalers and all have a current competency assessment. The registered nurses, enrolled nurses and senior caregivers administer medicines. There has been training around medication administration and all staff who administer medicines have current competency assessments. All eye drops sighted have been dated when they were opened. Eighteen of 18 medication charts sampled have photo identification and all medication charts document allergies. All medication administration signing sheets sampled have all prescribed medications signed as having been administered.

D16.5.e.i.2; Eighteen of 18 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Food services policies and procedures are appropriate to the service setting. All main meals are cooked in the rest home and hospital and transferred to the dementia unit in hot boxes. Evening meals are reheated or prepared by caregivers and breakfast is prepared by caregivers in the dementia unit. Not all caregivers have food safety training and this is an area requiring improvement. The menu has t been approved by a dietitian last on 17 May 2013. There are documented protocols for management of residents with unexplained weight loss or gain, including referral to a dietician and speech language therapist as required. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Copies of dietary profiles reviewed in the kitchens and in resident files and likes and dislikes are catered for. Special equipment is available as needed. Additional snacks are available for residents when the kitchen is closed e.g. fruit, sandwiches, biscuits, bread and fillings. Residents are offered fluids throughout the day. Residents' files sampled demonstrate regular monthly monitoring of individual consumer’s weight and nutritional needs, and nutritional needs and interventions are identified and documented. Residents and family members interviewed were very complimentary of the food service provided and report their individual preferences are well catered. Residents interviewed confirmed that adequate food and fluids are provided.

Visual inspection of the kitchen provides evidence of compliance with current legislation and guidelines.

D19.2:The kitchen staff have completed food safety education and evidence of this was reviewed on their files. However, care staff who are responsible for reheating and serving meals in the dementia unit have not had safe food handling training. Improvements are required in this area.

Monitoring records available include food temperatures, and fridge / freezer temperature recordings for the kitchens. It was noted that the freezer in the main kitchen has some recordings outside acceptable temperature ranges. The hot meal dishes are at evening meal times are reheated by care staff. It was also noted that tea time meals is not routinely checked for temperature and three temperatures that were checked in Victoria wing in June 2013 were below required temperatures. This is an area requiring improvement.

E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours at Wiltshire House dementia unit.

**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:** Moderate

The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expired. Fridge/freezer temperatures are checked daily. Food in the fridge and chiller were covered and dated. The kitchen is clean and all food is stored well above ground level. Chemicals are locked away. Visual inspection of the kitchen provides evidence of compliance with current legislation and guidelines.

D19.2:The kitchen staff have completed food safety education and evidence of this was reviewed on their files. However, care staff who are responsible for reheating and serving meals in the dementia unit have not had safe food handling training.

Monitoring records available include food temperatures, and fridge / freezer temperature recordings for the kitchens. It was noted that the freezer in the main kitchen has some recordings outside acceptable temperature ranges. The hot meal dishes are at evening meal times are reheated by care staff. It was also noted that tea time meals is not routinely checked for temperature and three temperatures that were checked in Victoria wing in June 2013 were below required temperatures.

**Finding Statement**

(i)care staff who are responsible for reheating and serving meals in the dementia unit have not had safe food handling training; ii) the freezer in the main kitchen has had some recordings outside acceptable temperature ranges; iii) tea time meals is not routinely checked for temperature and three temperatures that were checked in Victoria wing in June 2013 were below required temperatures.

**Corrective Action Required:**

(i) Ensure that care staff who have food service responsibilities receive safe food handling training; ii) ensure all fridge and freezers are maintained at safe levels; iii) ensure all food that is reheated is heated to safe levels and monitor and record same.

**Timeframe:**

1 month

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facilities and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

A visual inspection of the facility evidences the provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by service providers. Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.

**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 service is over two sites. Wiltshire Home and Hospital has two wings - Ivory wing with 27 beds and Victoria wing with 30 beds. Both wings are spacious and well maintained and provide rest home and hospital level care. Wiltshire House is at a separate address and is a 28 bed secure dementia unit.

There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose at both sites. Planned and reactive maintenance systems are in place and were reviewed. At Wiltshire Home and Hospital the scales were calibrated in February 2013 and the blood pressure monitor and thermometers are less than one year old. At Wiltshire House the scales have not been calibrated and this is an area requiring improvement. At Wiltshire Home and Hospital one hoist is less than one year old and the service is not able to provide evidence that the other hoists have been serviced. This is also an area requiring improvement. Hot water temperatures are checked monthly and records show that they are maintained in a safe range.

There is a current building warrant of fitness at each facility with Wiltshire Home and Hospital expiring on 1 February 2014 and Wiltshire House expiring on 20 June 2014.

A visual Inspection of the facility provides evidence of: safe storage of medical equipment. Corridors are wide enough in all areas to allow residents to pass each other safely; safety rails are secure and appropriately located; minimal changes in floor surface and levels occur; equipment does not clutter passageways etc; transitions between surfaces or coverings are without abrupt change in level or gradient; and floor surface changes are identifiable by the consumer. The external areas are safely maintained and are appropriate to the resident group and setting and include seating and shade.

Ten of 10 caregivers (seven from the hospital and rest home and three from the dementia unit), two registered nurses (from the hospital and rest home), one enrolled nurse (from the hospital and rest home), one clinical manager, one nursing support manager and one nurse manager (from the dementia unit) interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

ARC D15.3: The following equipment is available: shower chairs, three hoists (at the home and hospital) and lifting aids.

E3.4d: The lounge area at Wiltshire House is designed so that space and seating arrangements provide for individual and group activities.

E3.3e: ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c: There is a safe and secure outside area at Wiltshire House that is easy to access .

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

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

The service is over two sites. Wiltshire Home and Hospital has two wings - Ivory wing with 27 beds and Victoria wing with 30 beds. Both wings are spacious and well maintained and provide rest home and hospital level care. Wiltshire House is at a separate address and is a 28 bed secure dementia unit.

There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose at both sites. Planned and reactive maintenance systems are in place and were reviewed. At Wiltshire Home and Hospital the scales were calibrated in February 2013 and the blood pressure monitor and thermometers are less than one year old. Hot water temperatures are checked monthly and records show that they are maintained in a safe range.

**Finding Statement**

(i) The scales at Wiltshire House have not been calibrated. (ii) The service is not able to provide evidence that the two hoists that are more than one year old have been serviced.

**Corrective Action Required:**

Ensure that all equipment that requires calibration is calibrated.

**Timeframe:**

6 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

Visual inspection evidences toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned in both facilities

The requirements of the New Zealand Building Code are met. There are adequate number of toilets and showers to cater to all residents. In Ivory wing there are 27 rooms. 20 of these rooms have a full ensuite and seven have a toilet only ensuite. There are two communal toilets and showers. In Victoria wing all 30 rooms have a full ensuite. At Wiltshire House there are two wings with 14 beds each. One wing has three rooms with toilet ensuites and two communal toilets and one communal shower. The other wing has five rooms with ensuite toilets and two showers and two toilets. The toilets have appropriate access for residents based on their needs and abilities and facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two staff. Communal toilet facilities have a system that indicates if it is engaged or vacant. There is also a safe locking system that provides for privacy but allows service providers access in the case of emergency. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

**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

Adequate personal space is provided in all bedrooms in each facility to allow residents and staff to move around within the room safely. This was confirmed during interviews of staff, families and residents.

**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

Adequate access is provided to lounge, dining and other communal areas and that residents are able to move freely within these areas in each facility. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander at Wiltshire House.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

Cleaning policy and procedures, and laundry policy and procedures are available. Product user Charts, chemical safety data sheets for all chemicals used in the facilities, and cleaning & laundry task sheets reviewed. There are policies and procedures for the safe storage and use of chemicals / poisons. There is a full laundry at Wiltshire Home and Hospital and another at Wiltshire House. The effectiveness of the cleaning and laundry services has been audited via the internal audit programme - cleaning audit completed July 2012 and laundry audit completed in September 2012. Visual inspection of the facilities evidences: safe and secure storage areas are available and service providers have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste - i.e. sluice room/facilities; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas. Staff files reviewed indicate attendance at chemical safety education. This finding was confirmed during staff interviews where they confirm education on chemical safety and management of waste and hazardous substances has occurred. Residents and family interviewed state their satisfaction with the cleaning and laundry services.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Wiltshire Lifecare has comprehensive emergency plans in place for both the rest home/hospital and dementia unit. There are flip charts displayed on the walls of the facilities to guide staff in an emergency. Both facilities have an approved fire evacuation scheme - approved for the rest home and hospital on 24-Aug-2010 and for the dementia unit on 12-May-2009. Fire evacuations are held six monthly and the time of the drill is varied (the last evacuation was held on 28-March-2013 for rest home and hospital and on 5-June-2013 for the dementia unit. Appropriate training, information, and equipment for responding to emergencies is provided (Staff training in fire safety last occurred on 1-Feb-13). Fire equipment is available (extinguishers and fire blankets). There is a civil defence kit which is stored in an internal cupboard with first aid and pandemic supplies. Each facility has sufficient water storage for all residents for at least three days. There is access to gas BBQs for alternative cooking. There is 24 hours a day, seven days a week registered nurse cover in the rest home and hospital facility and registered nurse cover during the working hours with on-call cover provided. Staff are trained in first aid and CPR. There is an up to date register maintained that lists all residents at both sites. Emergency food supplies sufficient for three days are kept in the kitchen and some extra blankets are also available. The facility has oxygen cylinders for use in an emergency. List of names and contact details of staff listed on roster if needed to contact in an emergency. The afternoon and night staff ensure that the buildings are secure after hours with checks conducted on doors and windows. The call bell system is electric and indicator panels are placed throughout the facility. Residents have easy access to the call bells and staff answer bells promptly (confirmed in discussion with 10 residents and nine relatives).

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

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

Restraint policy states that Wiltshire Lifecare's philosophy is "We are committed to promoting a restraint free environment and to provide the staff with good guidelines to enable them to prevent the need for restraint." Wiltshire do allow safety enablers to prevent residents from falling, to keep residents safe and at the resident’s own requests. Restraint is acknowledged as a serious intervention, which requires clinical rationale, is not to be undertaken lightly and is considered as one of a range of possible interventions.

There is a restraint approval committee which is incorporated in to the quality/management meeting group. Restraint use is discussed at each meeting in order to reviews restraint practices. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures.

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has nine residents on the register with restraint - all hospital level care. There are two hospital level residents with enablers - both with bedrails. Six files were reviewed - five restraint and one enabler. All six files evidenced that a comprehensive assessment has been conducted, consent was signed by the RN, GP, resident and/or family member, monthly reviews are conducted and restraint use is documented in the long term care plan. All six residents files evidenced that monitoring is conducted when restraint is in use. Advised by the clinical manager (restraint coordinator) that the service has reduced the number of residents requiring restraint. There are no residents at Wiltshire house dementia does assessed as requiring restraint. Advised by the nurse unit manager that restraint is not used.

A register for each restraint is also completed that includes a monthly evaluation.

There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

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

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

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort.

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. There are two hospital level residents requiring the use of an enabler (bedrails).

The service currently has nine residents who have been assessed as requiring the use of a restraint. These include one resident with bedrails and a fall-out chair, six residents with bedrails, one with a bedrail and a lap belt, and one resident with a lap belt.

There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits and quality/management meetings and staff meetings.

**Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

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

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

Assessments are undertaken by a registered nurse in partnership with the resident and their family/whanau. The clinical manager is the restraint coordinator. A job description in place and is signed. All staff complete a restraint competency assessment.

Restraint assessments are based on information in the long term care plan, resident and family discussions and on observations of the staff. There is a restraint assessment authorisation and plan available and this completed for the residents requiring the use of a restraint or enabler. The long term care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. A restraint assessment form is completed for those residents requiring restraint. Five restraint files and one enabler file were reviewed (all hospital level care). All files included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed monthly (written evaluation sighted).

**Criterion 2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:**

 (a) Any risks related to the use of restraint;

 (b) Any underlying causes for the relevant behaviour or condition if known;

 (c) Existing advance directives the consumer may have made;

 (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

 (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

 (f) Maintaining culturally safe practice;

 (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

 (h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

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

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

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is the clinical manager (registered nurse) and is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or family/whanau and the facility restraint coordinator. Restraint use is reviewed at least three monthly and also as part of monthly restraint register reviews and monthly RN meetings. Monthly clinical indicators reported to Oceania support office by the manger benchmark the use of restraint and can highlight is there are any issues corrective actions. Any restraint incidents/adverse events are discussed at the RN and quality meeting and corrective actions initiated. Monitoring and observation process is included in the restraint policy. Advised by the restraint coordinator that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.

The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of three hospital residents with restraint identified observations and monitoring occurring within the prescribed timeframes documented on individual residents’ restraint assessment. Restraint use is reviewed through the three monthly assessment evaluation, monthly RN and staff meetings and six multi-disciplinary meeting and includes family/whanau input. A restraint register is in place. This has been completed for all residents requiring restraint.

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

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

 (b) Following appropriate planning and preparation;

 (c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

 (d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

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

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

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations and restraint use review occurs monthly as part of the on-going reassessment for the residents on the restraint register. Families are included as part of this review. A review of six files identified that evaluations are up to date and have reviewed (but not limited to); a) whether the desired outcome was achieved, b) whether the restraint was the least restrictive option and c) the impact. Restraint use is reviewed on a formal basis at the monthly quality/management meetings and an annual review is conducted (minutes sighted for 14-May-2013 meeting).

**Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:**

 (a) Future options to avoid the use of restraint;

 (b) Whether the consumer's service delivery plan (or crisis plan) was followed;

 (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

 (d) Whether the desired outcome was achieved;

 (e) Whether the restraint was the least restrictive option to achieve the desired outcome;

 (f) The duration of the restraint episode and whether this was for the least amount of time required;

 (g) The impact the restraint had on the consumer;

 (h) Whether appropriate advocacy/support was provided or facilitated;

 (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

 (j) Whether the service's policies and procedures were followed;

 (k) Any suggested changes or additions required to the restraint education for service providers.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

ARC 5,4n ARHSS D5.4n, D16.6

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

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

Individual approved restraint is reviewed at least monthly and as part of six monthly multidisciplinary review with family/whanau involvement. Restraint usage throughout the organisation is also monitored monthly via the quality/management meetings and an annual overall review of restraint use is conducted. Restraint use is also discussed at staff meetings.

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

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

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

 (c) Adverse outcomes;

 (d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The scope of the infection prevention and control programme policy and infection prevention and control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines and accountabilities. These job descriptions are signed by the clinical manager (Wiltshire home and hospital IC coordinator) and by the dementia unit nurse manager (Wiltshire House infection control coordinator). The infection prevention and control (IPC) committee includes a cross section of staff from all areas of the service including the two IC coordinators nursing staff, care givers, cook, cleaner, laundry staff. The committee is responsible for the development of the infection prevention control programme and its review. The programme is developed by an external provider and is reviewed by the coordinators. The infection control policies and procedures manual was last reviewed in January 2013. The coordinators and committee have access to professional advice from an external IC consultant, GP's, local laboratory and infection control and public health departments at Canterbury DHB. There are monthly infection prevention and control meetings. The monthly quality/management meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the two monthly registered nurse meetings and two monthly staff meetings. Minutes are available for staff and are on display on the wall by the staff room. The facility has signage if the need to use it for outbreaks and displays this information as needed. Visitors are encouraged to stay away if sick. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy in place to ensure staff do not spread infections.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection prevention and control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the which includes the IPC coordinators, nursing staff, care givers, cook, cleaning, and laundry. Meetings are held monthly (minutes sighted). The facility also has access to an infection prevention and control consultant, infection control nurses from Canterbury DHB, public health nurses, G.P's and laboratory. The coordinators can access the laboratory for results if needed and has access to ongoing education. Both coordinators attended infection control training in March 2013.

**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

D 19.2a: Wiltshire Lifecare's infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines. The infection control manual includes policy on hand hygiene, standard precautions, transmission based precautions, prevention and management of infections, antimicrobial usage, outbreak management, cleaning of equipment, single use items and renovations and construction and other policies. There is also policy on waste disposal, and notification of diseases. Infection control procedures are included in the kitchen, laundry and the housekeeping manuals. External expertise can be accessed as required. Policy development is primarily driven by the external policy provider with review and input from IC coordinators as required.

**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 prevention and control coordinators are responsible for coordinating and providing education and training to staff. The IPC coordinators have attended education in March 2013. The clinical manager and dementia unit manager organise the education for staff. They are able to utilise outside resources to provide education as well - infection control education provided by laboratory IC specialist in February 2012. Education was last provided for staff in January 2012, February 2012, and in October 2012. External IC expert provided infection control education in October 2012 with 24 attendees. Staff who attended supplied evaluation feedback. The orientation package for all staff includes specific training around hand washing and standard precautions. Resident education is expected to occur as part of providing daily cares. Care plans can also reference infection control as needed. Residents and relatives are provided with education on influenza prior to flu vaccinations occurring. This education is ongoing during the flu season.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection prevention and control coordinators use the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections (both asymptomatic and symptomatic, plus those treated with antibiotics and those not treated with antibiotics). Individual infection logs are completed to record a running record of infections. All infections are then included on a monthly summary and collated month by month. Standardised definitions of infections are in place and are appropriate to the complexity of service provided. Infection prevention and control data are collated monthly and reported at the quality/management meetings and staff meetings. The surveillance of infection data assists in evaluating compliance with infection prevention and control practices. Internal audits are conducted - infection control and hand washing audit last completed in January 2013 in both the rest home and hospital and dementia unit. There is close liaison with the GP's who advise and provide feedback to the service (confirmed in discussion with the GP). Quality improvement initiatives are developed and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. Infection numbers are counted per month and graphed. There is a flu vaccination programme in place. Residents were offered vaccinations.

**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:**