**Presbyterian Support Services Otago Incorporated - Taieri Court**

**Current Status:** **12-Jul-13**

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

**General overview**

Taieri Court rest home is one of seven aged care facilities owned and operated by Presbyterian Support Otago Incorporated Board. The service is part of the Services for Older People, a division of the Presbyterian Support Otago. Taieri Court is managed by a registered nurse who reports to the director of services for older people, and is also supported by an operations support manager and a clinical nurse advisor. The service is certified to provide rest home level care for up to 33 rest home residents with full occupancy on the day of audit. The organisation has an implemented quality and risk programme that includes resident and family input. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required relating to aspects of assessment prior to care plan development and documenting allergies or nil know allergies on medication charts. The service continues to maintain a continued improvement focus and is commended for achieving four continued improvement ratings relating to good practice, governance, quality/risk management and integration of care.

**Audit Summary AS AT** **12-Jul-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

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| **Consumer Rights** | Day of Audit  12-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Organisational Management** | Day of Audit  12-Jul-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Continuum of Service Delivery** | Day of Audit  12-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit  12-Jul-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  12-Jul-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  12-Jul-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Audit Results AS AT** **12-Jul-13**

**Consumer Rights**

Taieri Court rest home strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are promptly managed with no formal complaints in the past two years.

**Organisational Management**

There is an implemented quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following internal audits and meetings. Key components of the quality management system link to monthly quality committee meetings and monthly staff meetings. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed biennially. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

**Continuum of Service Delivery**

There is a needs assessment completed prior to entry to Taieri Court. Care plans have been developed with resident and/or family input and are coordinated to promote continuity of service delivery. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. Residents' clinical files validate the service delivery to residents. Evaluations of care plans are an area of strength with completion more than stated requirements and involve a meeting with the resident, family and staff and relevant allied health personal. A registered nurse evaluation process takes place more frequently if a resident's condition changes and this is noted on a short term care plan or the long term care plan altered.

Planned activities are appropriate to the group setting with one to one activity support provided for those who choose not to or cannot participate in the group activities. Residents and family interviewed confirm satisfaction with the activities programme.

An appropriate medicine management system is implemented. Policies and procedures record service provider responsibilities. Staff responsible for medicine management have attended in-service education on medication management and have current medication competencies. Policy on residents who wish to self- administer medicines is recorded.

Improvement is required to ensure detailed assessment and reassessment contributes to the development of the long term care plan and that medication allergy information is known to all staff administering medications.

**Safe and Appropriate Environment**

The service has waste management policies and procedures. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Staff receive annual training on the management of waste and hazardous substances. All buildings and equipment comply with legislation. There is a current Building warrant of fitness. Furniture and fittings are selected with consideration to residents' abilities and functioning. Corridors are wide enough and allow residents to mobilise safely. There is sufficient space to allow the safe use of mobility equipment. Each room is personally furnished with the residents personal possessions. The service has an adequate number of toilets and showers with access to a hand basin and paper towels. Hot water temperature is monitored and maintained at the recommended temperature. Fixtures, fittings and floor and wall surfaces are of accepted materials for this environment. Communal toilets and showers are signed and easily identifiable. There is adequate lounge and dining areas. There are designated areas for activities and areas which ensures residents rights and privacy is not compromised. The service has in place policies and procedures for effective management of laundry and cleaning practices. Policies and procedures have been developed for civil defence and other emergency situations and are implemented. There are staff on duty with a current first aid certificate at all times. Fire drills are conducted 6 monthly and the NZFS approved the evacuation scheme. Emergency lighting and cooking is available. Call bells are in use. Security procedures are established. General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural sun light in their rooms and there is adequate external light in communal areas.

**Restraint Minimisation and Safe Practice**

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

**Infection Prevention and Control**

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

Taireri Court Rest Home

Presbyterian Support Otago Incorporated

Certification audit - Audit Report

Audit Date: 12-Jul-13

**Audit Report**

To: HealthCERT, Ministry of Health

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| **Provider Name** | Presbyterian Support Otago Incorporated |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Taieri Court Rest Home | Hartstonge Avenue | Mosgiel | Dunedin |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 12-Jul-13 **End Date:** 12-Jul-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

**Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXX | RCpN,Health auditor, CertQA, AdDipBusMan | 8.00 | 5.00 | 12-Jul-13 |
| Auditor 1 | XXXXXX | RN, Health Auditor | 8.00 | 4.00 | 12-Jul-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXX |  |  | 2.00 |  |

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| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 11.00 | **Total Audit Hours** | 27.00 |
| **Staff Records Reviewed** | 6 of 30 | **Client Records Reviewed** *(numeric)* | 6 of 33 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 6 |
| **Staff Interviewed** | 9 of 30 | **Management Interviewed** *(numeric)* | 4 of 4 | **Relatives Interviewed** *(numeric)* | 4 |
| **Consumers Interviewed** | 9 of 33 | **Number of Medication Records Reviewed** | 12 of 33 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 3 |

**Declaration**

I, (full name of agent or employee of the company) XXXXXX (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 5 day of August 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**

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|  |  |  |  | **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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Taieri Court Rest Home | 33 | 33 |  | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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**Executive Summary of Audit**

*General Overview*

Taieri Court rest home is one of seven aged care facilities owned and operated by Presbyterian Support Otago Incorporated Board. The service is part of the Services for Older People, a division of the Presbyterian Support Otago. Taieri Court is managed by a registered nurse who reports to the director of services for older people, and is also supported by an operations support manager and a clinical nurse advisor. The service is certified to provide rest home level care for up to 33 rest home residents with full occupancy on the day of audit. The organisation has an implemented quality and risk programme that includes resident and family input. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required relating to aspects of assessment prior to care plan development and documenting allergies or nil know allergies on medication charts. The service continues to maintain a continued improvement focus and is commended for achieving four continued improvement ratings relating to good practice, governance, quality/risk management and integration of care.

*1.1 Consumer Rights*

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*1.2 Organisational Management*

There is an implemented quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following internal audits and meetings. Key components of the quality management system link to monthly quality committee meetings and monthly staff meetings. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed biennially. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

*1.3 Continuum of Service Delivery*

There is a needs assessment completed prior to entry to Taieri Court. Care plans have been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. Residents' clinical files validates the service delivery to residents. Evaluations of care plans are an area of strength with completion more than stated requirements and involve a meeting with the resident, family and staff and relevant allied health personal. A registered nurse evaluation process takes place more frequently if a resident’s condition changes and this is noted on a short term care plan or the long term care plan altered.

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*1.4 Safe and Appropriate Environment*

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*2 Restraint Minimisation and Safe Practice*

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

*3. Infection Prevention and Control*

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

**Summary of Attainment**

* 1. ***Consumer Rights***

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **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 | CI | 1 | 0 | 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 |

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| Consumer Rights Standards (of 12): N/A:0 CI:1 FA: 11 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:1 FA:22 PA:0 UA:0 NA: 0 |

* 1. ***Organisational Management***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | CI | 1 | 1 | 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 | CI | 1 | 7 | 0 | 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 | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:2 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:2 FA:20 PA:0 UA:0 NA: 0 |

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

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|  |  | **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 | FA | 1 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | PA Low | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Low | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 10 PA Neg: 0 PA Low: 2 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:1 FA:18 PA:2 UA:0 NA: 0 |

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

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

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 8 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:17 PA:0 UA:0 NA: 0 |

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

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

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

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

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|  |  | **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 |

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| Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 5 **CI:** 3 **FA:** 40 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 4 **FA:** 87 **PA:** 2 **UA:** 0 **N/A:** 8 |

**Corrective Action Requests (CAR) Report**

Provider Name: Presbyterian Support Otago Incorporated

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:12-Jul-13 End Date: 12-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXX

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| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.4 | 1.3.4.2 | PA  Low | **Finding:**  One of six files reviewed the nutrition assessment was completed after the RN had developed the long term care plan which included nutritional information gained only from the initial nursing assessment. There was no evidence of routine re-assessment of nutritional requirements for all residents by the dietitian to ensure identification of any developed issues. One file for a resident transferred from respite to permanent did not have recently updated risk assessment tools to ensure the lifestyle plan more fully reflected effective assessment.  **Action:**  Ensure completion of all assessment and reassessment requirements prior to the development of the long-term lifestyle care plan and evaluation of the care plan. | 3 months |
| 1.3.12 | 1.3.12.1 | PA  Low | **Finding:**  Six of 12 medication charts reviewed evidenced that the section for listing allergies was blank.  **Action:**  Ensure to document on the medication prescribing chart that there is no known allergy for those that do not have known allergies - to confirm that the information has been gathered and is known by those administering medications. | 3 months |

**Continuous Improvement (CI) Report**

Provider Name: Presbyterian Support Otago Incorporated

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:12-Jul-13 End Date: 12-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXX

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| **Std** | **Criteria** | **Evidence** |
| 1.1.8 | 1.1.8.1 | **Finding:**  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are regularly updated and reviews are conducted. A comprehensive quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking within PSO facilities, with QPS benchmarking programme, residents meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff. There is an internal audit schedule.  The organisation has developed 16 continuous quality improvement work streams with responsibilities for chairing and facilitating of the groups delegated to various senior staff members within the organisation. Each work stream is responsible for review of programmes and implementing and disseminating information.  In 2011, Presbyterian Support Otago identified the need to strengthen the quality of monitoring and reporting on clinical related matters at both a governance and operational level. The purpose of the Clinical Governance Advisory Group (CGAG) is to monitor the effectiveness of existing systems and processes to support acceptable clinical outcomes in all areas. Meetings are quarterly, and feedback is provided to PSO Board. CGAG reports and minutes are distributed and discussed at Managers Day meetings to ensure organisational learning opportunities are maximised. PSO’s progressive approach led to the appointment of a Clinical Nurse Advisor in 2012. Examples of some initiatives/changes made by the Clinical nurse advisor include (but not limited to); PRN medicine sticker, neuro observations chart, documentation and Policy Roll out presentations, arranging Adult Health assessment training for RNs. Trialling a new Assessment and Monitoring tool for Challenging behaviours, providing feedback to Managers and RNs/ENs around management and documentation of serious harms and other incidents or care situations.  Quality initiatives at Taieri Court implemented are resident focused and seek to improve outcomes for residents within the home environment and in the garden. The resident survey conducted in 2012 evidences that 100% of respondents agreed that the care and services received at Taieri Court makes a positive difference in their lives. Taieri Court has been proactive in responding to benchmarking: the following quality initiatives were developed as a result of benchmarked KPI's and resident feedback. Initiatives include falls and skin tear reduction with improvements made to the Taieri Court resident environment; the activities programme has been improved with projects for residents including enhancing the garden to attract native birds to the garden for residents to enjoy. |
| 1.2.1 | 1.2.1.1 | **Finding:**  PS Otago has a Vision that they want to provide “a fair, just, and caring community for the people of Otago”. For the last eight years they have introduced and implemented a quality initiative organisational wide project called “Valuing the lives of Older People”. This has a major focus on the way they provide care, and staff are involved in this quality project (which includes specific training) and a focus to making a difference to the lives of people using their services is apparent.  Taieri Court has embraced this vision and it is evident in service delivery and feedback. Following review of policies, procedures, discussion with staff and management, residents and relatives it is apparent that the service is passionate about the project and should be commended for the continued on-going quality improvement focus around ‘what is important to the resident’. Valuing lives is incorporated into all aspects of service eg. Regular agenda item at quality meetings and is embedded in all staff training. The service has a mission statement and values listed to fulfil that vision. Valuing lives action plan is regularly reviewed and communicated to all staff. The managers from all the PSO homes meet approximately six weekly and there is a series of work streams that focus on developing best practice in a number of specific areas. Early in 2011, a working party was set up to develop a new direction for the way in which necessary work across the Services for Older People was achieved. This included policy development and review, at the same time ensuring that there were opportunities for staff professional development and succession planning. The result of this is the Continuous Quality Improvement (CQI) work groups, currently numbering thirteen, eleven of which have a clinical focus, with four other discrete groups that sit alongside which deal with management aspects of service provision. PSO manager days held approximately six weekly include feedback from a number of areas including (but not limited to); conferences, aged care providers group, CQI reporting feedback from the different work streams. dementia, valuing lives, benchmarking, medication, infection control, moving & handling, workforce development, continence, documentation group. This has allowed for the leadership (including clinical leadership) to be developed across the organisation in going forward. The organisation has made a number of changes to service delivery processes, review and on-going monitoring as a result of complaints investigated at one of their facilities in 2010. There is a clinical governance advisory group established that includes; PSO board member, GP, Nurse Practitioner, independent quality advisor, director of aged care, and PSO clinical Nurse advisor and PSO Quality Advisor The organisation changed their benchmarking practises to a more formal benchmarking agreement with QPS Benchmarking Agency - Aged Care. Continuous Quality Improvement groups have evolved over the last two years and there is an expectation that personnel from every Home will participate in some of the groups, with each Manager either chairing or leading at least one group. The Manager of Taieri Court Leads the Documentation CQI and is a member of the Falls and Valuing Lives CQI. The Registered Nurse from Taieri Court is a member of the Competencies, Infection Prevention and Control, and Medications groups. |
| 1.2.3 | 1.2.3.7 | **Finding:**  The processes to measure achievement against the quality and risk management plan are implemented in the following ways: resident meetings (held two monthly), resident and family surveys - 90 -100% feedback that the service has made a difference in the lives of residents and families, complaints process ( two for 2012 or 2013), resident and family participation in care planning, benchmarking within PSO and with QPS benchmarking programme against key performance indicators, implementation of continuous quality improvement work streams, incident and accident reporting, policies and procedures are implemented, health and safety in action, education and training for staff, six weekly management meetings to review progress of the quality and risk programme and establishment of a clinical governance advisory group. Taieri Court is part of the QPS benchmarking programme with feedback provided three monthly on data provided to the benchmarking system. A report, summary and areas for improvement are received and actioned. The clinical governance advisory group also receives reports for all PSO homes and provides oversight and follow up on areas for improvement. Quality improvement initiatives for Taieri Court have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. There are currently five quality improvement initiatives being implemented and relate to falls and skin tears, safety issues in the garage where residents with mobility scooters enter, medication storage in the clinic room, activities plan documentation, and storage and handling of linen bags. It was identified that falls and skin tears were tracking above the mean for low care facilities. Two improvements have been implemented - rounding off of sharp corners on bedroom furniture, and changing the hinges on wardrobe doors to allow wider opening. Another improvement relating to falls prevention in in the garage where residents store their mobility scooters - the service has installed a window in the garage to improve lighting and visibility when entering or exiting the garage. |
| 1.3.3 | 1.3.3.4 | **Finding:**  Care workers are encouraged to be part of the care planning and delivery process. Six residents files reviewed evidenced lifestyle notes were written at the end of each shift. Stamps are used to differentiate different staff input i.e.: physiotherapist, dietitian and registered nurse. Lifestyle notes reviewed for six residents were signed and dated by those making the entry in lifestyle notes and time of entry and designation of staff member completing lifestyle notes was documented. Multi-disciplinary team meetings known as three monthly review meetings include an evaluation of the goals outlined in the lifestyle plans (with input from the team members). The clinical review includes (as indicated) the resident, general practitioner, registered nurse, occupational therapist, physiotherapist, dietician if any nutritional issues or needs, primary carer, family and significant others. Input is available at the scheduled meetings by way of prior completed documentation for those members of the team who are unable to attend. The three monthly review meetings cover all aspects of the lifestyle care plan; physiotherapy needs, skin integrity, medication/pain management, social interaction, family concerns, risk management. Three monthly review meetings were evidenced occurring in this timeframe in all four files for residents in residence over three months. Records of the meeting documented discussion and clarification of all matters including resident and / or family questions. Documentation dates demonstrated links between the meetings, lifestyle care plan evaluation, and medication review. There are regular staff meetings where information and 'short falls' are discussed, documented and minuted. Telephone interview conducted with three GP’s confirmed that the registered nurse and / or nurse manager are proactive and inform the GP by fax or telephone of any concerns regarding residents health status in a timely manner, all complimented the communication flow. The RN stated that the three monthly reviews give opportunity to fully discuss all aspects of the residents plan of care or seek clarification of any matters from all service providers . The meetings foster good partnerships and trust between members of the team, residents and /or family members or the resident's representative of choice. The implementation of the ‘valuing lives’ philosophy ensures that the resident is the focus of clinical review/evaluations. |

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

The code of health and disability rights is incorporated into care. Discussions with four care workers identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with nine residents and four family members confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in November 2012.

**Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

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

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

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

D6, 2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission.

**Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.3 Independence, Personal Privacy, Dignity, and Respect**

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

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

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

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people’s beliefs and values. Interventions to support these are identified and evaluated. The philosophy of support for PSO Services for Older People, states "…will promote and enable older people to have positive roles that build on a person's strengths and abilities that are relevant to individual needs that support older people to be as healthy as possible, and that treat people with respect and dignity." There is a policy that covers elder abuse and neglect (ETH 010) and staff have completed training in June 2011 conducted by Aged Concern - with 15 attendees. PSO Taieri Court implements the organisation's Valuing Lives philosophy whereby people receiving services feel valued and respected.

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

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

D4.1a Six of six resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. Nine residents interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

There are current policies and procedures for the provision of culturally safe care for Māori residents including a Maori health plan, Tikaka best practice guidelines, cultural protocols, consultation with Maori and Pacific peoples services, bicultural commitment, principles in Te Reo, and spiritual, family and other support. Specialist advice is available and sought when necessary. PSO Otago has a memorandum of understanding with Arai Te Uru Whare Hauora signed in July 2013. The service's philosophy results in each person's cultural needs being considered individually. Cultural awareness and Tangihanga training occurred in November 2012.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The cultural service response policy (BA 002) guides staff in the provision of culturally safe care. The philosophy of support for PSO Services for Older People, states "…will promote and enable older people to have positive roles that build on a person's strengths and abilities that are relevant to individual needs that support older people to be as healthy as possible, and that treat people with respect and dignity." This flows through into each person’s care plan and could be described by four care workers and one registered nurse interviewed. During the admission process, the registered nurse or nurse manager, along with the resident and family/whanau, complete the documentation. Regular reviews are evident and the involvement of family/whanau is recorded in the resident care plan. Four family members interviewed feel that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. Chaplaincy services are provided to residents as well as weekly church services.

D3.1g: The service provides a culturally appropriate service by implementing the PSO mission statement.

D4.1c: Six of six care plans reviewed included the residents social, spiritual, cultural and recreational needs. Seven of seven residents interviewed confirmed that the care provided meets their 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 service has a discrimination, coercion, exploitation and harassment policy and procedures in place that include (but not limited to): code of rights, elder abuse and neglect, residents’ financial/legal/personal affairs management, code of conduct for staff. Job descriptions are in place. The Code of Rights is included in orientation and in-service training. Training is scheduled and provided as part of the staff training and education plan. Interviews with four care workers confirmed an understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Training is included at orientation and through in service training (last provided June 2012). Interviews with staff reinforce professional boundaries. There are policies and procedures for staff around maintaining professional boundaries and code of conduct. Discussions with nine residents identify that privacy is ensured. Discussions with the nurse manager and a review of complaints identified no complaints of this nature.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

A2.2: The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are developed by various CQI work streams within the organisation - depending on the nature of the policies. Regular updates and reviews are conducted. The organisation has employed a clinical nurse advisor (February 2012) who has been responsible for facilitating the review of clinical policies and procedures to ensure best practice. A comprehensive quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking within PSO facilities, with QPS benchmarking programme, residents meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff.

There is an internal audit schedule. It includes (but is not limited to): risk management, restraint use, care planning, continence, food servicers, fire drill, standard precautions, medication management, workplace inspection, hand hygiene, resident handling and transfers, admissions, and infection control. The organisation has developed 16 continuous quality improvement work streams with responsibilities for chairing and facilitating of the groups delegated to various senior staff members within the organisation. Each work stream is responsible for review of programmes and implementing and disseminating information. The organisation has well imbedded systems of communication, quality review and risk management. Taieri Court implements a multi-disciplinary team approach with three monthly MDT meetings held to review all residents. Those present at these meetings include representatives from all areas of service and care. Quality improvement initiatives currently in place at Taieri Court are as a response to needs and issues identified through resident and family feedback, staff feedback and internal auditing and risk management practices.

Nine residents and four family members interviewed spoke very positively about the care provided.

D1.3 All approved service standards are adhered to.

D17.7c. There are implemented competencies for care workers and registered nurses. 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:** CI **Risk level for PA/UA:**

Presbyterian Support Otago's quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through a) resident participation including the complaints process, clinical reviews, resident meetings, implementation of the services philosophy; b) review of clinical effectiveness and risk management including benchmarking within PSO and QPS around a range of key performance indicators, internal audits, CQI work streams, incident and accident reporting, development and review of policies and procedures that meet best practice and a health and safety programme; c) providing an effective workplace including recruitment processes, competency programme, annual appraisals, education and training programme, leadership development, and a multi-disciplinary team approach to care. The manager of Taieri Court attends six weekly Services for Older People's (SOP) management meetings where the manager participates in peer review, and is part of the wider organisations review implementation of policies and procedures. A clinical governance advisory group (CGAG) reports to the PSO board three monthly on a range of performance issues and is responsible for quality of care, continuous quality improvement, minimising risk and fostering an environment of excellence in all aspects of service provision. The clinical advisory group reviews all clinical indicators benchmarked by QPS.

At Taieri Court, a multi-disciplinary team approach is implemented with the RN completing a range of assessment tools prior to facilitating a three monthly review meeting of the residents current health status, goals, and issues. A multi-disciplinary team meeting is held every three months and the long term lifestyle care plans are reviewed with the resident and / or family, as appropriate, the resident's GP, DT, care workers, with input from the physiotherapist, dietitian and OT. Meetings are minuted with attendance record and cover all aspects of the lifestyle care plan. The RN then documents the review on each section of the lifestyle care plan and the GP documents the medical review in the medical section as sighted on three of the six files reviewed, one file was respite and two for new residents. As a result of the three monthly care plan review, any issues or concerns are identified at the earliest possible time and care requirements are implemented as evidenced in files reviewed (link 1.3.3.4).

**Finding Statement**

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are regularly updated and reviews are conducted. A comprehensive quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking within PSO facilities, with QPS benchmarking programme, residents meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff. There is an internal audit schedule.

The organisation has developed 16 continuous quality improvement work streams with responsibilities for chairing and facilitating of the groups delegated to various senior staff members within the organisation. Each work stream is responsible for review of programmes and implementing and disseminating information.

In 2011, Presbyterian Support Otago identified the need to strengthen the quality of monitoring and reporting on clinical related matters at both a governance and operational level. The purpose of the Clinical Governance Advisory Group (CGAG) is to monitor the effectiveness of existing systems and processes to support acceptable clinical outcomes in all areas. Meetings are quarterly, and feedback is provided to PSO Board. CGAG reports and minutes are distributed and discussed at Managers Day meetings to ensure organisational learning opportunities are maximised. PSO’s progressive approach led to the appointment of a Clinical Nurse Advisor in 2012. Examples of some initiatives/changes made by the Clinical nurse advisor include (but not limited to); PRN medicine sticker, neuro observations chart, documentation and Policy Roll out presentations, arranging Adult Health assessment training for RNs. Trialling a new Assessment and Monitoring tool for Challenging behaviours, providing feedback to Managers and RNs/ENs around management and documentation of serious harms and other incidents or care situations.

Quality initiatives at Taieri Court implemented are resident focused and seek to improve outcomes for residents within the home environment and in the garden. The resident survey conducted in 2012 evidences that 100% of respondents agreed that the care and services received at Taieri Court makes a positive difference in their lives. Taieri Court has been proactive in responding to benchmarking: the following quality initiatives were developed as a result of benchmarked KPI's and resident feedback. Initiatives include falls and skin tear reduction with improvements made to the Taieri Court resident environment; the activities programme has been improved with projects for residents including enhancing the garden to attract native birds to the garden for residents to enjoy.

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

There is an open disclosure policy (ETH 011), a complaints policy and procedures, an incident reporting policy and adverse events policy.

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

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

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

D16.4b: The four family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

Policies around informed consent and Advanced directives include responsibilities and procedures for staff. This is also included as part of the training on Consumer rights and the 'Valuing Lives' / Philosophy of Care. Interviews with four care workers, identify that consents are sought in the delivery of personal cares and this is confirmed by nine residents interviewed. Written consent includes the signed admission agreements, informed consent, and advanced directive/resuscitation form. All six resident files reviewed had signed consent forms.

D13.1 Admission agreements were signed and on file in all six files reviewed.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

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

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy training was provided as part of Code of resident’s rights and cultural awareness training in November 2012.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources**

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

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

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

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

D3.1h Discussion with the registered nurse, four care workers, nine residents and four family members identified that residents are supported and

encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e: Interviews with the diversional therapist described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Residents are assisted to meet responsibilities and obligations as citizens. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping, community clubs, church services. Entertainers are included in the rest home activities programme. The DT and nurse manager described how outings in the facility owned van are tailored to meet the interests of the residents.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation. There have been two verbal complaints received in the past two years as evidenced in the complaints/compliments folder. The nurse manager is responsible for complaints management and advised that both verbal and written complaints would be actively managed. There is a complaints register which is utilised for documenting complaints or concerns should they occur. Nine residents and four family members advised that they are aware of the complaints procedure and how to access forms.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

Taieri Court rest home is one of seven aged care facilities under residential Services for Older People (SOP) - a division of Presbyterian Support Otago (PSO). The director and management group of Services for Older People provide governance and support to the nurse manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management. Organisational staff positions also include a full time operations support manager, a 0.8 FTE clinical nurse advisor and a 0.8 FTE quality Advisor (position currently not filled). The director attends six weekly management meetings for all residential managers where reporting, peer support, education and training takes place. The nurse manager of Taieri Court provides a monthly report to the Director of SOP on clinical and financial matters. The nurse manager is a registered nurse with experience in management and aged care and is also supported by a registered nurse (28 hours per week) and care workers. She has been in the role of nurse manager for seven years - prior to this RN at Taieri Court. The rest home has 33 rooms with full occupancy on the day of audit. The organisation has a current strategic plan for 2012 - 2015, a business plan 2013 - 2014 and a current quality plan for 2012 - 2013. The organisational quality programme is managed by a quality advisor (position currently being filled) and the director of SOP. The nurse manager is responsible for the implementation of the quality programme at Taieri Court. The service has an annual planner/schedule which includes audits, meetings, and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The quality committee at Taieri Court includes the nurse manager, the registered nurse, health and safety rep, and food service manager. The committee meets monthly to assess, monitor and evaluate quality care at Taieri Court rest home. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for PSO.

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

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

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

The director and management group of Services for Older People provide governance and support to the nurse manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management.

Organisational staff positions also include a full time operations support manager, a 0.8 FTE clinical nurse advisor and a 0.8 FTE quality advisor (position currently not filled). The director attends six weekly management meetings for all residential managers where reporting, peer support, education and training takes place. The nurse manager of Taieri Court provides a monthly report to the Director of SOP on clinical and financial matters.

There is a PS Otago organisational chart.

The organisation has a current strategic plan for 2012 - 2015, a business plan 2013 - 2014 and a current quality plan for 2012 - 2013.

**Finding Statement**

PS Otago has a Vision that they want to provide “a fair, just, and caring community for the people of Otago”. For the last eight years they have introduced and implemented a quality initiative organisational wide project called “Valuing the lives of Older People”. This has a major focus on the way they provide care, and staff are involved in this quality project (which includes specific training) and a focus to making a difference to the lives of people using their services is apparent.

Taieri Court has embraced this vision and it is evident in service delivery and feedback. Following review of policies, procedures, discussion with staff and management, residents and relatives it is apparent that the service is passionate about the project and should be commended for the continued on-going quality improvement focus around ‘what is important to the resident’. Valuing lives is incorporated into all aspects of service eg. Regular agenda item at quality meetings and is embedded in all staff training. The service has a mission statement and values listed to fulfil that vision. Valuing lives action plan is regularly reviewed and communicated to all staff. The managers from all the PSO homes meet approximately six weekly and there is a series of work streams that focus on developing best practice in a number of specific areas. Early in 2011, a working party was set up to develop a new direction for the way in which necessary work across the Services for Older People was achieved. This included policy development and review, at the same time ensuring that there were opportunities for staff professional development and succession planning. The result of this is the Continuous Quality Improvement (CQI) work groups, currently numbering thirteen, eleven of which have a clinical focus, with four other discrete groups that sit alongside which deal with management aspects of service provision. PSO manager days held approximately six weekly include feedback from a number of areas including (but not limited to); conferences, aged care providers group, CQI reporting feedback from the different work streams. dementia, valuing lives, benchmarking, medication, infection control, moving & handling, workforce development, continence, documentation group. This has allowed for the leadership (including clinical leadership) to be developed across the organisation in going forward. The organisation has made a number of changes to service delivery processes, review and on-going monitoring as a result of complaints investigated at one of their facilities in 2010. There is a clinical governance advisory group established that includes; PSO board member, GP, Nurse Practitioner, independent quality advisor, director of aged care, and PSO clinical Nurse advisor and PSO Quality Advisor The organisation changed their benchmarking practises to a more formal benchmarking agreement with QPS Benchmarking Agency - Aged Care. Continuous Quality Improvement groups have evolved over the last two years and there is an expectation that personnel from every Home will participate in some of the groups, with each Manager either chairing or leading at least one group. The Manager of Taieri Court Leads the Documentation CQI and is a member of the Falls and Valuing Lives CQI. The Registered Nurse from Taieri Court is a member of the Competencies, Infection Prevention and Control, and Medications groups.

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

During a temporary absence of the nurse manager, the facility is managed by the registered nurse, with support from the operations support manager and the clinical nurse advisor. The registered nurse is experienced in aged care and management. The service has well developed policies and procedures at a service level and a strategic plan, business plan and quality plan that are structured to provide appropriate safe quality care to people who use the service including residents that require rest home level care.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

There is a board approved PSO strategic plan for 2012 - 2015 and incorporates residential and non-residential services for the older persons as well as community, family and youth support programmes provided by PSO.

The business plan for 2013-2014 outlines the financial position for PSO with specific goals for the coming year. Goals and objectives relate to building strong and connected communities, provide leadership within the sector, and maximise resource to deliver on the PSO mission.

The quality plan for 2012 - 2013 includes the quality framework, model and processes, benchmarking, meetings, monitoring and reporting, internal and external audits, food safety, Valuing lives programme, policies and procedures, gaining feedback from residents and families, and ensuring a safe environment. A quality Advisor's role (.8 FTE) is currently being filled. The organisation has 16 continuous quality improvement work streams in place which include: infection control, documentation, continence, restraint, dementia, wound care, moving and handling, falls, medications, palliative care, policies and procedures, benchmarking, financial, competencies, workforce development, and Valuing lives. Each group is led by a designated manager/leader. The role of each group is to address the needs identified within each specialised work stream. Projects and issues are identified by the managers group (approximately six weekly meetings) and allocated to the appropriate work stream for research, review and action planning.

Quality improvement initiatives for Taieri Court have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. There are currently five quality improvement initiatives being implemented and relate to falls and skin tears, safety issues in the garage where residents with mobility scooters enter, medication storage in the clinic room, activities plan documentation, and storage and handling of linen bags. Taieri Court is part of the QPS benchmarking programme with feedback provided three monthly on data provided to the benchmarking system. A report, summary and areas for improvement are received and actioned. The clinical governance advisory group also receives reports for all PSO homes and provides oversight and follow up on areas for improvement.

Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning.

Progress with the quality assurance and risk management programme is monitored through the six – eight weekly residential managers’ meetings, monthly Taieri Court quality committee meetings, and one - three monthly staff meetings. Monthly and annual reviews are completed for all areas of service and include infection rates, incidents and accidents, restraint use, internal audits, wounds, complaints, and health and safety . The quality committee meeting agenda includes (but is not limited to): previous meetings minutes, food service, infection surveillance, complaints, laundry service, health and safety, occupancy, restraint, audits, surveys, QPS reports, activities, nursing/clinical, and review of action plans. Minutes are maintained (sighted for 26 June 2013) and staff are expected to read the minutes and sign off when read. (confirmed by four care workers at interview). Staff meetings agenda includes a report from the quality committee, internal audits, general housekeeping, and is followed by an education session.(minutes sighted for 1 May 2013). Minutes for all meetings include actions to achieve compliance where relevant. This, together with staff training, demonstrates Taieri Court's commitment to on-going quality improvement. Discussions with the registered nurse and four care workers confirm their involvement in the quality programme. Resident/relative meetings take place two monthly with laundry, activities and food/meals as regular agenda items. Minutes sighted for 21 May 2013.

There is an internal audit schedule. It includes (but is not limited to): risk management, restraint use, care planning, continence, food servicers, fire drill, standard precautions, medication management, workplace inspection, hand hygiene, resident handling and transfers, admissions, and infection control.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

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

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

D5.4 The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. The clinical nurse advisor, the Quality Advisor and the policies and procedures CQI work stream is responsible for overseeing and participating in development and review of policies and procedures.

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

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

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

D19.2g Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by care workers and given to the registered nurse who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the nurse manager who completes any additional follow up. The nurse manager collates and analyses data to identify trends. Results are discussed with staff through the one- three monthly staff meetings, the monthly facility quality committee meetings, six weekly Services for Older People management meetings, and provided to QPS benchmarking. Internal Audits for 2012/2013 have been completed and there is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. A resident survey (February 2012) and a family survey (March 2013) is conducted biennially. The surveys evidences that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via meetings (resident meeting minutes sighted for 29-May-2013) and a letter sent to all family with the survey outcomes.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

The quality plan for 2012 - 2013 includes the quality framework, model and processes, benchmarking, meetings, monitoring and reporting, internal and external audits, food safety, Valuing lives programme, policies and procedures, gaining feedback from residents and families, and ensuring a safe environment. The organisation has 16 continuous quality improvement work streams in place which include: infection control, documentation, continence, restraint, dementia, wound care, moving and handling, falls, medications, palliative care, policies and procedures, benchmarking, financial, competencies, workforce development, and Valuing lives. Each group is led by a designated manager/leader. The role of each group is to address the needs identified within each specialised work stream. Projects and issues are identified by the managers group (six weekly meeting) and allocated to the appropriate work stream for research, review and action planning.

**Finding Statement**

The processes to measure achievement against the quality and risk management plan are implemented in the following ways: resident meetings (held two monthly), resident and family surveys - 90 -100% feedback that the service has made a difference in the lives of residents and families, complaints process ( two for 2012 or 2013), resident and family participation in care planning, benchmarking within PSO and with QPS benchmarking programme against key performance indicators, implementation of continuous quality improvement work streams, incident and accident reporting, policies and procedures are implemented, health and safety in action, education and training for staff, six weekly management meetings to review progress of the quality and risk programme and establishment of a clinical governance advisory group. Taieri Court is part of the QPS benchmarking programme with feedback provided three monthly on data provided to the benchmarking system. A report, summary and areas for improvement are received and actioned. The clinical governance advisory group also receives reports for all PSO homes and provides oversight and follow up on areas for improvement. Quality improvement initiatives for Taieri Court have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. There are currently five quality improvement initiatives being implemented and relate to falls and skin tears, safety issues in the garage where residents with mobility scooters enter, medication storage in the clinic room, activities plan documentation, and storage and handling of linen bags. It was identified that falls and skin tears were tracking above the mean for low care facilities. Two improvements have been implemented - rounding off of sharp corners on bedroom furniture, and changing the hinges on wardrobe doors to allow wider opening. Another improvement relating to falls prevention in in the garage where residents store their mobility scooters - the service has installed a window in the garage to improve lighting and visibility when entering or exiting the garage.

**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

There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly facility quality committee meetings, six weekly Services for Older People management meetings, and one - three monthly staff meetings including actions to minimise recurrence. Falls and skin tears are reported and benchmarked through QPS programme. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and four family members interviewed stated they are informed of changes in health status and incidents/accidents. Incident reports for June 2013 were reviewed. A sample of incidents for three residents (one with three falls, one skin tear and two bruises; one with one fall and a fracture; and one with two falls) were reviewed. Reports were completed and family notified as appropriate. Monthly incident/accident collation and analysis occurs with subsequent annual summary and analysis. Medication errors are also reported. A monthly summary of accidents and incidents is compiled by the nurse manager with subsequent analysis and investigations.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurses and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (nurse manager, one registered nurse, two care workers, one cook and the diversional therapist). Advised that reference checks are completed before employment is offered as evidenced in six of six staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Four care workers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in six of six staff files reviewed.

Discussion with the nurse manager, registered nurse and care workers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Care workers have completed either the national certificate in care of the elderly or have completed or commenced the Career force aged care education programme. The nurse manager and registered nurse attends external training including conferences, seminars and sessions provided by PSO and the local DHB. The nurse manager has attended education and training sessions from external providers in 2012.

Education provided so far in 2013 includes: introduction of reviewed policies and procedures, fire training, documentation, first aid, medication, skin and wound care, back care and manual handling, continence management. Education for 2012 included food handling, waste management, fire training, back care, lifestyle support planning and ageing process, health and safety including incidents and accidents reporting, cultural safety and code of consumer rights, and chemical safety.

Fire evacuation drill last conducted February 2013. Annual appraisals are conducted for all staff as evidenced in six of six files reviewed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

The staffing levels guide and HR policies includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home residents. At least two staff are rostered on at any one time with an RN on-call. The registered nurse or nurse manager provide first on call. Advised that extra staff can be called on for increased resident requirements. Roster includes: nurse manager 40 hours per week, registered nurse 28 hours per week. There are four care workers during the am shift, three care workers in the pm shift and two staff on overnight - one care worker and one cook/cleaner. Activities staff include one DT for 30 hours per week and one activities assistant for six hours per week. Cleaning staff work every day. Kitchen staff include a food service manager, a cook, a tea cook and a kitchen assistant. Maintenance person works seven hours per week. Interviews with four care workers, nine residents and four family members identify that staffing is adequate to meet the needs of residents.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

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

D7.1 entries are legible, dates and signed by the relevant health care assistants or RN including designation

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

**Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

**STANDARD 1.3.1 Entry To Services**

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

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

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

Resident’s needs are assessed prior to entry. The service has an admissions to the facility policy, admission agreement, resident welcome pack available for residents/families at entry. The Taieri Court pamphlet and Residential Services booklet includes all relevant aspects of service and residents and / or family are provided with associated information such as the health and disability code of rights and the MOH long term residential care in a rest home,

Nine of nine residents and four family members interviewed confirmed they received information prior to admission and discussed the admission process with the Nurse Manager.

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.2 Declining Referral/Entry To Services**

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

ARHSS D4.2

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

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

The service has a Waiting List for Prospective Client policy. Consumers are advised of decline of entry when there are no beds available, the facility manager reports there have been no declined entry for any other reason. The service records the reason for declining service entry to residents and communicates this to residents/family/whanau. Anyone declined entry is referred back to the Needs Assessors or referring agency for appropriate placement and advice.

**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:** FA

There are policies and procedures that guide the admission of a resident and planning interventions with timeframes.

The registered nurse at Taieri Court is responsible for development of the care plan, with input from the care workers. The initial assessment is completed on the day of admission which also forms the initial care plan. Continuing assessments are completed with the long term care plan being developed within three weeks. Family are, where appropriate, involved from time of admission and continue to be involved when there is a review of the care plan. Communication with family is documented on the family communication form. A hand over sheet is used to document any issues and verbal handover occurs at the end of each shift. The attending GP assesses the resident within 48 hours of admission.

Activity assessments / profile of the resident is conducted by the OT and there is an initiative to add an activity section in the Lifestyle care plan which is developed by the DT in conjunction with the OT and the RN.

D16.2, 3, 4; An initial assessment is completed within 24 hours which forms the initial care plan. The lifestyle care plan is evaluated by the registered nurse at least three monthly with amendments at any time there is a current health changes. There is a full evaluation which includes the resident, family, GP, OT or DT and care workers at least every three months.

Four of six resident files were reviewed and identified that the initial admission assessment and plan was developed within 24 hours of admission and long term lifestyle care plan were completed by the registered nurse within a three week timeframe (two were for long term residents >five years).

D16.5e; Medical assessments were documented in four of six long term files within 48 hours of admission (two files for long term residents)

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

There are four GP’s providing services to Taieri Court. At interview the registered nurse advised that residents may choose to remain with their own GP.

Progress notes are written at least daily or more frequently to document any matters of note or untoward events.

The PSO physiotherapist visits weekly and assesses all new residents for mobility and develops a transfer support plan as required. The RN alerts the physiotherapist to any changes in health status and the resident is seen at the next visit. The physiotherapist carries out individual physiotherapy as required. The physiotherapist is involved and usually attends the three monthly review meetings.

Three GP’s interviewed stated that the service provided meets the needs of their residents and they are notified in a timely manner whenever a residents needs medical attention without unnecessary consultation and they have confidence in the ability of the registered nurse and nurse manager.

One current and three healed wound documentation was reviewed. All had statements of type of wound, location with photographs with detailed wound care requirements including a short term care plan. Evaluation documentation was written each time the wound was redressed by the RN.

Tracer Methodology rest home:

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

The RN completes a range of assessment tools prior to facilitating a three monthly review meeting of the residents current health status, goals, and issues. A multi-disciplinary team meeting is held every three months and the long term lifestyle care plans are reviewed with the resident and / or family, as appropriate, the resident's GP, DT, care workers, with input from the physiotherapist, dietitian and OT. Meetings are documented with attendance record and cover all aspects of the lifestyle care plan. The RN then documents the review on each section of the lifestyle care plan and the GP documents the medical review in the medical section as sighted on three of the six files reviewed, one file was respite and two for new residents.

**Finding Statement**

Care workers are encouraged to be part of the care planning and delivery process. Six residents files reviewed evidenced lifestyle notes were written at the end of each shift. Stamps are used to differentiate different staff input i.e.: physiotherapist, dietitian and registered nurse. Lifestyle notes reviewed for six residents were signed and dated by those making the entry in lifestyle notes and time of entry and designation of staff member completing lifestyle notes was documented. Multi-disciplinary team meetings known as three monthly review meetings include an evaluation of the goals outlined in the lifestyle plans (with input from the team members). The clinical review includes (as indicated) the resident, general practitioner, registered nurse, occupational therapist, physiotherapist, dietician if any nutritional issues or needs, primary carer, family and significant others. Input is available at the scheduled meetings by way of prior completed documentation for those members of the team who are unable to attend. The three monthly review meetings cover all aspects of the lifestyle care plan; physiotherapy needs, skin integrity, medication/pain management, social interaction, family concerns, risk management. Three monthly review meetings were evidenced occurring in this timeframe in all four files for residents in residence over three months. Records of the meeting documented discussion and clarification of all matters including resident and / or family questions. Documentation dates demonstrated links between the meetings, lifestyle care plan evaluation, and medication review. There are regular staff meetings where information and 'short falls' are discussed, documented and minuted. Telephone interview conducted with three GP’s confirmed that the registered nurse and / or nurse manager are proactive and inform the GP by fax or telephone of any concerns regarding residents health status in a timely manner, all complimented the communication flow. The RN stated that the three monthly reviews give opportunity to fully discuss all aspects of the residents plan of care or seek clarification of any matters from all service providers . The meetings foster good partnerships and trust between members of the team, residents and /or family members or the resident's representative of choice. The implementation of the ‘valuing lives’ philosophy ensures that the resident is the focus of clinical review/evaluations.

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

Demographic details such as NHI, next of kin, ethnicity, previous and current health and / or disability conditions are gathered on admission.

All residents are admitted with a completed needs assessment prior to admission and an initial assessment completed within 24 hours of admission.

The documentation responsibilities policy describes the process for completing assessment and lifestyle care plan. Resident assessment is comprehensive and include assessment tools; a) mobility assessment, b) pressure area assessment, c) falls risk assessment, d) continence assessment and e) pain. Information gained through the assessment process was congruent with the lifestyle care plans sighted in five of the six files reviewed (one was for a respite resident).

The initial assessment tool forms the initial support plan. The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of interventions. Nine residents and four family members confirmed an inclusive process for care planning and delivery.

There is an improvement required to ensure that when a resident becomes permanent a full assessment is completed and the nutritional assessment is completed prior to the development of the nutritional section of the long term lifestyle care plan.

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

The nutritional assessment is completed by the dietitian who visits once every four to six weeks. The RN uses information reported by the caregivers to contribute to the nutritional section of the lifestyle care plan during initial development of the lifestyle care plan and for evaluation.

One of six files reviewed the nutrition assessment was completed after the RN had developed the long term care plan which included nutritional information but did not refer to dietician assessment. Routine re-assessment of nutritional requirements is usually recorded in the Resident Review Summary Sheet under Nutritional requirements in three of six files reviewed prior to review of the lifestyle care plan to ensure identification of any developed issues. (one file was a respite resident and two new residents).

One file reviewed was for a resident who transferred from respite to permanent resident, the resident was well known by Taieri Court after three years of regular respite care. The previously developed respite lifestyle care plan was evaluated and altered to align with the current mobility requirements with a physiotherapy developed transfer plan and other aspects of care. There was some use of the service risk assessment tools to ensure the lifestyle plan was developed from a range of resources used to enable effective assessment.

**Finding Statement**

One of six files reviewed the nutrition assessment was completed after the RN had developed the long term care plan which included nutritional information gained only from the initial nursing assessment. There was no evidence of routine re-assessment of nutritional requirements for all residents by the dietitian to ensure identification of any developed issues. One file for a resident transferred from respite to permanent did not have recently updated risk assessment tools to ensure the lifestyle plan more fully reflected effective assessment.

**Corrective Action Required:**

Ensure completion of all assessment and reassessment requirements prior to the development of the long-term lifestyle care plan and evaluation of the care plan.

**Timeframe:**

3 months

**STANDARD 1.3.5 Planning**

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

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

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

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

A review of six resident files indicated the use of short term and comprehensive long term lifestyle care plans that address all care needs. These reflect variances in resident health status. The long term lifestyle care plan is completed within three weeks by the registered nurse, providing an holistic approach to care planning with resident and / or family input ensuring a resident focused approach which is evidenced by the signing of the plan. There is evidence of three monthly review meetings and RN evaluations with alteration of the lifestyle care plan to ensure it remains current. There is a newly developed activities section of the long term care plan that that is being completed by the DT . Four family interviewed stated they were fully informed and involved in the care plan process.

D16.3k, Short term care plans are in use for changes in health status such as wounds and infections.

D16.3f; Five of six resident files reviewed evidenced inclusion of family in the care planning process, one was for a respite resident who did not have a long term lifestyle care plan.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.5.3 Service delivery plans demonstrate service integration.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

Six resident files were reviewed.

On interview nine residents confirmed that their needs were being appropriately met. Four family interviewed stated their relatives care needs were meet. All were very complimentary of the care, meals and staff and none identified any areas for improvement.

Interview with the RN stated family were invited to give input to the care planning in particular for the three monthly review meeting for which minutes were sighted..

The five long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs, and goals/objectives. There were short term care plans in four files reviewed, and documentation sighted for wound management, for identified changes of health status. New short term care plan templates are being implemented that includes prompts of interventions for common short term care needs.

D18.3 and 4 Supplies of a wide range wound dressing products are available.

Continence products are available and resident files include a continence assessment for urine and bowel management, and continence products identified for day use, night use, and other management.

Continence management in-service conducted in August 2012 and wound management in-service in October 2012.

Wound assessment and management tool was sighted for the one resident with a current wound; three were sighted on files for healed wounds. All included photos of the wounds.

**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

The PSO group OT visits weekly and completes the activity profile assessment and to support one to one interaction with residents unable or prefer not to participate in the group activities. There is a qualified diversional therapist and an activities assistant who between them provide activities including one to one contact five days per week and two weekends per month.

Group activities are voluntary and developed by the DT that they are appropriate to the capabilities of residents. Residents are able to participate in a range of activities including indoor bowls, exercises, reminiscing, crafts, music and a variety of activities to maintain strength and interests. Taieri Court has its own nine seater van which is used for resident outings at least weekly with a record maintained to ensure all resident get an opportunity to participate.

The group activity plans are displayed on notice boards around the facility. All residents who do not participate regularly in the group activities are visited by a member of the activity staff with records kept to ensure all such residents are included.

All interactions observed on the day of the audit indicated a friendly relationship between residents and activity staff.

D16.5d The five permanent resident files reviewed included a section of the lifestyle care plan was for activity and is reviewed when at the three monthly care plan review which the DT attends.

Nine residents interviewed spoke very positively of the activity staff and confirmed either group participation or visits by a member of the team to assist with activities.

Residents are able to provide feedback and suggestions for activities as the activities are completed, at the bi-monthly resident meetings and annual survey’s. The DT stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions. The attendance records are also utilised to decide on what activities to continue including.

**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

D16.4a The RN completes a range of assessment tools prior to facilitating a three monthly review meeting of the resident’s current health status, goals, and issues. A multi-disciplinary team meeting is held every three months and the long term lifestyle care plans are reviewed with the resident and / or family, as appropriate, the resident's GP, DT, care workers, with input from the physiotherapist, dietitian and OT. Meetings are documented with attendance record and cover all aspects of the lifestyle care plan. The RN then documents the review on each section of the lifestyle care plan and the GP documents the medical review in the medical section as sighted on three of the six files reviewed, one file was respite and two for new residents.

Three monthly medication reviews were documented for nine of the 12 medication records reviewed; three files were for residents not yet in residence for three months.

There is a short term care plan system implemented that utilises prompts of interventions for common short term issues such as infections and wound management.

There was evidence of alteration to the long term care plan in the four of the six resident files reviewed; one file was respite and one for a new resident, in between the three monthly review process.

D16.3c: All initial care plans were evaluated as a part of the development of the long term lifestyle care plan by the RN 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:**

The RN completes a range of assessment tools prior to facilitating a three monthly review meeting of the resident’s current health status, goals, and issues. A multi-disciplinary team meeting is held every three months and the long term lifestyle care plans are reviewed with the resident and / or family, as appropriate, the resident's GP, DT, care workers, with input from the physiotherapist, dietitian and OT. Meetings are documented with attendance record and cover all aspects of the lifestyle care plan. The RN then documents the review on each section of the lifestyle care plan and the GP documents the medical review in the medical section as sighted on three of the six files reviewed, one file was respite and two for new residents. As a result of the three monthly care plan review, any issues or concerns are identified at the earliest possible time and care requirements are implemented as evidenced in files reviewed.

**Finding Statement**

Multi-disciplinary team meetings are conducted three monthly to review all aspects of residents care including care plans and medical review. There is evidence of input from a range of service providers which contributes to the timely response of any care issues.

**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

The service facilitates access to other medical and non-medical services, evidenced by documentation of the GP, the PSO physiotherapist, OT and dietitian, and a resident psychiatric services involvement. Referral forms and documentation are maintained on resident files.

There is information available pre-admission and in the admission documentation on the health and disability code of rights, advocacy, and informed consent.

D16.4c: There was evidence on six of six files reviewed of use of allied health, mainly the PSO physiotherapist and occupational therapist who visit weekly and the dietitian who visits four to six weekly. The resident had input from community psychiatric services.

D 20.1: Interview with the nurse manager confirmed knowledge of referral processes to Southern DHB continence and wound care specialist.

**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

The service has policies for transfer or exit of the service which describes guidelines for death, discharge, transfer, documentation and follow up using the set PSO documentation. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities with accompanying photocopied relevant documentation including medication charts, copy of the transfer form for the tracer transferred to acute care was on file. The nurse manager or registered nurse is available for any follow up or queries.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

Individually prescribed resident medication charts are in use that record prescribed medications by residents’ general practitioner, including PRN and short course medications. Prescribing charts are legible, medications individually signed and dated including ceased medications.

Each resident prescribing chart had attached a PSO PRN medication order form that describes medications that have standing orders of common over-the-counter preparations, paracetamol, oxygen, GTN spray with information on possible side-effects, and common doses, which is signed for by each residents GP and there is a facility stock of such items for use. At interview with the RN and the PSO clinical nurse advisor it was explained that this is a group document and that Taieri Court is the only facility without an attached hospital level care with 24/7 RN support on site. On discussion it was stated that the document and process had recently been discussed and further review was anticipated.

The service uses the medico-Douglas blister packs. The medications are delivered monthly and checked in by the RN. Medication administration was observed at lunchtime as administered to guideline requirements by a caregiver. Medications and associated documentation are kept in medication folders which is stored in the locked clinic room.

Controlled drugs are stored in a locked cabinet inside a locked cupboard in the locked clinic room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly by the RN and a second medication competent staff member. Medication requiring refrigeration is stored in lidded containers in the kitchen fridge, with temperatures monitored weekly.

All senior caregivers complete medication training with an assessment for competency completed by either the nurse manager or RN. Annual medication training and administration competency is completed of each staff member with RN’s peer evaluating each other. Senior caregivers deemed competent are responsible for administering medication with support from the RN when on duty.

Medication training last occurred in April 2013. Medication competencies are completed annually for all staff who administer medications - as sighted in staff files reviewed.

There is a self-medicating resident’s policy in place. Three residents are currently self-administering medication and have been competency checked by the RN for correct technique with documented evidence with the medication documentation.

Improvement is required to document on the medication prescribing chart that there is no known allergy for those that do not have known allergies to confirm that the information has been gathered and is known by those administering medications.

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

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

The medication chart has an area to state allergies. Six of twelve charts this section was blank. On discussion with the RN she identified that the information is gathered in the medical section of the resident file - only those with known allergies have the information transferred. Blank meant that there was no known allergy.

**Finding Statement**

Six of 12 medication charts reviewed evidenced that the section for listing allergies was blank.

**Corrective Action Required:**

Ensure to document on the medication prescribing chart that there is no known allergy for those that do not have known allergies - to confirm that the information has been gathered and is known by those administering medications.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

All meals at Taieri Court and prepared and cooked on site. The service also provides meals on wheels service to the community of Mosgiel. There are four weekly summer and winter menus with dietitian review and audit of menus (last conducted April 2013). All diets are catered for including diabetic, soft, pureed, vegetarian, gluten free and lactose free. The meals are prepared in a well-appointed kitchen adjacent to the main dining room for serving. The food service has a HACCP approved food safety programme (April 2013). Food temperatures taken at each meal service and these are recorded. There are sandwiches and snacks available for residents outside of meal times. Special eating aids are provided as assessed to promote independence such as lip plates and large grip utensils. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurse or nurse manager. A dietitian visits the service every month and reviews all residents. The nurse manager provides the kitchen with an update of dietary requirements after the visit. Staff were observed wearing appropriate protective clothing. Chemicals are stored securely and safety data sheets and a first aid chart are readily accessible. Fridge and freezer temperature monitoring is recorded daily and records sighted.

Resident meetings allow for the opportunity for resident feedback on the meals and food services generally. Advised by the food services manager that residents have a choice of food and are able to request alternatives if desired. Specific diets are catered for. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by the dietitian. Interviews with nine residents and four family members indicate satisfaction with the food service. Menus are displayed in the main dining room.

D19.2 staff have been trained in safe food handling. Food service manager and cooks have unit standards 167 and 168.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

There are implemented policies to guide staff in waste management, these include Disposal of Sharps , Disposal of Infectious Waste, Disposal of Contaminated waste, Waste Management and Disposal of Non-Recyclable Continence Products. All staff receive training during orientation on the management of waste, and biennially last conducted in April 2012. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

The service uses the JohnsonDiversey system for chemicals which are labelled and there is appropriate protective equipment and clothing for staff. The cleaner and maintenance person interviewed are familiar with the management of waste and hazardous substances.

There is sluice room and steriliser for bedpans and bottles.

**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:** FA

Building maintenance is carried out when necessary and records are maintained. There is access to necessary and essential equipment. The service displays a current warrant of fitness which expires on 13 March 2014. There are maintenance policies and procedures in place including electrical checks which were completed during May 2013 and PSO maintenance preventative health and safety audits implemented.

The facility is carpeted throughout with vinyl surfaces in bathrooms/toilets, dining room and kitchen areas. Hand rails are available around the hall ways. While the hallways are narrow in places all have widened areas that allow resident with mobility equipment to pass.

The facility is designed in a square with central outside courtyard area with shade and seating. There is a pathway around the outside of the building with a widened courtyard area with seating and raised gardens that the gardener stated resident contribute to the upkeep with some vegetable planting. Some walking areas are raised or undulating. These are low use areas and are stated on the hazard register with controls to reduce risk. There are specified smoking areas for staff and residents.

There is a facility owned van and car that have current warrant of fitness and registration.

Interviews with four care workers and one registered nurse confirmed there was adequate equipment.

Interview with nine residents and four family members stated satisfaction with the facilities and care provided.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities**

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

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

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

All bedrooms are single rooms with a hand basin. All toilet and shower facilities are communal and have privacy locks and are centrally located for ease of access. All have disposable towels and liquid hand soap to allow for staff use. There are four large toilets that allow room for use of mobility equipment and staff assistance and four single person toilets. There are four showers with room for mobility equipment and staff assistance with one very large unit. There was alcohol based hand rub available throughout the facility. Water temperatures are monitored monthly and are within safe levels for the area.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

All bedrooms are single rooms and were observed to contain resident personal items and decorations. Two bedrooms having a shared doorway should a couple or related residents choice to have access - currently the door is locked. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids.

There is a range of communal areas that are spacious with a range of seating areas,

Residents and family interviewed are happy with their rooms and report adequate space. Residents were observed moving freely around the facility. Four care workers interviewed report resident rooms have sufficient space to allow for the use of mobility equipment.

**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

There is a large lounge area with a dividing sliding door to promote separation from the television. There is a second smaller lounge area called the 'snug' which contains the activity staff storage and therefore access to a range of activities. The dining room is adjacent to the large lounge. There is a separate hairdressers room and physiotherapy room.

All communal rooms have external opening windows and doors and allow freedom of movement for all residents including those with aids.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

The service has in place policies and procedures for effective management of laundry and cleaning practices. The service uses Johnson Diversey cleaning and chemical products and there is a locked storage area for these items. There is two cleaning cupboards where the chemical dispensers are located. There is a laundry and cleaning manual available that includes the use of personal protective equipment, handling of linen, waste disposal and with hazard controls in the staff clinic.

The washing machine chemicals are within a closed system. Material safety data sheets are displayed and in the laundry cleaning manual. The laundry and cleaning areas have hand-washing facilities. Effectiveness is audited as part of the infection control audit.

Residents and family interviewed report being happy facilities and 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

The service has implemented policies and procedures for civil defence and other emergency situations. There is staff on duty with a current first aid certificate at all times. Fire training and drills are conducted 6 monthly last 13/3/13 and the NZFS approved the evacuation scheme dated 31/5/13. The facility is heated by radiators powered with electricity that is backed up by diesel. There is battery emergency lighting and the kitchen has both electric and gas cooking available. There is sufficient storage of drinking water that is changed six monthly. A civil defence kit is stocked and checked.

Call bells are located in all rooms and sound when rung with a light above the door and on centralised boards throughout the facility. An external security service does two checks per night. Residents care plans identify additional needs as required.

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

Taieri Court is heated by radiators in each bedroom, hallway and communal rooms powered by a an electric water boiler that has diesel back-up. Each radiator is individually controlled with a temperature that is maintained to ensure it is comfortable, on the morning of the audit the outside temperature was cold but the facility was pleasantly warm. All rooms including resident’s bedrooms have access to natural light with external windows and there is adequate external light in communal areas. Residents and family reported facilities are satisfactory.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

Documented systems are in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint or enabler use on audit day. Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.

Staff education programme on RMSP was last conducted in August 2011 and is booked to be held in August 2013. Use of restraint audit is conducted six monthly last being February 2013. The quality team reviews restraint policy, education and audits.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The registered nurse at Taieri Court is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IPC) nurse maintains her practice by attending annual infection control updates (last attended a training session in July 2012). The IPC nurse and IPC team (comprising all staff) has good support from the PSO IPC Coordinator and external support from the local laboratory infection control team and SDHB IPC Team. The infection control team is representative of the facility. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions.

**Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

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

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

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

D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by an the PSO IPC Coordinator in conjunction with the IPC CQI group and reviewed and updated every two – three years.. Last review conducted October 2012. Taieri Court infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse with expert support from PSO IPC Coordinator and IPC CQI Workstream with advice on current and best practice from external sources as necessary. . All infection control training is documented and a record of attendance is maintained. Infection control training was last provided in July 2012 as is part of the mandatory education programme provided to all staff in 2012. The IC nurse attends training annually - last session in July 2012. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

Infection surveillance and monitoring is an integral part of the infection control programme and is described in PSO infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly facility infection summary. This data is monitored and evaluated monthly and annually at facility level. Outcomes and actions are discussed at the monthly management/quality meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner in the facility and also discussed at the IPC CQI workstream meetings. 3/12 PSO wide IPC Reports are easily accessible to the nurse manager and to organisational management.

**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:**