

Lifecare Cambridge Limited

CURRENT STATUS: 16-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

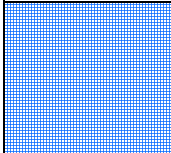
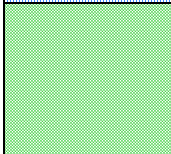



Lifecare Cambridge is privately owned. It offers 23 rest home and 24 hospital level care beds. On the day of audit occupancy is 19 hospital and 23 rest home level care residents. Services are overseen by a full time general manager who is supported by a registered nurse who is the clinical coordinator and an administrator.

All areas identified for improvement from the previous audit have been addressed by the service. There are six new areas identified for improvement from this certification audit.

AUDIT SUMMARY AS AT 16-JUL-13

Standards have been assessed and summarised below:

Key

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

| Consumer Rights | Day of Audit 16-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. | | Some standards applicable to this service partially attained and of low risk |

| Organisational Management | Day of Audit 16-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. | | Some standards applicable to this service partially attained and of low risk |

| Continuum of Service Delivery | Day of Audit 16-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 |

| Safe and Appropriate Environment | Day of Audit 16-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 |

| Restraint Minimisation and Safe Practice | Day of Audit 16-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 |

| Infection Prevention and Control | Day of Audit 16-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. | | Some standards applicable to this service partially attained and of low risk |

AUDIT RESULTS AS AT 16-JUL-13

Consumer Rights

Support provided to residents at Lifecare Cambridge is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Lifecare Cambridge currently supports one resident who identifies as Maori and has the appropriate policies, procedures and community connections to ensure culturally appropriate support is provided and barriers to access by Maori is reduced.

Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date with communications. Residents sign a consent form on entry to the service with separate consents obtained for specific events. All residents are also required to sign an Admission Agreement. The agreement needs to be updated to include the actual cost of any additional services (if required); this is identified as a required improvement.

Independent advocacy services are accessible and residents' meetings provide residents with opportunities to voice any concerns. Lifecare Cambridge encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

Residents are aware of how to make a complaint and of their right to do so. The complaints process ensures issues are managed in a timely manner. Details of complaints resolution, including dates, are recorded in the complaints register. All residents and family members interviewed confirm they are aware of the complaints process and have no complaints or concerns.

Organisational Management

The business plan shows that the directors, general manager (GM) and clinical co-ordinator ensure that services are planned and co-ordinated to meet residents' needs, and resident and family/whanau interviewed confirm this is the case. The organisation's purpose, values, priorities and goals are clearly set out.

Deficits to service are managed through corrective action planning as appropriate. The day to day operation of the facility is undertaken by staff that are appropriately experienced and qualified. This allows residents' needs to be met in an effective, efficient and timely manner.

Lifecare Cambridge implements documented quality and risk management systems to assist residents, visitors and staff safety. Quality is reviewed and measured through an internal audit schedule, complaints management and resident and family/whanau annual satisfaction surveys. All quality and risk activities are monitored by the GM and corrective actions are put in place as appropriate.

The service implements safe staffing levels and skill mixes that are clearly set out in policy to match contractual requirements. Human resources management processes are described in policy. Staff knowledge and skills are maintained through on-going education which is appropriate to their role.

Information management policy and procedures implemented ensure that residents' information is securely stored and not observable to the public. All residents' files are an accurate and integrated record which clearly identify who has made entries in the individual resident's file.

Two areas are identified that require improvement. These relate to staff annual appraisals not being up to date which does not meet contractual requirements, and policies and procedures not having documented evidence that they are aligned to current best practice.

Continuum of Service Delivery

Information packs for Cambridge Lifecare contain information on entry criteria, subsidies, service inclusions/exclusions and residents' rights. Cambridge Lifecare works closely with the local Needs Assessment Services Co-ordination (NASC) service to ensure access to service is efficient whenever a vacancy exists.

There is evidence that residents' needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. All residents' files sampled provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and their family, where appropriate. There is an improvement required to ensure that any additional short term needs are included in the care planning process.

An activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents. Residents participate in events organised by the diversional therapist and physiotherapy assistant.

Well defined medicine management policies guide practice, however an improvement is required to ensure that all medications have been individually prescribed. There are no issues of concern regarding medicine recording processes and the administration processes. All staff involved in medication management are assessed for competency and medicine records show that medicine reviews are occurring every three months.

Menus are reviewed by a dietitian and prepared by a qualified chef and trained kitchen staff. Any special dietary requirements and needs for feeding assistance or modified equipment are recorded and being met. Residents are weighed regularly to ensure nutrition is adequate. Residents interviewed are satisfied with the food service provided.

Safe and Appropriate Environment

Documented emergency planning, policies and processes are implemented by the service. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery. Documented emergency and security responses are understood by staff. Six monthly fire evacuations and emergency education is undertaken. The building has a current building warrant of fitness and the service has an approved fire evacuation plan.

The facilities are fit for purpose and provide an appropriate, accessible physical environment for both rest home and hospital level care residents. There are adequate toilet and showering facilities which are centrally located. Eight rest home level bedrooms have full ensuite facilities. In the rest home area all bedrooms are single occupancy, and in the hospital area there are four bedrooms with two beds, and two bedrooms with three beds. The dining and lounge areas meet residents' relaxation, activity and dining needs.

The facility is electrically heated. It is ventilated through opening doors and windows. There are appropriate outdoor areas that have seating and sheltered areas for residents' use.

Restraint Minimisation and Safe Practice

The service has five bedside rails which are used as restraints and six enablers (five bedside loops and one monkey bar) in use. Policies and procedures implemented meet the required Health and Disability Service Standards.

Restraint education is appropriate and is offered during orientation and annually as part of the in-service education programme. The service maintains a process to determine approval of all types of restraint, including enablers. Restraint assessment process is undertaken three monthly and a full evaluation is performed six monthly to ensure the least restrictive type of restraint is being used and that policy is being followed.

Assessment processes fully inform care planning and identify known risks. Restraint is only used for safety reasons and this is fully understood by clinical staff. There is a system in place to inform staff and management when the next assessment is due, any issues that may arise, and the need for continued restraint. Restraint is discontinued as appropriate.

Restraint use is reported at all levels of the organisation. Each episode of restraint is appropriately monitored by the restraint approval group every six months. Restraint quality reviews are clearly documented.

Infection Prevention and Control

There is a clearly defined infection prevention and control programme which includes the role of the infection control team. The programme is appropriate to the size and scope of the service, however the programme requires an annual review. An infection control

coordinator, the general manager and an infection control committee, is responsible for ensuring implementation of this programme, including education and surveillance.

Infection control policies and procedures are sufficient and are reviewed. Infection prevention and control education is included in the staff orientation programme and mandatory in-service education programme. Residents also receive information regarding preventing the spread of infection.

Surveillance of infections is occurring as required. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported throughout all levels of the organisation.

Lifecare Cambridge

Lifecare Cambridge Ltd

Certification audit - Audit Report

Audit Date: 16-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

| | |
|----------------------|------------------------|
| Provider Name | Lifecare Cambridge Ltd |
|----------------------|------------------------|

| Premise Name | Street Address | Suburb | City |
|---------------------|-----------------------|---------------|-------------|
| Lifecare Cambridge | 86 King St | | Cambridge |

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

| | |
|-----------------------------------|---|
| Type of Audit | Certification audit and (if applicable) |
| Date(s) of Audit | Start Date: 16-Jul-13 End Date: 17-Jul-13 |
| Designated Auditing Agency | The DAA Group Limited |

Audit Team

| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
|---------------------|----------|---------------------|-----------------------|------------------------|--------------------------|
| Lead Auditor | XXXXXXXX | RCN, BA, NZQA 8086 | 16.00 | 8.00 | 16-July-13 to 17-July-13 |
| Auditor 1 | XXXXXXXX | RN, LA, 8086 | 16.00 | 8.00 | 16-July-13 to 17-July-13 |
| Auditor 2 | | | | | |
| Auditor 3 | | | | | |
| Auditor 4 | | | | | |
| Auditor 5 | | | | | |
| Auditor 6 | | | | | |
| Clinical Expert | | | | | |
| Technical Expert | | | | | |
| Consumer Auditor | | | | | |
| Peer Review Auditor | XXXXXXXX | RN,MBA NZQA 8086 | | 3.00 | |

| | | | | | |
|----------------------------------|----------|--|---------|---|--------|
| Total Audit Hours on site | 32 | Total Audit Hours off site <i>(system generated)</i> | 19 | Total Audit Hours | 51 |
| Staff Records Reviewed | 11 of 49 | Client Records Reviewed <i>(numeric)</i> | 7 of 41 | Number of Client Records Reviewed using Tracer | 2 of 7 |

| | | | | Methodology | |
|------------------------------|----------|---|----------|---|---|
| Staff Interviewed | 16 of 49 | Management Interviewed <i>(numeric)</i> | 2 of 2 | Relatives Interviewed <i>(numeric)</i> | 2 |
| Consumers Interviewed | 8 of 41 | Number of Medication Records Reviewed | 14 of 41 | GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i> | 1 |

Declaration

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

I confirm that The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 13 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*):

Executive Summary of Audit

General Overview

Lifecare Cambridge is a privately owned by three directors and offers 23 rest home level care and 24 hospital level care beds. Eleven beds can be used for either hospital or rest home level care. The general manager confirms that the service considers a full occupancy when 45 beds are occupied as two double rooms are only used for couples if they choose to share a room. Both these rooms are single occupancy at the time of audit. On the day of this audit there are 19 hospital and 23 rest home level care residents. One rest home level care resident is under the age of 65 years. Services are overseen by a full time general manager who is supported by a registered nurse who is the clinical co-ordinator and an administrator.

There were thirteen areas identified for improvement from the previous audit; all been addressed by the service. There are six areas identified for improvement from this certification audit in regard to identification of additional costs, policies and procedures, staff performance appraisals, short term care planning, medication management and review of the infection control programme.

1.1 Consumer Rights

Support provided to residents at Lifecare Cambridge is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Lifecare Cambridge currently supports one resident who identifies as Maori and has the appropriate policies, procedures and community connections to ensure culturally appropriate support is provided and barriers to access by Maori is reduced.

Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date with communications. Residents sign a consent form on entry to the service with separate consents obtained for specific events. All residents are also required to sign an Admission Agreement. The agreement needs to be updated to include the actual cost of any additional services (if required); this is identified as a required improvement.

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1.2 Organisational Management

The business plan shows that the directors, general manager (GM) and clinical co-ordinator ensure that services are planned and co-ordinated to meet residents' needs, and resident and family/whanau interviewed confirm this is the case. The organisation's purpose, values, priorities and goals are clearly set out.

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1.3 Continuum of Service Delivery

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1.4 Safe and Appropriate Environment

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3. Infection Prevention and Control

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Infection control policies and procedures are sufficient and are reviewed. Infection prevention and control education is included in the staff orientation programme and mandatory in-service education programme. Residents also receive information regarding preventing the spread of infection.

Surveillance of infections is occurring as required. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported throughout all levels of the organisation.

Summary of Attainment

1.1 Consumer Rights

| | | Attainment | CI | FA | PA | UA | NA | of |
|-----------------|--|------------|----|----|----|----|----|----|
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | PA Low | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.6 | Recognition and respect of the individual's culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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

1.2 Organisational Management

| | | Attainment | CI | FA | PA | UA | NA | of |
|----------------|---|------------|----|----|----|----|----|----|
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Low | 0 | 7 | 1 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

| | | | | | | | |
|---|------------|-----------|-----------|-----------|------------|------------|------------|
| Organisational Management Standards (of 7): | N/A:0 | CI:0 | FA: 5 | 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 34): | CI:0 | FA:20 | PA:2 | UA:0 | NA: 0 | | |

1.3 Continuum of Service Delivery

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

| | | | | | | | |
|--|------------|-----------|-----------|-----------|------------|------------|------------|
| Continuum of Service Delivery Standards (of 12): | N/A:0 | CI:0 | FA: 10 | PA Neg: 0 | PA Low: 2 | PA Mod: 0 | PA High: 0 |
| | PA Crit: 0 | UA Neg: 0 | UA Low: 0 | UA Mod: 0 | UA High: 0 | UA Crit: 0 | |
| Criteria (of 51): | CI:0 | FA:19 | PA:2 | UA:0 | NA: 0 | | |

1.4 Safe and Appropriate Environment

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

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

2 Restraint Minimisation and Safe Practice

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

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

3 Infection Prevention and Control

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

| | | | | | | | | | | | | | | |
|--|------|------|------|------|-------|--|--|------------|-----------|-----------|-----------|------------|------------|------------|
| Infection Prevention and Control Standards (of 5): | | | | | | | | N/A: 0 | CI:0 | FA: 4 | PA Neg: 0 | PA Low: 1 | PA Mod: 0 | PA High: 0 |
| | | | | | | | | PA Crit: 0 | UA Neg: 0 | UA Low: 0 | UA Mod: 0 | UA High: 0 | UA Crit: 0 | |
| Criteria (of 29): | CI:0 | FA:8 | PA:1 | UA:0 | NA: 0 | | | | | | | | | |

| | | | | | | | | |
|--------------------------------|------------------|------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| Total Standards (of 50) | N/A: 0 | CI: 0 | FA: 44 | PA Neg: 0 | PA Low: 6 | 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: 0 | FA: 95 | PA: 6 | UA: 0 | N/A: 0 | | | |

Corrective Action Requests (CAR) Report

Provider Name: Lifecare Cambridge Ltd

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:16-Jul-13 End Date: 17-Jul-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

| Std | Criteria | Rating | Evidence | Timeframe |
|-------|----------|-----------|--|------------|
| 1.1.2 | 1.1.2.3 | PA Low | <p>Finding: Lifecare utilises the New Zealand Aged Care Providers Resident Agreement. This includes liability of payment for any additional services, however there is currently no defined process for identifying the actual cost to the resident should additional services be required. For example, the cost of podiatry services.</p> <p>Action: Define and implement a process for identifying any additional costs which the resident may incur. For example, the cost of podiatry services.</p> | 6 months |
| 1.2.3 | 1.2.3.3 | PA Low | <p>Finding: Policies and procedure sighted have been signed off as current, however there is no documented evidence that they are aligned with current best practice or to identify the frequency policies and procedures are to be reviewed.</p> <p>Action: Ensure policies and procedures have a documented process to identify how they are aligned with current best practice and the frequency of review.</p> | Six months |

| | | | | |
|--------|----------|----------------|---|-------------|
| 1.2.7 | 1.2.7.3 | PA Low | <p>Finding: A review of 11 staff files undertaken, nine of these staff have been employed for over 12 months and they require an annual appraisal. Only two of the nine staff files have up to date annual appraisals. It is a requirement under ARRC requirements that all staff have an annual appraisals. The GM has already recognised this as a service deficit and has a documented system in place to get all staff appraisals up to date.</p> <p>Action: Ensure annual staff appraisals are undertaken annually to meet contractual requirements.</p> | Six months; |
| 1.3.5 | 1.3.5.2 | PA Low | <p>Finding: Short term care plans have not been consistently documented where additional (short term) care needs are required.</p> <p>Action: Document short term care plans as required.</p> | 6 months |
| 1.3.12 | 1.3.12.1 | PA Moderate | <p>Finding: Four out of 14 medication charts sampled are those of residents who have been administered electrolytes without it being prescribed. The nurse initiation/standing orders process does not clearly define the numbers of doses that can be given. Six out of 12 visiting GPs have not signed approval of the standing orders/nurse initiation policy. Three medication charts in the sample have medications prescribed which have not been individually signed for by the GP.</p> <p>Action: 1) Procure a prescription for the administration of electrolytes. 2) Amend the standing orders to include the number of doses that can be given and gain approval from all visiting GPs. 3) Discontinue bracketing prescriptions and ensure each medication is individually signed for by the GP.</p> | 3 months |
| 3.1 | 3.1.3 | PA Low | <p>Finding: Evidence has not been maintained that the infection control programme, including the terms of reference for the infection control committee has been reviewed to reflect what is currently occurring in practice.</p> <p>Action: Provide evidence that the infection control programme has been reviewed.</p> | 6 months |

Continuous Improvement (CI) Report

Provider Name: Lifecare Cambridge Ltd

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:16-Jul-13 End Date: 17-Jul-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

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

How is achievement of this standard met or not met?

Attainment: FA

There are adequately documented processes regarding resident rights. This includes a reference to the 'Code of Residents Rights and Responsibilities' which is included in the resident information given on entry. Eight residents and two family members interviewed report they are well treated and expressed no concerns regarding their rights. Staff receive training on resident rights and the Code of Health and Disability Services Consumers' Rights (the Code) during orientation. Additional training on the Code (and advocacy services) has been provided. Staff interviewed are able to verbalise how they incorporate the principles of the Code into every day practice. This extends to verbal consent, reporting breaches of the Code and the residents right to refuse cares. The General Practitioner (GP) interviewed reports no concerns regarding residents' rights.

The relevant ARC requirement is met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

There are policies and procedures in place to ensure that resident' rights are not breached. The Code and information on advocacy services is provided on admission. A tour of the facility confirms that the Code is displayed, as is the Nationwide Health and Disability Advocacy Service pamphlet. Eight out of eight residents interviewed confirm information on their rights is provided, as are opportunities to discuss concerns.

The ARC requirements are met. Signed Resident Admission Agreements are sighted. Lifecare Cambridge uses the New Zealand Aged Care Providers resident agreement. The agreement meets the District Health Board contract requirements and includes liability of payment items, however the actual cost to the resident for additional services (in this case podiatry services) has not been identified by the provider and an improvement is required.

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: PA

Risk level for PA/UA: Low

The District Health Board requested the auditors ensure all residents have a signed resident agreement. There are currently three residents who have not signed an agreement. The agreements are currently with family members. Letters to family members, requesting they sign and return the agreements as soon as possible, are sighted. Lifecare utilises the New Zealand Aged Care Providers Resident Agreement. This includes liability of payment for any additional services, however there is currently no defined process for identifying the actual cost to the resident should additional services be required. For example, the cost of podiatry services.

Finding Statement

Lifecare utilises the New Zealand Aged Care Providers Resident Agreement. This includes liability of payment for any additional services, however there is currently no defined process for identifying the actual cost to the resident should additional services be required. For example, the cost of podiatry services.

Corrective Action Required:

Define and implement a process for identifying any additional costs which the resident may incur. For example, the cost of podiatry services.

Timeframe:
6 months

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Relevant policies contain clear statements about the rights of residents, and detailed descriptions of what the service expects in regards to staff respecting resident privacy (physical and auditory), protecting confidentiality, and ensuring residents are free from harassment, discrimination and exploitation.

Residents' rooms contain personal belongings and residents interviewed state their belongings are respected and understand the need to label personal clothing and items. Valuables are kept safe and a register maintained. Personal cash is held securely by the General Manager and regular reconciliation completed. Records are maintained of personal expenditure.

A review of care plans confirms that personal and privacy needs are considered and documented where required. A previous area of improvement was noted regarding visual and auditory privacy. Residents' visual and auditory privacy is respected and a tour of the facility confirms that full length curtains are provided for residents who share a room. There has been no reported complaints regarding breaches in privacy.

Residents are encouraged to set goals for independence as a component of care planning. This is confirmed in residents' records sampled and long term care plans clearly describe the level of support required. Rest home residents are observed during the audit participating in a range of self-care activities and staff state they are provided with guidance on how independence can be achieved/maintained.

Interviews and observations confirm that Lifecare Cambridge is committed to ensuring residents are not subjected to abuse or neglect. The Abuse and Neglect policy contains clear definitions of abuse and detailed procedures to follow in any event of suspected abuse including lists of other services for referral or involvement. There have been no reported incidents of alleged abuse or neglect. Training on elder abuse as been provided in the last 12 months. Eight out of eight residents interviewed state they feel safe at all times and are treated with dignity and respect.

The ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There are adequately documented policies, procedures and guidelines which address the needs of Maori residents. The Maori Health Plan includes potential barriers to Maori residents who may wish to access the service. Strategies to address these are detailed and include the involvement of family/whanau and consultation from tangata whenua if required. The Cultural Folder includes best practice when working with Maori including the three 'P's' and four cornerstones of health. The Maori Culture Policy identifies the provision of Maori cultural advisors and interpreters. In addition, there are guidelines on Dying and Grief - A Maori Perspective.

There is currently one resident who identifies as Maori and speaks te reo Maori. There is no evidence to the contrary that her cultural needs are not being considered, as supported in interview, observations and a review of her long term care plan. Staff receive training on the Treaty of Waitangi and an introduction to cultural safety is included in orientation.

The remaining relevant ARC requirements are met. The organisation identifies and eliminates barriers to Maori residents by ensuring appropriate people, training and resources are available should they be required. The General Manager is closely affiliated with local Maori.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The requirements of individual culture, values and beliefs is documented in the client rights policies. The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. Ethnicity, cultural and spiritual needs are identified during the initial assessment and this is evident in the residents' records sampled. Residents and family members interviewed indicate that they are consulted in the identification of spiritual, religious and or cultural beliefs. Residents can access church services if requested and religious services are held at the facility.

The ARC requirement is met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

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

How is achievement of this standard met or not met?

Attainment: FA

A review of policies, procedures and guidelines, staff and resident interviews and observations confirm that residents are protected from discrimination, coercion, harassment of exploitation. Any form of discrimination is not acceptable within the organisation. Staff receive adequate training on discrimination, professional boundaries and activities which constitute misconduct. Staff employment agreements also include house rules regarding the acceptance of gifts and reasons for termination of employment. The adverse event reporting system ensures any alleged breach in boundaries is reported. In addition, management ensures professional boundaries and codes of conduct are monitored and maintained through effective communication processes, completion of the required staff performance appraisals and an accessible complaints process. Residents and family members interviewed confirm they are treated with dignity and respect and are not subject to discrimination.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

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

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

How is achievement of this standard met or not met?

Attainment: FA

Interviews, observations and a sample of records confirm that services at Lifecare Cambridge are of an appropriate standard. The nursing process is used for care planning and evaluations. Assessment and care planning tools reflect acceptable standards of practice and clinical policies and procedures are developed and reviewed by registered nurses. Clinical risk is identified and monitored and adequate equipment and products (including wound and continence products) are provided.

The service implements the Eden Programme, Accident Compensation Corporation (ACC) Vitamin D programme, Aged Care Education (ACE) Programme, the Liverpool Care Pathway (LCP) and is a member of the New Zealand Aged Care Providers Network. The General Practitioner (GP) interviewed states that appropriate interventions are implemented for the management and treatment of health care needs. Special referrals and advice is sought as and when required.

There is adequate numbers of sufficiently trained staff on duty at all times. Services are overseen by an experienced clinical coordinator who is able to demonstrate a good understanding of the monitoring needs of residents. Training records confirm that the service is providing the nurses with a wide range of clinical training. Examples include the LCP, early dementia, the Eden Alternative, urinary tract infections in the elderly, diabetic care management, male catheterisation, gastrostomy and wound care.

The remaining relevant ARC requirements are met. The relevant health strategies are referenced in policies and reflect nationally consistent standards. Performance monitoring reports are provided to the District Health Board portfolio manager as required. The DHB identified no concerns requiring care standards to be followed up during the audit.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There are adequate processes in place to ensure effective communication. There is one resident who speaks French and one who speaks te reo Maori, however both understand English. The Interpreter Services Policy includes the contact details for local interpreter services and the services of the Hamilton Multicultural Services Trust Interpreting Service can be accessed if required. Residents receive adequate information regarding the services they will be provided and the resident agreement outlines subsidies (refer required improvement criterion 1.1.2.3).

Eight of eight residents and two family members interviewed state they have the opportunity to talk to management or staff and are able to request changes if needed. A family member interviewed also states that they are contacted if there are changes in a resident's health status. Incidents and adverse events are managed in an open manner and there is evidence of family contact in relative contact sheets and progress notes. There has been no reported complaints regarding communication difficulties.

A portable telephone and a mailbox are readily available to all residents. All staff are identifiable and resident meetings occur.

The remaining related ARC requirements are met. There is a process for advising non-subsidised residents of their eligibility and the process to become a subsidised resident should they wish to do so. There are currently three non-subsidised residents. A copy of the Ministry of Health "Long-term residential care in a rest home or hospital – what you need to know" is available on request and all residents sign a consent form on admission.

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

Informed consent guidelines are clearly documented and in accord with the right 10 of the Code of Health and Disability Services Consumers' Rights. The situation where general written consent is required is defined and includes outings, photos, treatments, and sharing of information with other health professionals.

Residents' records and interviews confirm residents receive good information, choice is given and the required general consent forms are sighted in the records sampled. One out of 14 general consent forms sampled has been signed by the previous clinical co-ordinator (on behalf of the resident). The Enduring Power of Attorney (EPOA) is contacted on the day of the audit and is scheduled to come and re-sign the required consent forms. Residents' day to day choices are generally documented on the care plan with regard to daily decisions regarding care and wellbeing.

There is a system which allows for the quick identification of competency and resuscitation status of all residents. The system for documenting advance directives is defined and well implemented. This includes a statement on competency by the General Practitioner.

The remaining ARC requirements are met. All residents are required to sign an admission agreement (refer required improvement criterion 1.1.2.3).

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11 Advocacy And Support

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Information about the right to advocacy and contact details for local services is included in the information pack and explained to residents and families on admission. Consumer rights training including the right to advocacy / support has been provided. The Nationwide Advocacy Services pamphlet is displayed at the entrance to the facility. The complaints process is cross-referenced to advocacy services. Residents interviewed are able to identify who they would talk to if they needed additional support and are aware of their right to access independent advocacy services.

The ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Residents have unlimited access to the visitors of their choice and are supported to access the community services of their choice. This is confirmed in interview with both residents and family members and evident in progress notes.

The ARC requirements are met.

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

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| 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.

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

STANDARD 1.1.13 Complaints Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

DOCUMENT REVIEW: Complaints policy and procedures sighted during audit are up to date.

Stage two: The GM confirms complaints management is discussed as part of the admission process. A copy of the complaints form is at the entrance of the facility and available to all staff in the nurses office. Interviews with two of two family/whanau members and eight of eight residents (three rest home and five hospital) confirm their understanding of the right to make a complaint.

The complaints register identifies there have been three complaints made since the previous audit. All complaints are now closed. Complaints are followed up as required to meet policy requirements and appropriate corrective actions are put in place when required. One example relates to a complaint made by a resident about the manner a staff member spoke to them. Follow up action includes following human resource management requirements related to disciplinary actions and a letter of apology being sent to the resident which they were happy to accept. The issue is now closed.

Monthly resident meetings are used as a forum for residents to voice any concerns. This is well documented in meeting minutes sighted.

family/whanau, residents and staff confirm they have access to the GM at any time either face to face or via telephone if required should a complaint be made.

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.

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| 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.

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| Audit Evidence | Attainment: FA | Risk level for PA/UA: |
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Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.2 ORGANISATIONAL MANAGEMENT

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

STANDARD 1.2.1 Governance

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

DOCUMENT REVIEW: The Business 2013 Plan describes the purpose, values, scope, direction and goals of the organisation.

Stage two: Services described in the business plan clearly identify how resident needs are met. The organisation identifies their values, philosophy of care and services offered. The plan is updated annually during a review by directors and the General Manager (GM) with input from the clinical coordinator and administrator as appropriate - last undertaken in June 2013. Quality systems include marketing and promotion strategies and human resource management planning.

The service is managed by suitably qualified and experienced people. The GM has been in the position for over five years. She has a background as a RN but does not maintain a current annual practising certificate. The administrator has worked in management positions for several years. They are supported by a registered nurse who is the clinical coordinator. She holds a current practising certificate (sighted). All staff attend appropriate ongoing education to maintain their skills and knowledge.

Job descriptions sighted for the above roles identify the authority, accountabilities and responsibilities for each role.

Interviews with three of three rest home, five of five hospital residents and two of two five of five family/whanau members confirm they are very happy with the services offered and that their needs are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.2 Service Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Stage two: An area identified for improvement in the previous audit is now fully attained. The administrator and clinical coordinator confirm during interview that they have the skills, knowledge and experience to cover the GM role as required. The service has eight RNs employed who ensure clinical processes are kept up to date. Members of the management team can access the directors via telephone as required.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

DOCUMENT REVIEW: The Quality Improvement Plan describes actions taken to improve services.

Stage two: One area identified for improvement from the previous audit is now fully attained. The quality and risk management system implemented by the service includes regular internal audits, and the use of corrective action planning as required. This is understood by 16 of 16 staff who were interviewed (three RNs, one EN, the clinical coordinator, the chef, kitchen assistant, maintenance person, cleaner, physiotherapy assistant, laundry staff, health and safety advisor, three health care assistants (HCAs) and the domestic supervisor).

Policies and procedure sighted have been signed off as current, however there is no documented evidence that they are aligned with current best practice or to identify the frequency policies and procedures are to be reviewed. This is an area identified for improvement. Staff interviews confirm the policies and procedures they use are up to date. The GM confirms the service implements a system of removing obsolete documents when there is an update.

Key components of service are incorporated into the audit system and any issues found are discussed at handover if required. Audit findings are also discussed at staff meetings. The GM stated that corrective actions are sent to staff as memos. The GM also confirmed that she verbally reports to the directors about complaints management, restraint numbers, health and safety, incidents and accidents and infection control at least six monthly. Monthly reports sighted on the staff notice board for key components of service delivery. This data is used to trend numbers of incidents and accidents, infections, complaints, and restraint numbers. Residents and family/whanau are kept informed as appropriate. This is confirmed by eight residents (five hospital and three rest home level) and two of two family/whanau member interviews related to the recent rota-virus outbreak.

Information gathered is used as an opportunity to improve services via corrective actions which are put in place for any deficit that is noted during internal or external audits, in response to complaints, residents' requests and satisfaction survey result findings as appropriate. One example relates to the stainless steel teapots used on residents' trays having insecure lids. The corrective action shows that new china teapots have been purchased with secure lids to aid resident safety.

The resident satisfaction survey undertaken in May 2013 identifies that residents are satisfied with the services provided and that staff treat them with respect at all times. There have been 22 responses by the time of audit, but the report has yet to be completed as the last response was received three days prior to audit. All responses sighted by the auditor identify that there are no major concerns only two minor issues which the GM stated would be followed up as required.

Monthly resident meetings are also used to identify any concerns. One resident confirmed during interview that they had discussed the temperature of porridge in the morning at the last resident meeting and this had been fully addressed by the service.

Actual and potential risks are identified and documented in the hazard register. They are communicated to staff and residents as appropriate. Hazards are reviewed and evaluated by the health and safety coordinator. Documentation identifies this occurred in May 2013. The health and safety coordinator has dedicated time (five hours per week) to monitor risks and keep the plan up to date.

A review of 11 of 11 staff files identifies that health and safety, including hazards and hazard management are part of orientation an ongoing education (October 2012). The domestic supervisor stated that if any hazards are identified in her (quarterly) environmental audit she reports them and they are added to the hazard register if they cannot be eliminated. Staff confirm during interview they are aware of the identified hazards and the processes in place to isolate or minimise risk.

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: PA

Risk level for PA/UA: Low

The service has policies and procedures to guide staff in all aspects of service delivery. All policies sighted are up to date and have been reviewed within the past 12 months, however, there is no documented evidence that they are aligned with current best practice or to identify the frequency policies and procedures are to be reviewed.

Finding Statement

Policies and procedure sighted have been signed off as current, however there is no documented evidence that they are aligned with current best practice or to identify the frequency policies and procedures are to be reviewed.

Corrective Action Required:

Ensure policies and procedures have a documented process to identify how they are aligned with current best practice and the frequency of review.

Timeframe:
Six months

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

Internal audit process.

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.4 Adverse Event Reporting

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

DOCUMENT REVIEW: The submitted Incident accident policy and procedures define and describe the reporting, documenting, investigation and overall management of adverse events. Open Disclosure policy is sighted.

Stage two: An area identified for improvement from the previous audit relating to event reporting is now fully attained. The GM and clinical coordinator verbalise their knowledge an understanding of statutory and regulatory obligations in relation to essential notification reporting. This is confirmed by reporting undertaken for a recent rota-virus outbreak.

Sixteen of 16 staff interviews and a review of 2013 incident and accident forms show that appropriate reporting is undertaken. Incident and accident information is used as an opportunity for improvement. For example the service has instigated a full assessment process for all residents who have a fall. A head to toe body assessment form is used and filed with the incident and accident form.

Monthly analysis and evaluation reports sighted identify the number of falls, skin tears, accidents, incidents, facility medication errors and pharmacy medication errors. Evaluation identifies any known reason for an increase in falls such as a resident who is a high falls risk but will not use their bell when they move around. This is identified in the resident's care plan and staff are asked to check the resident regularly when they are in their bedroom. The corrective action documented for staff who make a medication error identifies that the staff member has one on one education and up-skilling with the clinical coordinator. The staff member is then required to undertaken another medication competency to help eliminate errors.

The incident and accident form clearly shows that family/whanau are informed and if the GP is notified. This is also shown on the family contact sheet in the resident's clinical file as confirmed in seven of seven file reviews. Resident and family/whanau interviews confirm their is good communication. This is supported by the results of the resident satisfaction survey results sighted with 100% positive comments related to communication.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

Stage two: There is a system in place to record annual practising certificates for staff who require them. Annual practising certificates are sighted for twelve GPs, one physiotherapist, eight RNs, two ENs, and ten podiatrists.

A review of 11 of 11 staff files and interviews with 16 of 16 staff confirm that the orientation process prepares staff for the roles they undertake. Documented orientation covers all aspects of service relevant to the role the employee undertakes. All files contain signed employment agreements, job descriptions and other employment related items including policy vetting.

Every individual staff member has an up to date list of education undertaken. Education is related to the role the staff member performs and is offered onsite and offsite. The 2013 staff in-service education is listed on the annual calendar in the nurse's office. Interviews with 15 of 16 staff confirm they are satisfied with the amount and type of education offered. One Health Care Assistant said she would like more education but that what she is offered is appropriate to her role. She could not be specific about what additional education she wanted.

There is a system in place to update staff appraisals. Eleven files were reviewed, two for staff who have been employed for less than 12 months. Of the nine staff who have been employed over 12 months and require an annual appraisals only two are up to date. This is an area identified for improvement. Annual staff appraisals are a requirement to meet ARRC requirements.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Staff appointed are educated and/or experienced to enable them to provide services to meet residents' needs. This is confirmed in resident and family/whanau interviews and in the resident satisfaction survey results sighted for May 2013. Eleven staff files reviews undertaken and nine of these staff have been at the facility for over 12 months. Only two of the nine staff files have up to date annual appraisals.

Finding Statement

A review of 11 staff files undertaken, nine of these staff have been employed for over 12 months and they require an annual appraisal. Only two of the nine staff files have up to date annual appraisals. It is a requirement under ARRC requirements that all staff have an annual appraisals. The GM has already recognised this as a service deficit and has a documented system in place to get all staff appraisals up to date.

Corrective Action Required:

Ensure annual staff appraisals are undertaken annually to meet contractual requirements.

Timeframe:

Six months;

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

STANDARD 1.2.8 Service Provider Availability

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

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

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

| | |
|--|-----------------------|
| How is achievement of this standard met or not met? | Attainment: FA |
| DOCUMENT REVIEW: Policy sighted related to appropriate skill mix and staffing numbers for hospital and rest home level care to meet DHB contractual requirements. | |
| Stage two: An area identified for improvement in the previous audit is now fully attained. Resident and family/whanau interviews and the resident satisfaction survey results do not identify any areas of concern. All comments are positive. | |
| A review of six weeks roster identify that staffing numbers exceed the requirements shown in the DHB contractual requirements. Planned and unexpected leave is covered and replacement staff are shown on the rosters sighted. All shifts have at least one RN on duty at all times. Rosters identify the following staffing levels: | |
| The clinical coordinator works in this role Monday to Wednesday and then works two days on the floor undertaking RN duties. | |

The GM and administrator work Monday to Friday. The clinical coordinator and GM are on call as required.

Hospital staffing

0645-1500 - two RNs, four HCAs plus a 'bed maker' who also does morning teas and helps with lunch from 0800 to 1330

1445-2300 - one RN, one HCA

1445-2200 - two HCAs

2245 - 0700 - one RN and two HCAs to cover the whole facility. Additional staff are rostered as required (e.g. for palliative care).

Rest home staffing

0645-1500 - either an RN or an EN and two HCAs

1445-2300 - one HCA

1445-2000 - one HCA (this person will do a full shift if required).

2245-0700 - as above.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The administrator ensures all information entered into the computer related to resident details is accurate. The RN completes all admission information regarding clinical requirements. Information is collected in a timely manner and is appropriate to the service type and setting. All information is stored securely and not publicly accessible or observable. Seven of seven residents' files reviewed show that records are legible and the name and designation of staff are shown. All resident files are integrated. Obsolete documents are easily retrievable and securely stored in an archived area.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.1 Entry To Services

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The entry criteria, assessment and entry screening processes are clearly documented. Procedures require records of enquires/interest to be maintained and this is evident in records sampled. Residents' eligibility to receive rest home and/or hospital level care is assessed by the local needs assessment agency (NASC).

Adequate information about the facility and services is provided. The resident information pack includes the required health and disability information and pamphlets, the philosophy, complaints procedure, a range of appropriate policies, information on consent and resuscitation, a letter to family members encouraging their support and ongoing conduct in the event the resident becomes unwell, rights and responsibilities, a dietary profile and a personal profile which is used by the diversional therapist to gain information on previous activities and current interests.

Residents interviewed state they chose Lifecare Cambridge because of the location, bed availability and reputation. The service operates twenty four (24) hours per day seven days per week. Visiting hours for families are flexible (as confirmed in resident/family interviews).

The related ARC requirements are met. Four rest home and three hospital residents' files are sampled. Evidence of the completed admission documents and needs assessments are sighted in all files sampled. Details regarding the resident's right to receive additional services (with the exception of actual cost - refer required improvement criterion 1.1.2.3), how difficult residents are managed and circumstances in which the agreement can be cancelled is included in the residents' 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

There are adequately documented processes for the management of any declines to entry and waiting lists. The General Manager maintains records of enquiries and states that in the event of decline, information is given regarding alternative services and the local NASC. Prioritisation is based on the best fit with the service, assessment of acuity and bed availability. There is currently approximately 15 people on the waiting list.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.3 Service Provision Requirements

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The clinical coordinator, three registered nurses, one enrolled nurse, health care assistant, one GP, the physiotherapy assistant and kitchen staff are interviewed regarding service provision requirements and the remaining standards in section three.

Residents' and staff files sampled confirm that each stage of service provision is completed by a suitably qualified person. All assessments and care plans are developed and reviewed by the primary nurse. The primary nurse is either a registered nurse in the hospital or an enrolled nurse and/or registered nurse in the rest home. Daily interventions and support with activities of daily living are implemented with the help of trained healthcare assistants.

Timeframes for service delivery are defined and met as evident in seven out of seven residents' files sampled. An initial nursing care plan is developed on admission by the nurse and a medical assessment conducted by the GP within 48 hours. An initial care plan is used to guide staff for the first week, in which time a number of assessments are conducted in order to develop the long term care plan. The long term care plan is developed within two weeks of admission. Short term care plans are available for use (refer criterion 1.3.5.2) and care plan reviews are completed (at a minimum) every three months, with a comprehensive multi-disciplinary review completed annually. The previous finding regarding completion of multidisciplinary reviews for all resident has been addressed. GP reviews are completed every three months. The GP interviewed confirms her involvement in specialist referrals and medication reviews and states she is always contacted regarding any concerns in a timely and proficient manner.

Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement. For example, GP entries and visits from allied health providers are sighted. Residents' files are integrated and contain a section for allied health reporting. Daily handovers also ensure continuity. During the audit one handover is observed and confirms accurate and comprehensive information is communicated amongst staff.

Residents and family members interviewed confirm involvement in the assessment, care planning and review process. Comments from family are sighted in the records of multidisciplinary reviews sampled.

The relevant ARC requirements are met. Residents are assessed by their GP on entry. Responsibilities for the provision of daily care is identified during the handover reports. Care plans are adequate and include physical, spiritual and cultural abilities, deficits and expected outcomes.

Tracer methodology for a hospital resident:

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

Tracer methodology for a rest home resident:

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: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.4 Assessment

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

An initial care plan is documented on admission and a range of formal assessments are available for use. These include falls assessment, a pressure area risk assessment, dietary assessment, continence assessment (where applicable), pain assessment (where applicable) and a medical assessment. In addition, a physiotherapy assessment and diversional activity assessment is conducted.

It is noted that a structured/consolidated format for completing nursing assessments is not utilised. Assessment data is documented in a number of places within the file. For example there is some assessment data on the initial care plan, some in progress notes, some on the observation sheet and some on the pressure and falls assessments completed. This results in difficulty tracking the outcomes of assessment data, and generated a previous request for improvement. A recommendation was made to consolidate the nursing assessment process to ensure easier identification of assessed need, however a review of all admission data confirms the results are collated and transferred onto the long term care plan with a nursing diagnosis and nursing objectives documented. The pressure and falls assessments are reviewed and updated as required and are sighted in all seven resident files sampled.

Residents interviewed report involvement in the initial admission and care planning process. There are adequate areas within the facility to ensure assessments and observations are conducted in private.

The relevant ARC requirements are met. Long term care plans sighted have been completed within two weeks of entry. Assessment data sighted is current and commensurate with that of the needs resident.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.5 Planning

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

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

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

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

An initial care plan is developed on admission and a long term care plan developed within two weeks. The long term care plan is developed by the registered/enrolled nurse and includes goals and interventions for all physical, medical and psychosocial needs. The nursing care plan is utilised and each domain has a nursing diagnosis, objective and nursing intervention.

Interventions sighted are consistent with assessed need and good practice. The required level of dependence is documented for each section. Current long term care plans are sighted in all seven residents' files sampled.

Short term care plans are available for use as and when required. A number of short term care plans are sighted within the sample; however these have not been consistently documented when required. The short term care plans sighted for wounds have been reviewed regularly and closed out when discontinued.

Residents' files sampled evidence integration. Currently sections exist for care, progress, correspondence, medical notes, adverse event (falls), relative contacts, consents, laboratory results, referral letters, DHB letters and medical specialists records. NASC assessments, wound care plans and medication records are stored in a separate location. Staff interviewed confirm they have access to residents' records and were sighted completing their progress notes on the day of the audit.

The remaining relevant ARC requirements are met. Assessment data is gathered on admission and residents and family confirm input in the development and review of health care plans.

Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.**Audit Evidence****Attainment:** PA**Risk level for PA/UA:** Low

One of the samples is that of a resident who is currently in isolation for rotavirus. Additional care needs currently include barrier nursing, maintaining a fluid balance chart, applying zinc cream to irritated skin and provision of broth/clear fluids. Although these are recorded in the progress notes, a short term care plan has not been developed. Another example is that of a resident who had a teeth extraction and required additional care needs including pain medication (prn) and dressings for a period of time. Again a short term care plan was not documented.

Finding Statement

Short term care plans have not been consistently documented where additional (short term) care needs are required.

Corrective Action Required:

Document short term care plans as required.

Timeframe:

6 months

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.6 Service Delivery/Interventions

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The required clinical policies are documented and provide best practice guidelines for nursing interventions. Interventions are documented within each domain of the care plan. Interventions sighted are commensurate with the nursing diagnosis and objective. Interventions are detailed and documented clearly to guide staff. A previous area of improvement required interventions to be specific to assessed need. This has been adequately addressed and specific interventions are sighted in all seven files sampled. The short term care plans sighted for residents with a wound are detailed and include appropriate interventions for wound management.

Residents interviewed state they are encouraged to be involved in developing realistic and optimal levels of functioning to meet their own everyday living needs/goals and to maintain as much independence as possible.

The remaining relevant ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.7 Planned Activities

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The activities programme is appropriate for both rest home and hospital residents and reflects that independence is encouraged and choices are offered. An activities assessment and physiotherapy assessment/plan is documented for all residents. This identifies personal interests and hobbies. Activities are then planned to help maintain skills, interests and physical wellbeing.

There is one diversional therapist on site Monday to Friday. A weekly planner is documented for both the rest home and hospital and includes both external and internal activities, one on one and group activities. Individual records of attendance are maintained and confirm a good level of participation for the majority of residents. Some hospital residents are able to attend the activities provided in the rest home and five residents go on daily walks.

A physiotherapy programme is also implemented. A physiotherapist consultant is on site three times per week to conduct assessments and develop physiotherapy goals. A physiotherapy assistant is on site Monday to Friday and implements the physiotherapy/exercise programme.

Residents interviewed are complimentary of the variety of activities and outings that are provided. Preferences are considered and interests maintained. The General Manager meets with residents on a regular basis to discuss the provision of activities. Residents are observed involved in a number of activities during the audit.

The relevant ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Three monthly care plan evaluations, as stipulated in care planning policies occur, or more often if required. All care plans sampled have been evaluated with the required time frames, with a multidisciplinary (MDT) review annually. The MDT review includes input from the Manager, GP, diversional therapist, physiotherapist and family. Day to day response to care needs is documented in daily progress notes which are completed per shift. Any changes or support interventions are documented to achieve the nursing objectives and resident goals. Three monthly GP reviews are also evident. Residents interviewed and one family member state they are involved in the care planning and review process. The previous required improvement regarding initiating changes to care plans when a change occurs has been adequately addressed.

The relevant ARC requirements are met

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The GP interviewed states that resident support for access or referral to another health and disability provider is facilitated in a timely and safe manner. The GP confirms her involvement in the referral process. The clinical coordinator states that a formal referral process exists which includes the identification of risk and involvement of family. Evidence of a recent referral is included in the sample.

The ARC requirements are met. Residents have access to the community and allied health services of their choice. For example, residents chose their own GP and dentist.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

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

ARC D21 ARHSS D21

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

How is achievement of this standard met or not met?

Attainment: FA

Planned discharges or transfers are required to be conducted in collaboration with the resident/family. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a safe manner. There is a specific transfer and discharge procedure and form used to document the needs and requirements of residents during this process to ensure continuity of care. The GP interviewed confirms her involvement in the discharge/transfer process.

The clinical coordinator states there have been no discharges to another facility since her employment (October 2012), however in the event of a discharge the resident's records would be copied and necessary data would transfer with the resident.

The ARC requirement is met. The resident admission agreement states the reasons for termination.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements and safe practice; however an improvement is required to the standing orders/nurse initiated administration process to ensure it meets the 2012 standing orders guidelines. All visiting GPs are also required to sign approval of the standing orders/nurse initiated medication process.

A robotics medication system is implemented. The service has 12 visiting GPs and all medicines are prescribed by the GP using the pharmacy generated medication chart. An improvement is required to the prescribing process to ensure all medications are individually signed for the GP.

All medication charts include photo identification and allergies. Three monthly GP reviews are evident in all records sampled. Administration records are maintained and specimen signatures current.

Medications are safely stored in a locked medication cabinet in the treatment room and administered from a secure medication trolley. The previous required improvement regarding fridge temperatures has been addressed and records confirm the fridge is maintained at the required temperature. Controlled drugs are secure and the required controlled drug checks are maintained.

There is a range of stocked medication for the hospital residents. This is limited and includes a range of antibiotics and pain medication. Stored medication is checked regularly for expiry dates and its use monitored. All regular non-packaged medications are individually labelled.

Medications are administered by nurses. Competencies for medication management are monitored by the clinical coordinator. Records are sighted to verify the process. A lunch time medication round is observed in both the rest home and hospital and confirms administration is safely maintained and the administration record is accurately documented. It was noted during the observed medication round that electrolytes were being administered without a prescription and an improvement is required in relation to this.

Medication errors are reported and investigated. There were very few medication errors in the past year.

There is one resident who self-medicates. A competency assessment has been conducted and GP approval obtained.

The remaining ARC requirements are met. Policies comply with the Medicines Act 1981 and residents' medication is reviewed on entry to the facility. This includes medication reconciliation.

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

It is observed during the medication round that a resident (currently positive to rotavirus) is being administering electrolytes without a prescription; however its use has been suggested in the GPs progress notes. A review of 14 medication records confirms another three residents have also been administered electrolytes during the rotavirus outbreak without a prescription. The use of electrolytes is not included in the list of medicines approved as standing orders. The pharmacy is phoned to obtain details of dispensing and confirms the electrolytes are over the counter products, although have been labelled as 'hospital stock'.

The nurse initiated medications/standing order process also requires amending to include the number of doses which can be given. The current approval for standing orders has only been signed for by six out of 12 visiting GPs.

Three medication charts in the sample of 14 have medications prescribed which have not been individually signed for by the GP (these have been bracketed).

Finding Statement

Four out of 14 medication charts sampled are those of residents who have been administered electrolytes without it being prescribed. The nurse initiation/standing orders process does not clearly define the numbers of doses that can be given. Six out of 12 visiting GPs have not signed approval of the standing orders/nurse initiation policy. Three medication charts in the sample have medications prescribed which have not been individually signed for by the GP.

Corrective Action Required:

1) Procure a prescription for the administration of electrolytes. 2) Amend the standing orders to include the number of doses that can be given and gain approval from all visiting GPs. 3) Discontinue bracketing prescriptions and ensure each medication is individually signed for by the GP.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Residents are provided with a well-balanced diet which meets their nutritional needs. The menus have been reviewed by a registered dietician and confirm they are appropriate for the needs of the older person. Nutritional assessments are completed on entry. Special dietary needs are identified and the chef confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident. Adequate special equipment is also provided.

Residents are weighed monthly, or more regularly if required. There are two hospital residents receiving subsidised supplements. The related dietician referral is sighted and the GP monitors health needs at each review. Eight out of eight residents interviewed are very satisfied with the food and member of the community (who comes for meals) states the food is 'lovely'. Residents also state that they can ask for an alternative if they do not like what is on the menu. Lunch time is observed in both the rest home and hospital. There is adequate staff to ensure those needing assistance are supported as required.

The nutrition and safe food management policy defines the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers and records of temperature monitoring are maintained. Guidance is provided for staff on defrosting, environmental cleaning, storage, minimising risk of contamination and food hygiene principals. All kitchen staff have the required food safety qualifications. The kitchen staff at Lifecare Cambridge also provide meals on wheels.

The ARC requirements are met

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

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

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

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

DOCUMENT REVIEW: The waste management policy provides general guidelines for appropriate disposal and management of all types of waste including blood and body fluid spills, infectious materials, and needle stick injuries. There are also policies that discuss provision of personal protective equipment/clothing (PPE), secure storage of chemicals and hazardous substances, using recognised waste management services, disposing of unwanted products safely, using suppliers systems for handling and disposing of chemicals and hazardous substances, having systems in place for reporting and investigating incidents related to hazardous waste providing staff education.

Part two: Chemicals are supplied by Ecolab. Safety data sheets are visible in all areas where chemicals are stored.

Personal protective equipment/clothing (PPE) sighted includes disposable gloves and aprons, goggles and masks. Interviews with nine of nine clinical staff and kitchen, cleaning and laundry staff confirm they can access PPE at any time and they can verbalise appropriate use. Staff are observed wearing disposal gloves and aprons as required. Staff confirm they implement policy requirements for kitchen, sluice room waste and general waste. Approved yellow sharp bins are available for the safe disposal of sharps.

The service undertakes appropriate storage and disposal of waste, infectious and/or hazardous substances to comply with current legislation. The GM confirms there are no territorial authority requirements for waste disposal.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.2 Facility Specifications

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

DOCUMENT REVIEW: The reviewed Transportation of Residents policy contains fully described and detailed information which is directly related to the safe transporting of residents. This meets the intent of the standard and the requirements of the ARRC.

Stage two: An area identified for improvement relating to the testing timeframes of electrical equipment testing is now fully attained. Last testing shown on all electrical equipment sighted has occurred within the last 12 months. All processes are undertaken as required to maintain the service building warrant of fitness. The current warrant of fitness expires on 16 June 2014. An exterior maintenance schedule sighted for 2013.

A biomedical equipment performance verification reports sighted for medical equipment including, weigh scales (11-July-12), sphygmomanometers (19-June-13), and newly purchased thermometers sighted. The hoists were tested in July 2012. The approved provider was undertaking the annual check of equipment on the day of audit.

The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, the correct use of mobility aids and walking areas not being cluttered. Wide corridors with safety handrails assist residents to mobilise safely.

An environmental audit is undertaken every three months or sooner if any concerns arise. Follow up corrective actions are documented for areas that have a deficit identified. For example if any area requires maintenance it is written in the reactive maintenance book for repair. The maintenance book

and interviews with staff, including the maintenance person, confirm repairs are undertaken as soon as possible. There is a monthly maintenance checklist completed by the maintenance person to identify regular planned maintenance is undertaken.

Residents have access to outdoor areas with seating and shaded areas. Interviews with eight of eight residents (three rest home and five hospital level) and two of two family/whanau members confirm the environment is suitable to meet their needs. Residents were observed walking around inside and outside the facility both independently and with the use of walking aids.

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:

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

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

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

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

ARC E3.3d ARHSS D15.3c

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

| | |
|---|-----------------------|
| How is achievement of this standard met or not met? | Attainment: FA |
| Stage two: The facility has adequate numbers of accessible toilets and showers which are centrally located. Eight rest home level care bedrooms have full ensuites. Some rest home level care bedrooms do not have hand washing facilities but hand basins are centrally located and sanitising hand gel is available throughout the facility. There are no ensuites in the rooms used for hospital level care residents but all bedrooms have hand washing facilities. Hot water temperatures are monitored and recorded. Documentation shows they are kept below the required range of 45oC. A plumber is called should the water temperature go above 45oC. The facility has had an infinity gas hot water system installed in June 2013. Some of the recordings sighted showed that several rooms had a hot water temperature of between 14oC and 16oC. This was checked on the day of audit with the maintenance | |

person who confirmed he did not always wait for the water to run hot. All rooms checked had hot water between 41oC and 43oC. This was discussed with the GM who has added a sentence onto the hot water recording form to say temperatures must be between 41oC to 45oC.
There are separate staff and visitor toilets.

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

Audit Evidence

Attainment: FA

Risk level for PAUA:

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage two: An area identified for improvement from the previous audit is now fully attained. Observation shows that the four rooms with two beds and two rooms with three beds in the hospital area have clear floor space to safely allow the safe use of lifting equipment as required. This is confirmed during nine clinical staff interviews.

All rest home level care bedrooms are single occupancy and are large enough to allow residents with or without mobility aids to move around safely. Bedrooms are personalised by each resident.

Interviews with residents and family/whanau confirm they are happy with their bedrooms and they appreciate that they are all personalised to make residents feel at home.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

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

ARC E3.4b ARHSS D15.3d

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

How is achievement of this standard met or not met?

Attainment: FA

Stage two: The physical environment provides safe, age appropriate and accessible areas to meet resident's needs. Residents are free to move around the facility as they wish.

There are two lounges and one dining area. The hospital area lounge is also used as the dining area with table's one end of the room. Many residents were observed being assisted with meals and they remained in their easy chairs as appropriate. Residents who are able to eat independently or who only require minimal assistance sit at the tables. Activities are undertaken in lounge areas as appropriate. The rest home area lounge and dining rooms are separate rooms.

Resident and family/whanau interviews confirm their satisfaction with the facilities provided.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.6 Cleaning And Laundry Services

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

DOCUMENT REVIEW: Laundry and cleaning policies, procedures and task lists sighted on the day of audit. They were all reviewed and updated as required in June 2013. This includes two new polices related to washing shower curtains and the soaking of toilet brushes and the required amount of diluents to be used.

Stage two: Cleaning and laundry processes are undertaken as described in daily task lists. There are dedicated cleaning and laundry staff, seven days a week. The housekeeping supervisor undertakes regular audits which ensure all tasks are completed and that the supply and use of PPE is appropriate. Cleaning and laundry staff are observed using PPE as required. Staff verbalise their understanding of isolation techniques and ensure documented laundry and cleaning process are followed related to outbreak management.

Ecolab supply the chemicals used in the facility and they provide monthly service reports (sighted) for the kitchen, laundry and chemical usage. One documented corrective action includes staff education related to correct detergent use and that the following month detergent use was back to expected levels. Ecolab involvement in policy documentation update is shown. Up to date safety data sheets are available to staff in all areas chemicals are stored and in the emergency planning folder.

The laundry has a clean/dirty flow, with adequate equipment for the size of the facility - one large washing machine and dryer and one commercial washing machine for the cleaning of soiled linen prior to going into the large washing machine. The laundry assistant confirms during interview that she has time to complete all tasks. A laundry survey conducted in April 2013, with 10 responses, identifies that all residents are happy with the laundry service. One corrective action from a previous laundry survey relates to a comment made about some clothing being returned creased. The corrective action undertaken involved hanging up all clothes after they are ironed. No further negative comments have been received related to creased clothing. The laundry assistant confirms that all negative comments are addressed quickly, as soon as possible after the audit.

All chemicals sighted are appropriately labelled. Interviews with the caregiver undertaking laundry and the two cleaners confirm they have undertaken education related to safe chemical handling. Cleaning chemical bottles sighted in every hospital resident's bedroom which staff said they use to clean commodes after use. These were removed at the time of audit and staff stated they understand the need to store chemicals in secure areas.

There is a 'room cleaning' book in place which staff sign to say a spring clean has been undertaken. One room per day has a full spring clean on a rotating basis.

Interviews with residents and family/whanau confirm they are satisfied with laundry and cleaning 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage two: Emergency procedures and plans were reviewed in June 2013. The approved emergency evacuation plan signed off by the New Zealand Fire Service is dated 16 August 2006. There have been no changes to the facility foot print since this time. Six monthly trial fire evacuations are conducted. Last undertaken on 29-May-2013. The corrective action required a new batteries for the backup alarm systems. This was undertaken on the same day as the fire evacuation and signed off as compliant.

Fire equipment was checked by an approved provider in May 2013. The facility has smoke detectors and the fire alarm is connected to the fire service. Staff interviews confirm they had a false alarm when a smoke detector went off in June 2013 and that they felt very competent to undertake the approved evacuation process. Records are sighted for regular sprinkler, fire doors, emergency lighting and sign checks by Fire Security Limited.

Civil defence packs are checked on a regular basis. The civil defence folder contains emergency phone numbers for staff and community services. The GM confirms there are emergency food and water supplies for up to five days if required. Eight RNs and two ENs hold current first aid certificates to ensure there is always a staff member on duty in case of an emergency.

Staff are required to ensure doors and windows are securely closed at night. This is confirmed by a HCA who works afternoon and night duty.

Call bells are sighted in all resident areas. When the bell is activated a buzzer rings and a light shows up outside the room it has been activated from and at the end of corridor the room is in. Interviews with eight of eight residents (five hospital and three rest home) confirm staff respond in an appropriate timeframe if the call bell is activated. A monthly call bell log book sighted to show every room is tested to ensure call bells are operating.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Stage two: All resident areas have at least one opening window and/or door which provide natural light and ventilation. The facility is heated by use of electric heaters. Interviews with staff, residents and family/whanau confirm the facility is kept at an even temperature throughout the year. The facility was warm on the days of audit. The buildings are smoke free and there are dedicated outdoor smoking areas.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

DOCUMENT REVIEW: The Restraint Minimisation and Safe Practice policies contain definitions and information that are congruent with the requirements of this standard. The policy contains clearly described and complete processes for assessment, approval and consent, monitoring and review, evaluation, cultural considerations, de-escalation and staff training.

Stage two: At the time of the audit there are five bedside rail restraints and six enablers in use (five bedside loops and one above bed monkey bar).

A restraint assessment is completed by the registered nurse to ensure that restraint is the least restrictive option. A consent form is signed by the general practitioner, the resident (or their representative) and the restraint coordinator prior to any restraint being put in place.

Policy identifies that enablers shall be voluntary and the least restrictive option and that restraint is used for safety reasons only. Policy clearly states that restraint type will be decided by the approval group following assessment to ensure it is the least restrictive option to meet residents' needs. The restraint coordinator (RN) and GM confirm that the only types of restraint considered are bedside rails and chair lap belts.

An interview with one resident with bedside rails and one resident with a bedside loop confirm they are involved in the decision to use the equipment for safety reasons.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 2.2 SAFE RESTRAINT PRACTICE

Consumers receive services in a safe manner.

STANDARD 2.2.1 Restraint approval and processes

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The restraint approval group monitors all restraint use on at least a three monthly basis or sooner if required. The group includes the restraint coordinator, the GM, the physiotherapy assistant and one HCA. At the time of the audit five bedside rails and six enablers are in use. The review process is clearly documented.

Prior to restraint approval a full assessment is completed by a registered nurse who informs the restraint coordinator. A consent form is signed by the general practitioner, the resident (or their representative) and the GM. The duration of the restraint is documented on the restraint assessment form. All restraints used are for safety reasons only.

During interviews with three HCAs, three RNs and one EN they can verbalise safe restraint requirements as described in policy and procedures. They understand the lines of accountability for restraint use.

In-service training on restraint minimisation was held in July 2012 (17 staff) and May 2013 (24 staff).

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.2 Assessment

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Restraint and enabler assessment forms describe behaviour, duration of use, evaluation of effects, monitoring requirements, risks associated with restraint use and strategies for risk management. Restraint assessment forms also identify the impact of restraint on the resident/whanau and suggest changes to practice or training as required. The completed forms sighted in one restraint and one enabler file reviewed for restraint only and in one other full file review identify this process is well done. Alternative strategies, such as lowering the bed, are listed on the assessment form.

Family/whanau are included in any restraint decisions as appropriate. This includes discussion around past history to identify any risks with the use of restraint. Assessment findings inform resident care planning.

The restraint co-ordinator stated that family/whanau wishes are respected and she gave an example of one relative who declined to sign for a bedside rails for their relative. This was documented on the restraint form and bedside rails were not used. One current restraint was initially an enabler but the resident and their family/whanau requested bedside rails for safety reasons and documentation shows a full assessment and approval process was undertaken prior to this being put in place.

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

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;

- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

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

STANDARD 2.2.3 Safe Restraint Use

Services use restraint safely

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

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

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| How is achievement of this standard met or not met? | Attainment: FA |
| <p>All restraint is documented in the restraint register (sighted) by resident name, the date of the introduction of the restraint, and review date. Throughout each restraint episode the resident is monitored. The monitoring form documents monitoring requirements and the form of restraint. Each monitored observation is recorded with the date and signature of the observer. The use of restraint is also documented on the resident's care plan.</p> <p>Restraint is only used when required. For example the restraint register identifies that a resident who became temporarily non-weight bearing following a fractured patella, (December 2012), had bedside rails for one month only. The bedside rails were removed as soon as the resident was able to mobilise.</p> | |

Another example identifies a resident who did not fit well into a standard size bed. Bedside rails were used until an extra wide bed was purchased by the facility and then discontinued.

The restraint register identifies that if a resident becomes less mobile and does not move around the bed bedside rails are discontinued as the risk of falls is no longer present.

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

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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| Audit Evidence | Attainment: FA | Risk level for PA/UA: |
| Yes as part of assessment | | |
| Finding Statement | | |
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| Corrective Action Required: | | |
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| Timeframe: | | |
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Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

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

STANDARD 2.2.4 Evaluation

Services evaluate all episodes of restraint.

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

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

How is achievement of this standard met or not met?

Attainment: FA

When restraint is in use staff monitor residents at a minimum of two hourly depending of the resident's risk and acuity. Monitoring forms sighted identify change of position, when the resident is up and when the restraint is commenced. All forms are well documented. The use of restraint and frequency of monitoring is documented in the care plan (sighted in three care plan reviews). The restraint approval group meet every three months to review all restraint listed in the restraint register. A new review date is set at that time. Following review modifications are made or the restraint is discontinued as appropriate. Restraint use is discussed with the resident and/or their family/whanau at the six monthly resident care plans review. This is confirmed during interview with one resident with restraint.

All documentation is checked by the restraint coordinator every month to ensure policy is being implemented. If a resident's acuity level changes between reviews the restraint coordinator will review the need for continued restraint use at any time.

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

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;

- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

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

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

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

STANDARD 2.2.5 Restraint Monitoring and Quality Review

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Six monthly quality reviews are undertaken for all restraint in use. The last review was undertaken on 12-March-2013. The report identifies the total numbers of restraint and enablers in use, if compliance with policy has been maintained, if any alternatives to restraint have been tried and their effectiveness, such as supportive pillows and low bed to floor. The success and effectiveness of alternatives and restraint are clearly documented. Regular communication and involvement of family/whanau as appropriate is reviewed and identifies that the right to an advocate has been explained/offered.

The review and/or updating of policies and procedures is documented. The facility would benefit from undertaking comparison of numbers of use of restraint from previously collected data as a form of benchmarking restraint use.

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

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

STANDARD 3.1 Infection control management

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: PA Low

The infection control programme is clearly documented and is appropriate to the size and scope of the service. Responsibilities for infection prevention and control are clearly defined and include the terms of reference for the infection control team. Although the programme and terms of reference appear current, there is no evidence that the programme has been reviewed and an improvement is required.

Monthly infection control reports are forwarded to the General Manager for collation and the General Manager oversees the programme with the support of the clinical coordinator.

There are sufficient activities in place to prevent the spread of infection. For example, the service has recently had a rotavirus outbreak. The outbreak management procedure has been implemented and is still in place during the audit. Signage is placed at the entrance to the facility and information regarding spread and the risks are clearly visible. All residents and family members spoken to demonstrate a good awareness of the measures in place to prevent the spread. Extraordinary meetings have been held with staff to revisit infection control procedures and isolation requirements. There is alcohol based hand sanitizer, and hand washing information placed throughout the building. The outbreak has been contained to six rest home residents and one hospital resident.

The ARC requirement is met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

The infection control programme and terms of reference for the infection control team are documented, however there is no evidence that the programme has been reviewed, other than a recent sign off sheet for policy review.

Finding Statement

Evidence has not been maintained that the infection control programme, including the terms of reference for the infection control committee has been reviewed to reflect what is currently occurring in practice.

Corrective Action Required:

Provide evidence that the infection control programme has been reviewed.

Timeframe:

6 months

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

Adequate information, resources and on-going training are provided for implementation of the infection control programme. The infection control programme defines appropriate responsibilities for the infection control coordinator and team. The coordinator confirms that designated space and time are provided for infection control management activities and resources. The infection control coordinator is a registered nurse with relevant skills and expertise to implement the programme. She reports to the General Manager and has access to current information relevant to the size and complexity of the facility including infection control manuals, internet and expert advice from the DHB nurse specialist and laboratory specialist.

The infection control committee meets every six weeks as part of health and safety meetings. Meeting minutes confirm discussions regarding the programme and current trends. The infection control committee is responsible for providing advice, identifying best practice, monitoring compliance and liaising with other staff or organisations on infection control matters and the regular review of the programme.

Interview with the infection control coordinator and review of resident records indicate that an report and infection register is maintained for each resident documenting infection type, treatment and duration.

The ARC requirement is met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.3 Policies and procedures

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Documented policies and procedures are in place for the prevention and control of infection. The protocols are appropriate for the facility and reflect current accepted good practice and legislative requirements. Policies and procedures include hand washing, cleaning and sterilisation, standard precautions, isolation, outbreak management, management of staff with infections, health and safety, and a list of notifiable diseases. Policies and

procedures identify links to other documentation in the organisation. For example, health and safety and quality and risk. Policies are readily accessible to staff in service areas.

The ARC requirement is met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.4 Education

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

All staff receive training on infection prevention and control. Training is provided by the clinical coordinator, who is an experienced registered nurse. Mandatory training is included in the orientation/induction and again in an ongoing manner. Staff training records confirm attendance at the required training. The last in-service was conducted in August 2012. This included hand hygiene, ESBL and standard precautions. Since then additional training has been provided due to the rotavirus outbreak. This included hand washing and isolation techniques. The infection control coordinator has scheduled another in service for August 2013.

Sufficient information is provided to residents and visitors regarding infection prevention and control and how to reduce the spread. There is adequate signage and appropriate information displayed and residents interviewed are well versed with regard to hand hygiene.

The ARC requirement is met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.5 Surveillance

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

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

How is achievement of this standard met or not met?

Attainment: FA

The infection surveillance programme is appropriate for the facility and the level of care provided. Use of antibiotics is monitored and infection rates are monitored for quality improvement purposes. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Clinical staff interviewed report they are made aware of any infections of individual residents by way of feedback from the clinical coordinator and infection reports. Collated results and trends are also displayed in the staff room. This includes an analysis and proposed actions. Doctors are informed if a resident under their care has an infection.

The ARC requirement is met.

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: