**Bupa Care Services NZ Limited - Te Puke Country Lodge**

**Current Status:** **31-Jul-13**

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

**General overview**

Te Puke Country Lodge provides hospital/medical and rest home level care for up to 86 residents. On the day of audit there were 78 residents in occupancy (i.e., 42 rest home level care and 36 hospital level care).

Bupa is currently in negotiations to purchase the facility. Bupa's overall vision is "taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. There is a week by week transition plan established around the purchase, including establishing Bupa systems with the current management and staffing team. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

The audit identified three improvements required within self-administration of medicine management, calibration of equipment and minor refurbishment.

Te Puke Country Lodge Home

Bupa Care Services NZ Ltd

Provisional audit - Audit Report

Audit Date: 31-Jul-13

**Audit Report**

To: HealthCERT, Ministry of Health

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| **Provider Name** | Bupa Care Services NZ Ltd |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
|  Te Puke Country Lodge Home | Cnr Number One Rd |       | Te Puke |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| **Type of Audit** | Provisional audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 31-Jul-13 **End Date:** 01-Aug-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

**Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXX | RN, RM, ADN, BNurs, MBS, Lead Health Auditor Cert | 13.50 | 8.00 | 31-Jul-13 to 1 Aug-13 |
| Auditor 1 | XXXXXXX | Medical Technologist, MBA, Lead auditor cert | 13.50 | 6.00 | 31-Jul-13 to 1 Aug-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 2.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 27.00 | **Total Audit Hours off site** *(system generated)* | 16.00 | **Total Audit Hours** | 43.00 |
| **Staff Records Reviewed** | 9 of 90 | **Client Records Reviewed** *(numeric)* | 11 of 78 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 11 |
| **Staff Interviewed** | 3 of 90 | **Management Interviewed** *(numeric)* | 6 of 6 | **Relatives Interviewed** *(numeric)* | 5 |
| **Consumers Interviewed** | 12 of 78 | **Number of Medication Records Reviewed** | 18 of 78 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

**Declaration**

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

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

Dated this 14 day of August 2013

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

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

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

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

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

**Services and Capacity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  Te Puke Country Lodge Home | 86 | 78 |       | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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**Executive Summary of Audit**

*General Overview*

Te Puke Country Lodge is operated by the Cantabria Group. The facility caters for up to 86 residents at rest home and hospital level care. On the day of audit there were 78 residents in occupancy (i.e., 42 rest home level care and 36 hospital level care). The service is managed by a registered nurse who is suitably qualified for the role and she is supported by a team of clinical and non-clinical staff.

Bupa is currently in negotiations to purchase the facility. Bupa's overall vision is "taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. There is a week by week transition plan established around the purchase, including establishing Bupa systems with the current management and staffing team. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

*1.1 Consumer Rights*

Staff have a good understanding of consumer rights and receive training on consumer rights as part of their orientation to the service. On-going training is provided to staff at in house training. This is provided three times a year to ensure all staff are up-to-date. The home displays the health and disability code throughout its premises. The health and disability advocates are promoted through information on display and provided to the resident when they enter the service. Residents and families believe their rights are recognised by staff. Individual needs are identified when a resident enters the home. These needs form the basis of care planning. Activities in the community are encouraged and networks are sustained where possible. There is a complaints process in place and residents and families know how to complain if necessary. There is one open complaint with the Health and Disability Commission at the time of this assessment, which is expected to be closed in the near future.

*1.2 Organisational Management*

The home has a strong emphasis on quality management. Systems are managed by the Cantabrian Group through the governance and management structures. Regular reviews of the trends occurring in the home are conducted by the nurse managers' group. There is a quality improvement plan for the facility that identifies such areas as the menu, mobile chairs and maintenance as initiatives for this year. A comprehensive risk management plan is in place. The plan identifies key risks for the organisation and the provision of care. It is signed off by the manager as strategies are developed and implemented. Both documents show the history of the issues as they have arisen and been addressed. The facility manages incidents and events by recording and following up on the incident. Family are informed when an incident has occurred to their family member. Trends can be identified and corrective actions taken. The roster includes a mix of registered staff and trained care assistants. Information about residents is recorded each shift and this information is stored securely and is not accessible to the public.

*1.3 Continuum of Service Delivery*

The service has a comprehensive set of policies to guide practice. Service information is made available to residents prior to entry and in the entry pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision and oversee care provided throughout the facility. There are systems to assess, plan and evaluate care needs of the residents. Care plans demonstrate service integration and are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. The medicine management system is well established. Medicines are packaged using the robotics system and charting is based on the Douglas Pharmaceuticals system. There is an improvement required in the process related to the self-administration of medicines by residents. The activities programme is facilitated by two activities officers. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged and van outings are arranged on a regular basis. The majority of food served is prepared and cooked on site by cooks who prepare the lunch and evening meals. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented, age appropriate and enjoyed by residents.

*1.4 Safe and Appropriate Environment*

Te Puke Country Lodge is a large converted motel with an adjourning retirement village. The hospital and rest home is a large two-storey building with multiple lounge and dining areas and multiple bedroom wings. There are a number of lifts between each floor. All residents have their own bedrooms. The bedrooms are of varying sizes and all are large by industry standards. Bedrooms are furnished to reflect the home like nature of the rest home and hospital level of needs. The building holds a current warrant of fitness. External areas are safe and well maintained. The facility has two vans and two cars available for the transportation of residents. The facility has a preventative and reactive maintenance programme and there were a number of contractors working on site during the audit. All laundry and cleaning is done on site. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has electric heating and the temperature is comfortable and constant. Hot water temperatures are monitored and held at safe levels at the tap. Chemicals are supplied by Ecolab and stored using Ecolab storage systems. Improvements are required to ensure the seated weighing scales used for residents are calibrated and to ensure that some ensuite wall linings are repaired.

*2 Restraint Minimisation and Safe Practice*

The Cantabria Group is committed to minimising restraint use in the facility. A registered nurse has responsibility for overseeing the restraint and enabler use in the facility. Practice is guided by policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register in place which details which residents are using which type of restraints or enablers. There are 18 residents requiring restraints (which are a mix of bedrails, restraint harnesses and lap belts) and three residents voluntarily using enablers (all bedrails). Staff are trained in restraint minimisation. The service maintains a process to determine approval of all types of restraint, including enablers.

*3. Infection Prevention and Control*

There is an implemented infection prevention and control programme that is overseen by the Cantabria Group. It is described in the infection prevention and control manual. Staff have access to resources. A registered nurse has responsibility to manage the infection prevention and control programme in the facility. Regular audits of the programme are conducted by the infection prevention and control coordinator. Staff are provided with infection prevention and control training in orientation. On-going training is provided through in service education. Infections are monitored through the infection prevention and control surveillance process described in the manual. Any trends are identified and corrective actions taken. Data collected allows for benchmarking against other facilities in the Cantabria Group.

**Summary of Attainment**

* 1. ***Consumer Rights***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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

* 1. ***Organisational Management***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:22 PA:0 UA:0 NA: 0 |

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

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

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 11 PA Neg: 0 PA Low: 0 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:20 PA:1 UA:0 NA: 0 |

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

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

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 6 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: 0Criteria (of 36): CI:0 FA:15 PA:2 UA:0 NA: 0 |

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

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

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

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

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

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

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| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 47 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 98 **PA:** 3 **UA:** 0 **N/A:** 0 |

**Corrective Action Requests (CAR) Report**

Provider Name: Bupa Care Services NZ Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:31-Jul-13 End Date: 01-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.12 | 1.3.12.5 | PAModerate | **Finding:**Three rest home residents are self-administering medicines. The practice of self-administration of medicines does not meet policy and does not meet the process outlined in the medicines care guides for residential aged care for residents who self-administer medicines in that: there was no capacity assessment to assess the cognitive and physical ability of each resident to self-medicate; the residents had not signed an agreement regarding their responsibilities for safety; it was not clearly marked on the residents medicine charts that the residents were self-administering these medicines and that staff were to give them their other charted medicines; there was no process in place to check with the residents that they had taken or used the medicine on each shift as charted; and the medicines were not stored in locked containers when not in use.**Action:**Ensure policy and procedures for residents who self-administer medicines is consistent with the guidelines recommended in the medicine care guides for residential aged care published by the Ministry of Health. | 1 month |
| 1.4.2 | 1.4.2.1 | PALow | **Finding:**The siting scales used for weighing residents who are unable to stand are in need of calibration, as they were due for calibration in 2011.**Action:**Arrange to have the sitting scales used for weighing residents who are unable to stand calibrated.  | 3 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.4.3 | 1.4.3.1 | PALow | **Finding:**The surfaces in a number of ensuites are damaged and in need of repair to ensure that do not pose an infection risk or cause damage to any resident's skin.**Action:**Ensure damaged wall linings in ensuites are included in preventative maintenance schedule. | 3 months |

**Continuous Improvement (CI) Report**

Provider Name: Bupa Care Services NZ Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:31-Jul-13 End Date: 01-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

All staff interviewed had a good understanding of consumer rights and obligations (confirmed in discussions with the nurse manager, the clinical nurse leader, the hospital charge nurse, the rest home coordinator, two registered nurses (one restraint coordinator and one infection prevention and control officer) and three care assistants). Staff receive training in residents rights at orientation as they start work and on an on-going basis through regular in service training. The last such training to be provided to staff was delivered 5 June 2013 (attendance records were sighted for this training).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

Residents interviewed stated they received information on their rights when they are admitted (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and evidenced in resident meeting minutes). Family are satisfied with the way their family members are treated in the home (confirmed in discussions with five relatives (four relatives of hospital residents and one relative of a rest home resident). Information is provided throughout the home and at reception on how to access the health and disability advocates, the consumer code of rights and how to make a complaint.

D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, the Code of Rights pamphlet, and the nationwide advocacy service pamphlet.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Staff treat residents with respect and were observed knocking on doors before entering residents rooms and speaking to residents appropriately. All bedrooms have their own ensuite, which supports privacy in daily cares. Residents have their own belongings in their rooms, communal furniture is provided by the home. The service is tailored to the needs of aged persons. Activities reflect the interests of older people and are organised to encourage independence and wellbeing (eg, each morning there is a sit and be fit class to encourage physical activity). Activities are based on individual preferences and are recorded in the resident notes. Staff receive training in identifying the signs of elder abuse (the last training for staff in this area was delivered 25 July 2013). The home has an active health and safety programme that identifies hazards, monitors and manages them. Residents interviewed said they felt safe in the home (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents). Relatives believe that staff are highly respectful of all residents (confirmed in discussions with five relatives (four hospital and one rest home).

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The home has a Maori health plan and guidance documentation for staff, cultural awareness policy (which includes Tikanga) and cultural safety. Care assistants know the particular requirements of Maori and understood what needs to be considered for Maori residents (confirmed in discussions with three of three care assistants). When a resident chooses to identify as Maori this information is recorded on their plan of care. Residents who identify as Maori believe that they have their needs met (confirmed in discussion with one hospital level resident and one rest home resident who identified as Maori).

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

D20.1i The service has developed a link with local iwi should extra support be required.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Residents are consulted about their cultural and individual beliefs as they enter the service. The assessment is performed by the activities coordinator. All resident files contain a cultural and beliefs assessment (confirmed in review of 11 of 11 resident records reviewed). Residents and relatives are satisfied that their beliefs and values are respected by staff (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and confirmed in discussions with five relatives (four hospital and one rest home)). Church services are held in the home and residents are encouraged to attend their local churches if they want to do so.

D3.1g The service provides a culturally appropriate service by ensuring needs are identified and provided for where possible.

D4.1c 12 care plans reviewed included the residents social, spiritual, cultural and recreational needs.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

Residents report that they feel safe in the home (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents). Staff receive professional training in resident rights, understanding discrimination and resident care. Staff hold professional qualifications. There are a number of registered and enrolled nurses employed. Care assistants complete NZQA qualifications which include units in understanding discrimination and professional boundaries.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

Staff receive training at orientation and on-going throughout the year, that reflect good practice. Care observed was of an appropriate standard. A high level of registered nurse coverage is employed to oversee care. Staff interact with general practitioners, pharmacists, and a podiatrist all of whom maintain professional registration. Copies of their certificates were noted in the home's records. Residents have a choice of general practitioners. A general practitioner confirmed in interview that he believes care is of an appropriate standard and that he believes his colleagues hold the same opinion. A local pharmacist confirmed in interview that the pharmacy has excellent relationships with staff and that practice is of an appropriate standard. Registered nurses have access to specialist advice from the DHB staff and other key health providers and utilise these links appropriately.

A2.2 Services are provided at Te Puke Country Lodge that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for care assistants, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

Te Puke Country Lodge has written an open disclosure policy, located in the administration manual. Relatives are advised whenever an incident happens to their family member and this communication is recorded on incident forms located in resident files (confirmed in discussions with five of five relatives and sighted in review of 11 of 11 clinical records (six hospital and five rest home)). Relatives were seen visiting. Staff greeted relatives warmly and welcomingly. Residents confirm they have input and full choice as to care and activities provided by the home ((confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents).

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

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

D16.4 Relatives stated that they are always informed when their family members health status changes.

**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

Residents and family/whanau members are provided with information and a full explanation in a manner that allows them to make informed choices and give consent where required ((confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and (confirmed in discussions with five relatives (four hospital and one rest home)). The admission/transfer/discharge policy requires staff to give prospective residents a copy of the admission agreement as part of the information pack given to residents and or family prior to admission. Each resident (or their authorised representative) is required to sign a resident admission agreement before or on entry to the service. Section 10 of that agreement (which follows a template form that has been developed by the NZ Aged Care Association) contains a number of permissions which the resident grants to Te Puke Country Lodge. These permissions include a range of consents including the storage and sharing of health information. Staff are aware of the process required for ensuring residents are informed and have choices related to the cares they receive (confirmed in discussions with the nurse manager, two of two RNs, and three of three care assistants).

Staff education related to informed consent is included in the annual education calendar and was last provided in June 2013.

Active advance directives are signed by residents and countersigned by the GP and are clearly identified in the residents' clinical records (sighted).

Staff are aware of the need to respect advance directives where these exist.

D13.1 In the review of the sample of 11 of 11 residents records, there were 11e admission agreements sighted and 10 of the 11 agreements had been signed on the day of admission. The 11th resident (who was an ACC funded resident) had signed his admission agreement six months following admission. It was not clear whether this was a re-signing of the agreement or whether it was the initial agreement. The sample was extended and the practice of late signing of admission agreements was found not to be systemic.

D3.1.d Discussions with five of five family identified that the service actively involves them in decisions that affect their relatives lives.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

The role of the health and disability advocates is promoted throughout the home. Information is supplied to residents and their families on admission. Family members are involved throughout the care of the resident. Review of care planning, any changes to the resident's condition or any issues are discussed with the family or the resident's next of kin.

D4.1d; discussion with five of five family members identified that the service provides opportunities for the family or next of kin to be involved in decisions .

ARC D4.1e: Residents files include information on residents family/whanau and chosen social networks.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Residents are encouraged to access the community. Trips into town to go shopping and visiting are arranged and encouraged. One resident interviewed uses his mobility scooter to travel into town to attend church and visit local friends. Others attend the RSA and their local churches regularly. Five of five family members interviewed stated they are welcome to visit at any time with no restrictions placed on them.

D3.1h; Discussions with five of five family members state that they are encouraged to be involved with the service and care

D3.1.e Discussions with three of three care assistants and five of five relatives confirm that residents are supported and encouraged to remain involved in the community and to interact with external visiting groups such as musicians who visit the premises.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

A complaints procedure has been developed that meets the requirements of Right 10 of the health and disability code. The complaints register was reviewed. There have been five complaints this year. One complaint related to a request for a copy of a policy, another a maintenance concern, the third concerned communication, the fourth a query from a family member and the fifth came from a health advocate. The complaint is in the final stage of resolution. The other complaints have been resolved within the timeframes specified in the policy. Residents and relatives are aware of the process should they wish to make a complaint (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and confirmed in discussions with five relatives (four hospital and one rest home)).

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

The company values, scope, goals and direction are identified in promotional material, on the web site and in the business plan. The latest business plan was written in March 2013. The company Cantabria Group has identified its mission and philosophy as love, care, dignity and quality of life. The Cantabria web site states that the Cantabria Group operates on the mantra of "People before Profits". The Manager of Te Puke Country Lodge is a registered nurse who also has business management and infection prevention and control training.

ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

Bupa is currently in negotiations to purchase Te Puke Country Lodge. Bupa's overall vision is "Taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. There is a week by week transition plan established around the purchase, including establishing Bupa systems (Bupa Quality Programme / annual audit schedule /incident & accident reporting processes and policies/annual education schedule/staff competencies /formal orientation process will be implemented) with the current management and staffing team. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

The Cantabria group has a team of experienced managers who support and cover each other as required. The facility is managed by a nurse manager who is supported by a team of registered nurses. When the nurse manager is away the human resources manager deputises.

D19.1a; a review of the documentation, policies and procedures and discussions with staff identified that the service operational management strategies, and quality improvement programme is appropriate to the services provided.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The quality and risk system has been implemented across the Cantabria Group. All staff interviewed know how the systems work, especially for receiving and recording complaints, recording incidents and sharing information through meetings and suggestions. Policies and procedures reflect best practice, as demonstrated by the recent implementation of the Bug Control manual. Policies and procedures are discussed at the regional nurse managers’ meetings, held monthly. Minutes for meetings held in April 2013 show discussion about best practice initiatives within the group. All policies are reviewed every two years as a minimum. The infection prevention and control manual was reviewed in March this year.

All documents are controlled using a formal document control system. The footer of each document identifies the title, who authorised the document and when it was last reviewed. All documents reviewed on site are up to date. Key components of service delivery are linked to the quality management system through reporting and communication at all levels of the organisation. Examples of this are the review of incidents and accidents that occurs at the monthly nurse managers' meetings. Data are compiled by an administrator from each home and reported graphically. This allows trends to be identified and for the individual homes to bench mark themselves against each other. Minutes from the nurse manager and management board meetings show broad ranging conversations about key aspects of service delivery which are reviewed by the group.

Quality data are collected from many areas. Examples sighted include incidents/accidents, health and safety data, complaints data, infection prevention and control data, restraint data, information from the restraint coordinator and information gathered from internal audits.

The facility has shown initiative in reporting back to residents and their families, the results of the latest resident satisfaction survey. The results were collated, trends and special topics were identified and strategies developed to address some of the issues raised. The issues were not major but have been used as inputs into improvement projects. The feedback to residents and families consisted of a comprehensive response of four pages, that identified what was said, what initiatives are to be put in place and how the changes are going to be monitored going forward. Staff hope that by reporting back to the respondents in such a thorough manner, more people will want to input into future surveys, as they can see real changes being made as a result of their input.

The facility has a quality improvement plan in place. This has been developed over several years. Topics include, buildings, menu, manuals, interRAI, and new carpet. Progress is monitored and the plan updated when projects have been completed. There is an organisational risk plan that is structured to identify and manage risks in key areas, including governance, legislative compliance, service risk, organisational risk, human resources, finance and internal controls. As each risk is addressed it is signed off. Both plans for 2013 were sighted at this assessment. Examples of quality improvement initiatives for this year include the mobile chairs, a new alarm testing system that allows staff to practise to the different alarms and a review of the meals, that involved monitoring the presentation and wastage through photographing the meals.

D5.4 The service has a range of policies and associated procedures to support service delivery. Policies and procedures align with the client care plans

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

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

D19.2g Falls prevention strategies are implemented such as the recent purchase of new chairs that allow residents to prop their feet up and down easily.

The Bupa organizational goals will be introduced at the care home. Many of these are captured using Bupa's benchmarking process and regular reporting systems. The goals are; 10% reduction in incidents where staff are harmed by residents; 70% of CGs enrolled or completed a national qualification (Level 2 and 3); 20% of qualified nurses on the Bupa PDRP: No more than 20% of residents on antipsychotics; Introduction of BUPA Policies and forms will be phased in over coming weeks. The care home will continue to use any existing policies /procedures and forms until each is superseded by the Bupa documents as they are rolled out during the acquisition plan. As each new Bupa policy is rolled out the existing policies /procedures and forms must be removed from circulation and destroyed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

Adverse events are described in the facility's administration manual. Events are managed on a number of different levels in the home. When an event occurs it is recorded by staff (confirmed in discussion with three of three care assistants who described the process of recording and reporting). The event is followed through by the manager responsible for the area. Family are informed when appropriate (confirmed in discussions with five of five family who said they are always notified if something has happened to their family member). The form records all actions taken (confirmed in review of all events forms sighted). Events are then collated including the time and type of event. Once logged the form is filed in the respective resident's clinical record where appropriate. Collated information is forwarded to a staff member at Cantabria group who collates it and reports it back to the home. The information is able to be reported by type and time of event. The report was sighted for 2013. The data is then benchmarked against other homes in the group. Minutes of the Nurse Managers' meeting for April 2013 show this is occurring. The home averages 12 to 14 events per month (mostly falls related). There has been one reported medication error this year. Medication errors are collated within the events process and also undergo a quarterly analysis as part of the events monitoring process.

Statutory reporting includes notification of infectious diseases, health and safety reporting and unexpected death. Management interviewed were able to explain the processes required for statutory reporting.

The home has an open disclosure policy documented in the administration manual.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Te Puke Country Lodge employs a range of qualified staff to provide care to residents. Staff who do not hold a qualification are training towards one. Clinical staff are registered and hold current practising certificates (the practising certificates for 10 registered nurses and 4 enrolled nurses were sighted in the files). Police checks are performed (sighted in staff files). All staff receive an orientation when starting at the home. Three of three care assistants stated that they had received an effective orientation that involved following a staff member and then working under observation for two days. Nine staff files were reviewed, all had records of orientation. The staff training calendar for the year was reviewed. Recent training includes resident's care, personal cares, ageing process, rights including abuse/neglect, privacy and dignity, person- centred care (25 July 2013); Manual handling (18 July 2013); driving and van hoist competency (11 July 2013); Medication management (4 July 2013); Manual handling non-clinical (27 June 2013); n; infection control (2 April 2013). Other topics on the training calendar for 2013 include, civil defence, communication barriers, cultural safety, death and dying, and handling chemicals.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medicines management and insulin administration.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

The rationale for rostering is described in policy, human resources staffing rationale. Three of three care assistants described the rostering and the roster was also described by the nurse manager. The descriptions of the rosters matched the two months of rosters sighted.

Family members (five of five) and residents (12 of 12) said they thought the staffing numbers were adequate.

In planning staffing levels and safe skill mixes, Bupa refer to the Safe staffing Guidelines document which has helped to shape “WAS” as a tool to manage staffing levels. There are no changes to current staffing planned. The organisation has relieving FM/CM’s that are placed throughout the country as needs determine. The operations manager is covered by another colleague when on leave.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

Staff record consumer information on every shift (confirmed in review of 11 of 11 clinical records (six hospital and five rest home)). Records were seen to be stored securely, in locked cabinets or cupboards when not in use. Consumer records are integrated and medical staff document information when they are consulted. The majority of consumer records are held in paper-based records.

D7.1 entries are legible, dated and signed by the relevant caregiver or RN including designation.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

Entry occurs following pre-assessment by a needs assessment and service co-ordination (NASC) agency (confirmed in review of 11 of 11 clinical records (six hospital level residents and five rest home level residents)). Residents who are considered suitable for rest home or hospital level of care are then referred. Information on the service is available in the information brochure, admission agreement and the internet (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and confirmed in discussions with five relatives (four hospital and one rest home). The entry process is outlined in the administration manual. Entry criteria are verbally explained to anyone making an enquiry. Vacancies are updated daily on the Eldernet website. Prospective residents and family/whanau are informed of the services the facility provides and are provided with a comprehensive information pack (sighted). The local NASC service is familiar with the service, its entry criteria, and how to access the service, as evidenced by the appropriate referrals they make to the service. The service makes efforts to ensure they have contact details for a family member for each consumer.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract (and is based on a version produced by the NZ Aged Care Association).

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

The declining entry policy in the administration manual documents the process for declining entry to the service. The referring agency and family/whanau are notified if entry to the service is declined. All enquiries are recorded on an enquiry form with the outcome of the enquiry. The service has not declined entry to a prospective resident when there has been a bed available. If a bed is not available the enquirer is informed prior to any referral being made.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

Assessment, planning, evaluation, review and exit are undertaken by a registered nurse with input from enrolled nurses, allied health professionals and care assistants. Assessments commence on admission. Each stage of service provision is developed with the resident and where appropriate their family/whanau. A multidisciplinary approach to care is provided.

D16.2, 3, 4: The 11 files reviewed (six hospital and five rest home) identified that in all files an assessment was completed within 24 hours and all nine files identify that the long term care plan was completed within three weeks. Staff begin populating the assessment and nursing care plan form on admission. This form is used as both the initial assessment and care plan on admission and becomes the long term care plan within three weeks when it is signed off by a registered nurse. There is no separate care plan on admission. The assessment and nursing care plan is documented by an RN and amended when current the resident's health changes. All care plans for residents who had been admitted for more than six months contained evidence of evaluations in the assessment and nursing care plan.

D16.5e: 10 of 11 resident files reviewed identified that the GP had seen the resident within two working days. The 11th resident had been admitted from the DHB on a Friday and was seen the next Thursday. Where stable the GP was providing three monthly reviews and more frequent reviews when the resident was medically unstable.

A range of assessment tools were completed in resident files on admission and completed at least six monthly. Typically each resident on admission will have an assessment of their communication skills, food and fluid intake, personal hygiene and grooming, skin integrity, elimination, mobility, injuries and trauma, breathing, rest and sleep, medicines, allergies and sensitivities, pain levels, behaviours, usual routines, habits and idiosyncrasies, current health status including baseline observations (ie, weight, pulse, BP, Blood sugar levels), cultural identity and beliefs, sexuality and intimacy, social networks, and goals and aspirations and any preferences regarding death and dying. Assessment tools which may typically be used to aid assessment include a manual handling assessment, a falls risk assessment, a continence assessment, a pressure area assessment, a mini nutritional assessment. All new admissions have a dietary assessment and this information is forwarded to the kitchen.

Tracer Methodology: Rest Home

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

 Tracer Methodology: Hospital

*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 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

A range of information is used to inform the initial and on-going information for assessment. Information is gained from the resident and their family/whanau to ascertain the resident's individual needs, preferences and support required. Information from the NASC agency assessment, records from the place of transfer, health records from the resident's previous GP and other health professionals involved in the resident's care are used to assist in gaining appropriate assessment information.

A range of assessment tools are completed in resident files on admission and residents are re-assessed at least six monthly. Typically each resident on admission will have an assessment of their communication skills, food and fluid intake, personal hygiene and grooming, skin integrity, elimination, mobility, injuries and trauma, breathing, rest and sleep, medicines, allergies and sensitivities, pain levels, behaviours, usual routines, habits and idiosyncrasies, current health status including baseline observations (i.e., weight, pulse, BP, Blood sugar levels), cultural identity and beliefs, sexuality and intimacy, social networks, and goals and aspirations and any preferences regarding death and dying. Assessment tools which may typically be used to aid assessment include a manual handling assessment, a falls risk assessment, a continence assessment, a pressure area assessment, a mini nutritional assessment. The RN conducts nutritional assessments and associated resident dietary notes are provided to kitchen staff.

Residents and families are involved in their assessments and staff communicate with them throughout the process (confirmed in discussions with 11 of 11 residents (six hospital and five rest home) and five relatives (four hospital and one rest home).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

The care planning and evaluation policy requires that all service delivery plans are individualised, accurate and current. Plans are recorded on the assessment and care plan form. Acute problem treatment sheets are used to document short term needs (eg, if a resident has an infection or a wound). Short term care plans are used for short term admissions only (eg, respite care). All long term care is recorded on the assessment and care plan form (which is the long term care plan).

The assessment and care plan forms demonstrate the required support (confirmed in review of 11 of 11 clinical records).

There is integration of service delivery in the plans.

D16.3k, Short term care plans (called Acute problem treatment sheets) are in use for changes in health status.

D16.3f; Resident files reviewed show that family were involved where appropriate.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

Services delivered are consistent with the resident's assessed needs (evidenced by review of 11 of 11 consumer records (six hospital and five rest home). Residents and relatives believe that service delivery is appropriate and meets their needs (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and confirmed in discussions with five relatives (four hospital and one rest home)). Care plans document the desired goals to ensure delivered care and/or interventions are consistent with the residents' assessed needs. The documentation in progress notes indicates that support that is consistent with the assessed needs of the resident.

Continence products are available and residents' files include a urinary continence assessment where appropriate. Staff can access specialist continence advice from the DHB if needed. The charge nurse determines each resident's continence programme in consultation with care assistants Advice on wound management is available from the clinical nurse specialist from the DHB and representatives from Smith & Nephew who supply the dressing products. Wound management in-service is provided (last provided April 2013). Wound assessment and wound management plans are in place for 18 wounds. The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

D18.3 and 4 Dressing supplies are available and two treatment rooms are stocked for use (one in the hospital area and one in the rest home).

Consumers and relatives believe that consumers receive safe and appropriate services (confirmed in discussions with 12 of 12 consumers and five of five relatives).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The service employs two activities co-ordinators (1 is a diversional therapist in training and has just started this training and the other is not in training as yet but as nearly finished his ACE Basic qualification and intends to start diversional therapy training in the near future). They coordinate the programmes for both the rest home and the hospital area. The programme runs seven days a week with reduced programmes on the weekends when the programme is run by care assistants. The activities coordinators maintain links with other diversional therapists operating in the local area and they meet up with these therapists at regular support group meetings to discuss and share ideas for their programmes.

All residents have an individual assessment on admission to ascertain their background, interests, needs and appropriate group and individual activity requirements, which are conducted by the activities coordinators. Individual activities preferences are noted and one-on-one time is accommodated for those residents who prefer not to participate in the group programmes. Group activities are developed according to the needs and preferences of the residents who choose to participate. There is a monthly activities programme for residents (sighted). Planned group activities reflect ordinary patterns of life. The group programme includes: entertainment activities (eg, musical events, outings in the vehicles, happy hours, movies/DVDs), physical movement exercises (including sit and be fit, indoor bowls, supervised walks, shopping trips, skittles), cognitive activities (eg, newspaper reading, poetry, quizzes, bingo, housie, reminiscing, singing, games), event celebrations (eg, midwinter Christmas was celebrated on Day 1 of the audit), men’s group in the billiards room, massages. There is an on-site hairdresser. External groups visit the residents (eg, Lions, RSA) and the residents attend community activities (eg, go out to bowls and local cafes/garden centres). The facility has two vans (one which accommodates two wheelchairs and has hoist access, and the other which accommodates seven residents in the back) plus it has two passenger cars that seat 4 people comfortably. Residents are able to use this transport to go on community outings.

Church services are voluntarily run by the local parishes weekly and residents are welcome. Residents are able to be supported by their own spiritual advisors.

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

Residents and relatives are satisfied with the activities provided (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and confirmed in discussions with five relatives (four hospital and one rest home)).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Evaluations are conducted six monthly or earlier if needed. They are resident-focused, indicate the degree of achievement or response to the support and/or interventions, and progress towards meeting the goals of the resident. Where progress is different from expected the care plan is updated to reflect these changes. Evaluations are conducted by the RN with input from other RNs and the resident's GP the family. Residents and family are involved in reviewing care (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and confirmed in discussions with five relatives (four hospital and one rest home)).

D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Staff are guided by the resident transfer policy. If a resident needs to access other health and disability services, the facility manager or RN facilitates this in conjunction with registered staff, the resident, families and the GP. The GP requests specialist medical advice when necessary. Residents are given a choice of provider where appropriate. A record of the referral process is documented in the clinical record of the resident. The RN and or the GP often contact the referral agency to discuss and coordinate care both prior to the referral and following the referral.

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

D 20.1 discussions with registered nurses identified that the service has access to Tauranga Base Hospital for acute or emergency referrals and access to Whakatane Hospital for planned (booked) admissions.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer**

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

ARC D21 ARHSS D21

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

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

Planned discharges occur according to the admission/transfer/discharge policy, which identifies the measures taken by the service to facilitate a planned transition exit, discharge or transfer. Staff facilitate planned discharges in collaboration with the resident and or their families. Staff document the requirements of resident’s during this process to ensure continuity of care when a resident is transferred. Risks are identified prior to planned discharges (confirmed by interview with the hospital charge nurse). There is open communication between the service and family/whanau related to all aspects of care including exit, discharge or transfer. Documentation is provided to the next facility that covers all aspects of care provision and intervention requirements, including any known risks or concerns. The nurse manager and or charge nurse co-ordinates any discharge or transfer of residents for non-emergencies. The transfer process involves contact with the next service and with the families of the residents involved.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

The medication manual includes all aspects of medicine management including prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines. Medicines are dispensed and delivered by the pharmacy in the robotic sachet delivery system. The pharmacist reported on interview that he calls at the facility each working day. All medicines are prescribed by a GP. Each resident has an individual medicines folder, which contains their medicine chart and administration forms and individually dispensed robotically packaged sachets for their breakfast, lunch, dinner and evening medicines.

The received medicines are reconciled by an RN for accuracy when new sachets or medicines are delivered.

There is a medicines disposal box in the medicines room for pharmacy to pick up medicines needing to be returned to the pharmacy.

Changes in resident's medication prescriptions can be delivered the same or next day (confirmed in discussion with the pharmacist).

All medicines in the rest home are individually prescribed with the hospital having some imprest stock. Standing orders are not used.

There is secure controlled drug storage in both the rest home and hospital sections. Controlled drugs are checked out by two staff and the weekly controlled drug stock count occurs which is recorded in red pen in the register. Pharmacy perform a six monthly medicine reconciliation/stock take.

The medication round was observed for the rest home residents (a competent care assistant was administering the medicines) and the hospital (a competent RN was administering the medicines). Medicines are administered according to the guidelines and policy.

Medicine charts are signed appropriately (confirmed in review of 18 of 18 medication charts (nine sets of charts in the rest home and nine sets in the hospital area)). Medicine reviews by the GP's are recorded on the medicine chart at least three monthly. Medicines that require refrigeration are stored in the refrigerators in the rest home and hospital medicine rooms. Refrigerator temperatures are recorded daily and temperature records for the medicine fridges have readings between 2 and 8 degrees Celsius. Internal audits of the process occur six monthly (last internal audit of medicines management occurred in July 2013)

Staff who have completed the medicine management competencies can administer medications. Staff receive regular medicine management education, as sighted on the training schedule. Competency testing is undertaken annually (confirmed in the RN and EN personnel files reviewed). The sighted competency list for 2013 indicates that all RNs, ENs and one senior care assistant who administer medicines are currently assessed as competent.

The medication management policy includes a system for the facilitation of self-administration of medicines by residents. This includes ensuring they are assessed as competent by the GP and that all medicines being self-administered are kept in a locked, secure area in the resident's bedroom. There are currently three consumers in the rest home that self-administer medicines (see criterion 1.3.3). Practice does not comply with policy or the guidelines for self-administration as outlined in the medicine care guides for residential aged care (see 1.3.12.5)

D16.5.e.i.2; 18 of 18 medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed where the resident had been admitted greater than three months.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Staff are guided by policy for residents self-administering their medicines which are specified in the medication manual. There are three residents self-administering medicines.

**Finding Statement**

Three rest home residents are self-administering medicines. The practice of self-administration of medicines does not meet policy and does not meet the process outlined in the medicines care guides for residential aged care for residents who self-administer medicines in that: there was no capacity assessment to assess the cognitive and physical ability of each resident to self-medicate; the residents had not signed an agreement regarding their responsibilities for safety; it was not clearly marked on the residents medicine charts that the residents were self-administering these medicines and that staff were to give them their other charted medicines; there was no process in place to check with the residents that they had taken or used the medicine on each shift as charted; and the medicines were not stored in locked containers when not in use.

**Corrective Action Required:**

Ensure policy and procedures for residents who self-administer medicines is consistent with the guidelines recommended in the medicine care guides for residential aged care published by the Ministry of Health.

**Timeframe:**

1 month

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The majority of food is prepared and cooked on site by cooks who work daily from 6 am to 2 pm and from 1.30 to 7pm. The cooks are supported by kitchen hands who work 8 am to 2pm only. There are no kitchen hands employed in the evening. The breakfast meal is prepared by night staff. The main meal is served at lunchtime. The evening meal is cooked and served by the afternoon cooks. The kitchen is a large industrial kitchen. Food is cooked in the kitchen and transferred by trolley to a bain marie in the hospital servery area. The kitchen serves residents in the rest home dining room as this dining room is situated directly opposite the kitchen. Kitchen surfaces are easily clean stainless steel and were clean on the day of audit. The food services manual sets out the standards and expected outcomes for food service. Food, fluid and nutritional needs of the residents are intended to be provided in line with recognised nutritional guidelines that are appropriate to the residents. Resident nutritional profiles are held in the kitchen to ensure likes, dislikes and additional or modified nutritional requirements or special dietary needs are met. Dietary supplements (eg, Fortisip) are given by the clinical staff. There is a five weekly summer/winter rotating menu in place. The menu is reviewed by the dietitian to ensure the nutritional requirements are based on the New Zealand Dietetics Association guides for long term care facilities. Menus are followed with seasonal availability of vegetables and fruits. Additional or modified nutritional requirements or special diets are part of the care planning process. Policies, procedures and protocols are in place for all aspects of food procurement, production, preparation, storage, delivery and disposal to comply with current legislation and guidelines. The food service information is comprehensive and covers meal servings, ordering processes, cleaning schedules, kitchen safety and security, safe chemical handling, food hygiene and food storage temperatures. The facility meets regulations in all aspects of food management. Food is delivered by several commercial companies. The kitchen has two walk-in chillers, a mini fridge and one walk-in freezer. It has a dedicated preparation area. There are gas hotplates, a deep fryer, and three gas ovens. There is a bain marie for heated storage and serving in the kitchen. A commercial dishwasher is used. Food waste is disposed of by an insinkerator and other waste is collected by commercial operators. Decanted and prepared food is dated and covered. Kitchen and food storage areas are clean and tidy and there are documented procedures for food safety in place. Temperature recordings of the fridges, freezer and internal cooking temperatures of food and food in bain maries are recorded.

D19.2 All cooks have been trained in safe food handling.

Residents and relatives are very satisfied with the food service (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and confirmed in discussions with five relatives (four hospital and one rest home)).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

The safe and appropriate environment policy includes documented processes for waste management, including infectious or hazardous material. The facility has a colour coded method of ensuring compliance with waste disposal and infection prevention and control. Buckets and mops are coded for usage and comply with the facility's policies and procedures, (i.e., blue for general communal areas, green for residents, red for bathrooms and yellow of infectious areas). Used continence products are double plastic bagged and removed to the outside bin which is emptied as part of the councils rubbish service.  Personal protective equipment is used by staff (observed). Staff have access to plastic aprons and disposable gloves. Interviews with the three of three care assistants, one cleaner and one laundry worker confirm they have training on PPE. Ecolab provide training on the use of chemicals. The last internal audit of waste management was conducted on 26 January 2013.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The building has a current warrant of fitness which expires 28 October 2013. The lifts are included in the building warrant of fitness. The building was originally a motel which has been converted to the care facility. The facility is in reasonable repair for the age of the building and appropriate for rest home and hospital level care. The exterior has tidy gardens, which residents are able to access. There is access to shade and outdoor furniture is available.

The siting scales used for weighing residents are in need of calibration as they were due for calibration in 2011. These scales are used regularly according to staff working in the hospital. Staff have access to hoist scales (which are calibrated). All other hoists are in the process of being tested. Electrical testing and tagging is completed by a certified electrician as per electrical safety standards (last tested 6 & 13 July 2013). All fire safety equipment was last checked on 30 July 2013. Calibrations of medical equipment (except the sitting scales) was last carried out in July 2013. There is a planned maintenance schedule as well as a reactive maintenance schedule in place. Staff log issues for maintenance as they occur. .

The facility is a two storey building with a rest home and hospital wing with central recreational areas. Although it is a multi-level building, due to the slope of the terrain there are ground floor entrances both levels of the building. Residents are able to walk freely with mobility aids through the facility with lifts and stairs between the levels. All corridors, toilets and bathrooms have hand rails. The residents have access to outside areas through exits off communal areas and a number of rooms have direct external access to the courtyard. Due to the close proximity of the busy main road the manager reports that residents with cognitive impairment or a tendency to wander are not suited to the facility.

The facility has multiple external areas which are safe for the movement of residents. Most rooms have ranch sliding doors that lead directly to the grounds or a veranda. There are shaded areas in the courtyards with outdoor furniture. Due to the slope and layout of the facility there are ground level access from both levels of the facility.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, and lifting aids.

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

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

The building has a current warrant of fitness which expires 28 October 2013. The siting scales used for weighing residents who are unable to stand are in need of calibration as they were due for calibration in 2011. These scales are used regularly according to staff working in the hospital

**Finding Statement**

The siting scales used for weighing residents who are unable to stand are in need of calibration, as they were due for calibration in 2011..

**Corrective Action Required:**

Arrange to have the sitting scales used for weighing residents who are unable to stand calibrated.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

Each bedroom has full ensuite facilities. There is a communal bathroom with bath in the hospital wing. Additional facilities are provided for staff and visitors. Each toilet has a hand basin and there are hand basins in other areas. Hand gel dispensers are located throughout the facility for staff, residents and visitors to use. Hot water temperatures are monitored to ensure they are maintained at 45 degrees Celsius or below. All hot water cylinders have tempering valves installed and temperatures are tested at hot water outlets monthly.

The surfaces in a number of ensuites are damaged and in need of repair to ensure that do not pose an infection risk or cause damage to a resident's skin.

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

There are adequate numbers of toilets and showers as every resident has their own ensuite in their bedroom. There are separate toilets for visitors and staff

**Finding Statement**

The surfaces in a number of ensuites are damaged and in need of repair to ensure that do not pose an infection risk or cause damage to any resident's skin.

**Corrective Action Required:**

Ensure damaged wall linings in ensuites are included in preventative maintenance schedule.

**Timeframe:**

3 months

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

All rooms are very spacious and have ensuites and some have functional kitchenettes with refrigerators. Some rooms have separate lounges and bedrooms. Most rooms are single occupancy with double rooms available for couples if needed. The rooms provide adequate space, contain a bed and easy chair, wardrobe and dressing table. They have enough room for the resident to move around safely with or without a mobility aid.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

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

ARC E3.4b ARHSS D15.3d

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

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

There are multiple communal areas for recreation, entertainment and dining on each level of both the rest home and hospital. There is also a centrally located recreational room which includes an indoor bowling area. Access to these rooms is via wide corridors all of which have hand rails for safety. Each floor of both the rest home and hospital has a communal lounge and sitting areas. The dining rooms are located on the upper level of the rest home and hospital wings, with lift and stair access to these areas. The facility has a pleasant, sunny lounge and a separate dining room, both are spacious. The central lounge that joins the rest home and hospital has seating that is arranged to provide small gatherings or can be converted for group activities, such as a concert. Access to these rooms is via wide corridors all of which have hand rails for safety.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

The housekeeping services manual and the laundry manual outline the cleaning and laundry procedures. Ecolab chemicals are used throughout the facility. There are comprehensive policies and procedures kept in the laundry covering all areas of cleaning and laundry. All laundry is done onsite with a fully equipped laundry for the rest home and hospital. The laundry has three commercial washing machines and two commercial dryers. There are designated laundry and cleaning staff. Cleaners have purpose-built cleaning trollies. Staff understand the cleaning and laundry processes including infection prevention and control measures (confirmed in discussions with one cleaner and one laundry staff member) Machines are tested for effectiveness and information is provided to the nurse manager (evidence sighted). The methods, frequency and effectiveness for cleaning and laundry are monitored formally by six monthly audits (last audit 3 July 2013).

The chemical supplier Ecolab provides a monthly report on the cleaning products and effectiveness of the laundry equipment (last report dated 10 July 2013). No issues were identified.

Chemicals are stored in the locked storage rooms and are labelled to indicate the chemical, its usage and first aid treatments in the event of splashing or ingestion. MSD sheets are available.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Staff receive training in emergency procedures when they start work, through the orientation process (confirmed in review of nine of nine staff files reviewed which included orientation records that showed training in emergency preparedness). Fire evacuation training is performed every six months. The last training was delivered 29 July 2013. Attendance at the training was reviewed and 59 staff attended. The approved evacuation plan was sighted (dated August 2005). The facility has back up lighting and has gas and electric power supply. It has also developed a civil defence kit for use in an emergency. Back up water is stored on site in a 24000L tank should the town water supply fail. Call bells are in each resident’s room and ensuite. Call bells were last checked on 10 July 2013. Staff were seen to respond to call bells when residents rung them.

The building is locked each evening. Visitors can ring the front bell if the doors are locked. An external security service is also used by the home.

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

**Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.8 Natural Light, Ventilation, And Heating**

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

ARC D15.2f ARHSS D15.2g

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

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

The facility has a good level of natural lighting. It is maintained at a comfortable temperature and appropriately ventilated (confirmed in discussions with 12 of 12 residents (six hospital and six rest home residents) and confirmed in discussions with five relatives (four hospital and one rest home)). Each living area has at least one external opening window and all bedrooms have individual electric heaters attached to the walls. The heating in common areas is from electric heaters attached to the wall. The site is smoke free (no residents smoke).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The restraint minimisation policy of the facility is to minimise the use of restraint throughout the facility wherever possible (confirmed in discussions with the restraint coordinator who is a RN and the nurse manager). Restraint management is delegated to the restraint coordinator who is the clinical nurse for the facility (as shown in her job description). She is required to be accountable for safe restraint use and undertaking or organising staff education on the floor. Formal restraint education is done by the facility's educator who works in liaison with the restraint coordinator. The restraint coordinator maintains the restraint and enabler register in hard copy, as she has only recently had access to an Excel database. She is in the process of transferring it over to manage the register electronically.

There are a total of 18 restraints in use in the facility (17 in the hospital and 1 in the rest home). Approved restraints in use in the facility are as follows: 17 residents with bedside rails, 2 of those 17 residents also wear restraint harnesses and four of those residents in the hospital area also wear lap belts. The resident in the rest home has bedrails. There are three enablers in use in the hospital and all three are bedrails. The restraint register identifies these restraints and enablers (sighted).

Restraint is stopped if it is no longer assessed as being required or appropriate (refer 1.3.3).

There has been a slight reduction in restraint use since July last year and the reason is thought to relate to reduced resident acuity. Policies and procedures are in place to allow staff to use restraint safely if required. The definition of restraints and enablers are congruent with the Health and Disability Service Standards definition. All enablers are voluntary and have been implemented in response to the residents' personal requests. All enablers are signed for by the resident.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

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

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

Restraint and enabler approvals are undertaken by the restraint committee which consists of the restraint coordinator, the charge nurse (hospital), the rest home coordinator and the nurse manager. The resident's GP and family/whanau input occur when restraint or enabler is being considered (confirmed in review of the documentation in 1.3.3 and in review of the files of the three residents who are using enablers). The restraint committee through the nurse manager reports to the owners on the use of restraints and enablers in the resident population.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

The service undertakes assessment of residents prior to restraint approval. The pre-restraint assessment includes a-h of this criterion (sighted in restraint documentation and confirmed in discussion with the restraint coordinator). The restraint assessment form is developed to match the criterion requirements. All assessments are undertaken by the restraint coordinator who is a RN. They are developed in partnership with the resident and/or family/whanau. Possible alternative techniques are identified (confirmed in three completed assessments sighted).

One family member of a resident who has restraints confirmed in interview that they are involved in the on-going approval process for the use of the restraint.

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

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

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

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

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

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

 (f) Maintaining culturally safe practice;

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

 (h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

The use of restraint is monitored by the restraint committee. All restraint is used for safety reasons only as a last resort option. All restraint is approved prior to use following appropriate assessment processes being completed and reviewed by the approval group. There is a restraint register which identifies all restraint and enabler use. Frequency of monitoring is determined by the identified risk of restraint use with policy identifying that a minimum of two hourly monitoring is required for all restraint and enabler use. Two hourly monitoring is well documented there are clip boards used throughout the facility and the clip board follows the resident when the resident moves throughout the facility. A review of monitoring forms confirms that restraints and enablers are monitored two hourly to meet policy requirements). Staff education is appropriate for the type of restraint used and includes alternatives to restraint. All assessments are undertaken by the restraint coordinator who is a RN. Bedside rails have protectors to prevent residents from getting their limbs stuck (sighted) except for one set of bedrails where the resident does not like to be visually closed in . This resident is physically unable to climb over the rails or get stuck so the risk is minimal. The residents who wear harnesses are placed visibly within staff eyesight range. These two residents will try to get out of their harnesses and the harnesses are on to stop them standing and falling. Their harness are released and they are walked to the toilet and stood up to walk around to relieve pressure and frustrations and these episodes are recorded. Each episode of restraint is documented with 'on and off' times. Appropriate information is transferred to progress notes. Restraints and enablers are documented in care plans. Review forms are completed by the restraint coordinator and presented to the restraint approval group six monthly unless required to be presented earlier. The forms cover the reason for initiating restraint (which is always for safety reasons only), alternative strategies which have been trialled, the type of restraint that has been approved and the identified risks. The form details the evaluation process and the start time. The restraint register sighted on the day of audit allows sufficient information to provide an auditable record of restraint use. It identifies the name of the resident, method/ type of approved restraint, date commenced and when the last evaluation (review) was undertaken and when the next review is due.

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

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

 (b) Following appropriate planning and preparation;

 (c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

 (d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

The service undertakes an evaluation of all restraint and enablers at a system level through the quality and risk management system. Individual evaluation occurs for each resident. Residents initially using restraints are reported each shift and reviewed daily to see how the situation is progressing and whether the restraint is safe. Evaluation for those residents who are using restraints in an on-going manner are scheduled six monthly as part of their total care evaluation. Family/whanau or a nominated representative is encouraged to be involved in all evaluation processes and to articulate their views on the use of restraint. This process is well documented. Policy identifies that evaluation processes are determined by the nature and risk of the restraint in use. Evaluation occurs sooner if any issues arise around restraint use or if staff feel the restraint being used is not having the required results.

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

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

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

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

 (d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

The service reviews the use of restraints and trends at the restraint committee's six monthly meetings. Annual policy and procedure reviews are undertaken and six monthly restraint use reports are prepared by the restraint coordinator and the nurse manager is advised. The nurse manager reports the results to the Board. Restraint use is trended and for Te Puke Country Lodge a slight decrease in use has been identified in the last year. This is shown in the report to the board. Staff education is monitored by the Cantabria group educator. The service has a policy of annual review (last review May 2013).

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

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

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

 (c) Adverse outcomes;

 (d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

A registered nurse oversees the infection prevention and control programme in the facility. The responsibilities of the role are described in the infection prevention and control manual as is the infection prevention and control programme. The programme was last reviewed and reissued in March 2013 by the Cantabrian nurse managers group. The facility has a procedure describing how precautions are to be taken when someone has an infectious disease. A kit has been developed that contains all equipment necessary to manage an infectious disease. One resident was identified as suffering from ESBL and the precautions being taken in this instance were observed. The infection control coordinator conducted two weekly audits of staff and rooms to ensure infection control practises are being followed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection prevention and control coordinator is supported in the role by the nurse manager. She has access to the resources of the Cantabrian Group, including the nurse mangers' group and resources available in the community such as the laboratory and the district health board.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

The facility has an infection prevention and control manual, which was reviewed and reissued in March 2013. The manual includes the policies and procedures required by this standard. Additionally the organisation has just purchased a Bug Control manual, which is up to date and reflects current best practice in infection control in aged care. The infection control coordinator has also printed the Ministry of Health guidelines for management of Norovirus, diagnosis and control of scabies within rest homes and multi-resistant organisms in New Zealand.

D 19.2a: Infection control policies include standard precautions, hand washing, transmission-based precautions, outbreak management, notifiable diseases and antimicrobial usage.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

Education is provided to staff as part of their orientation when they start work at the facility (confirmed in review of nine of nine staff records). On-going training is also provided to staff in infection prevention and control and standard precautions. The last training to be provided this year was 6 June 2013 (records of attendance sighted). Training is provided to residents as required. The resident with ESBL has had the requirements explained to her. She is compliant with the requirements to ensure she washes her hands regularly and visitors use alcohol rub as they enter and leave the room.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

The facility has an infection prevention and control surveillance programme, described in the infection prevention and control manual. All infections are recorded, the organism, treatment and resolution are monitored. Results are then collated monthly for the site and sent to the Cantabrian Group administrator for collation and identification of any trends. Trends are reviewed (eg, May 2013 saw a rise in respiratory infections, since then there have been no further rises or identifiable trends). Results of surveillance are discussed in staff meetings, posted on the staff room notice board and discussed at the Nurse Managers' Group.

**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:**