**Waverley Aged Care Limited**

**Current Status:** **24-Jul-13**

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

**General overview**

Waverley House is certified to provide rest home level care for up to 20 rest home residents. On the day of the audit there were 15 residents residing at Waverley House. The owner, who is the manager, is supported by a registered nurse. Staff interviewed and documentation reviewed identified that the service has an established quality system to meet the needs of residents.

Family interviewed all spoke very positively about the care being provided at the rest home.

This audit identified areas for improvement required (including two high risk) around reassessment and timely referral of residents with higher needs, an aspect of medication management, an implemented process for document review and evaluation of resident surveys completed.

**Audit Summary AS AT** **24-Jul-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  24-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit  24-Jul-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit  24-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit  24-Jul-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  24-Jul-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  24-Jul-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Audit Results AS AT** **24-Jul-13**

**Consumer Rights**

Residents and their families/whānau are informed of their rights as part of the resident information pack. Caregivers were observed to respect resident privacy. Initial and on-going assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. Residents are encouraged to continue with their spiritual activities. Cultural awareness training occurred as part of the staff training programme. There is Maori Health Plan.

Relatives spoke positively about care provided at Waverley House Rest Home. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented.

**Organisational Management**

Waverley House Rest Home has an established quality and risk management system that supports the provision of clinical care and support. An annual resident and relative satisfaction survey is completed and regular resident/relative meetings occur. There is an improvement required around the evaluation of resident surveys completed. There is a hazard register documented. The monthly quality/staff meetings include health and safety, restraint, infection control, review of incidents and accidents and discussion of quality and risk.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is well supported.

The staffing policy aligns with contractual requirements and includes skill mixes.

**Continuum of Service Delivery**

A service information pack is made available prior to entry or on admission to the resident and family/whanau. Relatives confirmed the admission process and the admission agreement are discussed with them. The registered nurse is responsible for each stage of service provision. Each resident has a plan of care developed on admission. Within three weeks a long term care plan is developed. Long term plans are goal orientated and are reviewed at least six monthly and are completed on discussion with the resident and/or family/Whanau. Short term care plans are utilised for changes in health status such as infections. There is an activities programme which offers activities that are varied, age appropriate and include local community and entertainment events. There is an establish medicines management system in place. Residents have a dietary profile developed on admission and likes, dislikes and allergies are communicated to staff. All food is cooked on site by a council approved kitchen. Dietary profiles are reviewed six monthly or as residents needs change. The menu has been designed by a registered dietician. All staff have completed appropriate food safety training. Improvements are required around the reassessment and referral of residents when there is an increase in resident need and stocktake of controlled medication is to occur weekly.

**Safe and Appropriate Environment**

The building has a current building warrant of fitness and fire service evacuation approval. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are utilised for group and individual activity. The dining and lounge seating placement encourages social interaction. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely in the kitchen and the laundry. The internal facility is laid out in a square with communal areas and bedrooms built around an internal courtyard. Each resident has their own bedroom. Resident’s rooms are personalised, warm, with natural light and have call bells. Residents are able to decorate their room with their own possessions. Hazardous waste is managed appropriately to minimise risk. Water temperatures are monitored to ensure they are within an acceptable temperature. The facility is heated by electricity and ventilated by opening windows and internal doors to the courtyard. Cleaning and laundry is done on site. There are policies and procedures to guide staff.

**Restraint Minimisation and Safe Practice**

Waverley House Rest Home has a restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers.

The policy includes that enablers are voluntary and the least restrictive option. There are no residents requiring the use of an enabler and three residents requiring the use of a restraint (bed rail and lap belts). Staff receive training on restraint minimisation and managing residents' behaviours that can be challenging. The facility has a locked front door which is an environmental restraint. Potential residents and family/EPOA are informed of the locked door and sign a consent form to agree to reside in a facility which has a locked front door on admission. The locked front door is interfaced with the fire alarm system and unlock in the event of a fire. The policy for the locked front door is under review in discussion with the District Health Board.

**Infection Prevention and Control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (registered nurse) is responsible for surveillance of infections. Infection control training is provided annually for staff. The infection control manual outlines a range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

Waverley House Rest Home

Waverley Aged Care Limited

Certification audit - Audit Report

Audit Date: 24-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Waverley Aged Care Limited |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Waverley House Rest Home | 5 Lannie Place | Greenmeadows | Napier |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 24-Jul-13 **End Date:** 24-Jul-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

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| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RN, auditor certificate | 8.00 | 6.00 | 24-Jul-13 |
| Auditor 1 | XXXXXXX | RN, RM, ADN, BNurs, MBS, Lead Health Auditor Cert | 8.00 | 5.00 | 24-Jul-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** | 16.00 | **Total Audit Hours off site** *(system generated)* | 13.00 | **Total Audit Hours** | 29.00 |
| **Staff Records Reviewed** | 5 of 17 | **Client Records Reviewed** *(numeric)* | 4 of 15 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 4 |
| **Staff Interviewed** | 7 of 17 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 2 |
| **Consumers Interviewed** | 0 of 15 | **Number of Medication Records Reviewed** | 15 of 15 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 19 day of August 2013

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

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

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

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

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

# Services and Capacity

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Waverley House Rest Home | 20 | 15 |  | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Waverley House is certified to provide rest home level care for up to 20 rest home residents. On the day of the audit there were 15 residents residing at Waverley House. The owner, who is the manager is supported by a registered nurse. Staff interviewed and documentation reviewed identified that the service has an established quality system to meet the needs of residents. Family interviewed all spoke very positively about the care being provided at the rest home. This audit identified areas for improvement required (including two high risk) around reassessment and timely referral of residents with higher needs, an aspect of medication management, an implemented process for document review and evaluation of resident surveys completed.

1.1 Consumer Rights

Residents and their families/whānau are informed of their rights as part of the resident information pack. Caregivers were observed to respect resident privacy. Initial and on-going assessment includes gaining details of people’s beliefs and values. Interventions to support these are identified and evaluated. Residents are encouraged to continue with their spiritual activities. Cultural awareness training occurred as part of the staff training programme. There is Maori Health Plan.

Relatives spoke positively about care provided at Waverley House Rest Home. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents’ rights. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented.

1.2 Organisational Management

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There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is well supported. The staffing policy aligns with contractual requirements and includes skill mixes.

1.3 Continuum of Service Delivery

A service information pack is made available prior to entry or on admission to the resident and family/whanau. Relatives confirmed the admission process and the admission agreement is discussed with them. The registered nurse is responsible for each stage of service provision. Each resident has a plan of care developed on admission. Within three weeks a long term care plan is developed. Long term plans are goal orientated and are reviewed at least six monthly and are completed on discussion with the resident and/or family/Whanau. Short term care plans are utilised for changes in health status such as infections. There is an activities programme which offers activities that are varied, age appropriate and include local community and entertainment events. There is an establish medicines management system in place. Residents have a dietary profile developed on admission and likes, dislikes and allergies are communicated to staff. All food is cooked on site by a council approved kitchen. Dietary profiles are reviewed six monthly or as residents needs change. The menu has been designed by a registered dietitian. All staff have completed appropriate food safety training. Improvements are required around the reassessment and referral of residents when there is an increase in resident need and stocktake of controlled medication is to occur weekly.

1.4 Safe and Appropriate Environment

The building has a current building warrant of fitness and fire service evacuation approval. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are utilised for group and individual activity. The dining and lounge seating placement encourages social interaction. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely in the kitchen and the laundry. The internal facility is laid out in a square with communal areas and bedrooms built around an internal courtyard. Each resident has their own bedroom. Residents rooms are personalised, warm, with natural light and have call bells. Residents are able to decorate their room with their own possessions. Hazardous waste is managed appropriately to minimise risk. Water temperatures are monitored to ensure they are within an acceptable temperature. The facility is heated by electricity and ventilated by opening windows and internal doors to the courtyard. Cleaning and laundry is done on site. There are policies and procedures to guide staff.

2 Restraint Minimisation and Safe Practice

Waverley House Rest Home has a restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers.

The policy includes that enablers are voluntary and the least restrictive option. There are no residents requiring the use of an enabler and three residents requiring the use of a restraint (bed rail and lap belts). Staff receive training on restraint minimisation and managing residents' behaviours that can be challenging. The facility has a locked front door which is an environmental restraint. Potential residents and family/EPOA are informed of the locked door and sign a consent form to agree to residing in a facility which has a locked front door on admission. The locked front door is interfaced with the fire alarm system and unlock in the event of a fire. The policy for the locked front door is under review in discussion with the District Health Board.

3. Infection Prevention and Control

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (registered nurse) is responsible for surveillance of infections. Infection control training is provided annually for staff. The infection control manual outlines a range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

Summary of Attainment

* 1. Consumer Rights

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

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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: 0  Criteria (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 | PA Low | 0 | 6 | 2 | 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: 6 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:20 PA:2 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 | PA High | 0 | 2 | 1 | 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) | PA High | 0 | 0 | 1 | 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: 9 PA Neg: 0 PA Low: 0 PA Mod: 1 PA High: 2 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:18 PA:3 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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

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

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | 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: 0  Criteria (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: 0  Criteria (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:** 46 **PA Neg:** 0 **PA Low:** 1 **PA Mod:** 1 **PA High:** 2 **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:** 96 **PA:** 5 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Waverley Aged Care Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:24-Jul-13 End Date: 24-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.3 | 1.2.3.3 | PA  Low | **Finding:**  The policies submitted for document review prior to audit evidenced review dates ranging from 2010-2012. However there is no process implemented to ensure that policies are regularly reviewed.  **Action:**  Ensure that polices are reviewed and updated at regular intervals. | 6 months |
| 1.2.3 | 1.2.3.8 | PA  Low | **Finding:**  A resident survey conducted in February 2013 evidences a low response rate. However, a survey evaluation has not been conducted for follow up and corrective actions identified.  **Action:**  Ensure that surveys are evaluated with identified issues managed through the corrective actions process. | 6 months |
| 1.3.3 | 1.3.3.3 | PA  High | **Finding:**  Two residents were observed to be immobile and require assistance with all activities of daily living, were doubly incontinent and needed assistance with food and fluid intake. Files reviewed of these two residents evidenced the date of NASC assessments occurring as 2000 and 2001. Of the fifteen residents, 13 have a medical diagnosis of dementia (link 1.3.9.1). Interview with the RN and review of care plans evidenced that there is a high number of residents residing in the facility who wander and that have diminished awareness and lack of insight around safety and potential/possible dangers/hazards. The RN completed and faxed urgent referrals on the day of audit to the NASC team requesting urgent reassessments for the two residents who are immobile and require assistance with all activities of daily living. There are one grade three and one grade two pressure area wounds currently being treated. The grade two pressure area is almost healed. The grade three pressure area was observed being redressed on the afternoon of audit. The wound had been dressed by the RN two days prior to this dressing change. The wound was observed to be necrotic with signs of infection. The RN stated there had been a deterioration in the wound since it was last dressed. There was evidence of input from DHB wound care nurse specialist and GP. Referral for further input from wound care nurse specialist is required. There was no pressure relieving mattress in place on resident’s bed. A pressure relieving mattress was immediately placed on the bed on day of audit.  **Action:**  Ensure a needs assessment is completed on all residents identified above to ensure a rest home environment is appropriate for their current level of care. | immediate-1 month |
| 1.3.9 | 1.3.9.1 | PA  High | **Finding:**  Two residents are immobile and requiring full assistance (link 1.3.3.3). The digital lock on the front door has been in place for ten years. Historically this has not been identified as an issue in previous audits as residents were more cognitively able and were able to demonstrate that they could access the code which is displayed by the door, and leave and enter the building as they wished. However this audit identified that 13 of fifteen residents residing at the facility have a diagnosis of dementia and two residents a diagnosis of being cognitively impaired. The RN advised that none of the current residents would be able to leave the building independently as they would be unable to understand or work the keypad lock to allow exit. On the informed consent which residents/EPOA sign on admission there is a section which states the "resident to be physically restrained using …in order to maintain safety." In consent forms reviewed the word "physically" had been crossed out and replaced with the word environmentally. The consent forms were evidenced signed by residents and or resident’s representative and registered nurse and GP. There is a Locked Facility policy which documents "all personnel involved in the placement of a client at Waverly House are informed of the locked facility policy, including family members, friends, visitors, social workers, GPs and other related health professionals. It is the policy at Waverly House that all residents and family members/whanau capable of moving freely in and out if the rest home shall be made aware of the combination, and instructed in the operation of the door, so as not to restrict the freedom of movement. The keypad is interfaced with the fire alarms, so that in the event of a fire alarm activation the door lock will automatically be opened." The policy is clearly displayed on the notice board at entrance foyer of the facility. There is a consent for the acceptance of locked facility form which states that the facility “provides a safe secure environment for client who have a tendency to wander.” The forms have a designated area for signatures of next of kin, (relationship to resident stated), GP, Registered Nurse and Manager. Consent forms were evidenced completed in all resident files reviewed. The Consent for the acceptance of a locked facility form does not have a date the form was issued or due for review as per document control policy.  **Action:**  Ensure that referral for reassessment/review is initiated when there is an increase in resident needs within timeframes that safely meet the needs of the resident. This includes those residents that require a secure environment for safety. | immediate-1 month |
| 1.3.12 | 1.3.12.1 | PA  Moderate | **Finding:**  Controlled drugs are stored on site and stocktakes of these medicines have been completed monthly as opposed to weekly.  **Action:**  Perform stocktakes of controlled drugs weekly. | 1 month |

# Continuous Improvement (CI) Report

Provider Name: Waverley Aged Care Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:24-Jul-13 End Date: 24-Jul-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

Waverley House Rest Home has information available on the Code of Health and Disability Services Consumers’ Rights. There is a code of rights policy in place that describes the code and the responsibilities of staff. Three caregivers interviewed are familiar with the policy. They could describe ways in which residents rights are acknowledged and incorporated in their day to day work such as obtaining informed consent, resident choice and complaints procedure. Code of rights training was conducted in October 2012. Code of Rights poster is displayed in the front foyer on the rest home.

**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

The service has available information on the Code of Health and Disability Services Consumers’ Rights. The Code was evident in the entrance foyer of the service and posters are on the wall. Information in relation to the service is in a format that suits the needs of residents. The service has a copy of the Code of Rights at the front door entrance.

Due to the diagnosis of dementia for 13 of 15 residents it was not possible to interview residents during this audit. The other two residents are both deaf and mute since birth.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Staff can describe the procedures for maintaining confidentiality of resident records. Discussions with two family members identified that staff are respectful of resident’s personal property. The staff were observed to maintain residents dignity and privacy by closing doors when carrying out personal cares.

Cultural safety policy guides staff in the delivery of care and incorporates care of Maori residents and other ethnicities. The Maori health plan policy includes practical application of the treaty of Waitangi and caring for Maori residents.

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

Information about the client’s spiritual orientation needs and values is collected on admission and documented. The admission form includes the religion of the person. There are church services held weekly at the facility.

The registered nurse reports that discussion on values and beliefs including cultural and spiritual needs takes place at assessment and planning with discussion around the resident needs.

Education on privacy and dignity was conducted on 13-Jun-13 with six staff attending.

The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. Resident choice is part of the client code of rights policy and this promotes the right of clients to independence. Discussions with two family members confirmed that residents are able to choose to engage in activities and access community resources.

Three caregivers interviewed could describe examples of giving residents choice including: what time they would prefer a shower or breakfast, choices on food, what time they would like to get up, what clothes they would like to wear.

The abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Discussions with owner/manager, registered nurse and three caregivers identified that there were no incidents of abuse or neglect. There have been no identified complaints around abuse or neglect and family members (two) were very positive about the quality of care and support provided. Abuse and neglect training was conducted on 07-Mar-13 with eight staff attending.

D3.1b, d, f, i The service has a philosophy " Residents in our care receive the highest quality of care, delivered with honesty, integrity in a relaxed, happy and warm atmosphere."

The facility has a locked front door which has been in place for 10 years which is an environmental restraint. Potential residents and family members are advised of the locked door and are given the code to allow access and exit from the facility. The code is also displayed at the front door. A consent form is signed by resident/family/EPOA regarding the locked door. An assessment is completed for all residents for environmental restraint and this is documented in care plans.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

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

The service has policies to support practice i.e. guidelines for the provision of culturally safe services for Maori residents and cultural awareness. Maori health plan and ethnicity awareness policy/procedure includes health definitions, concepts and ideology, Maori models of health - te whare tapa wha, cultural safety, treaty of Waitangi, protocol for mourning and care of Maori before and after death. Education in Cultural Safety which included Treaty of Waitangi training was conducted in March 2011 and is scheduled on the education planner for November 2013.

D20.1i: The plan includes contact details for local Maori, Maori health services and local marae. Discussions with three caregivers, owner/manager and registered nurse confirms that they are aware of the need to respond appropriately to individual cultural difference. There are currently no residents who identify as Maori.

D20.1i The service has developed a link with local Maori iwi.

**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

D3.1g The service provides a culturally appropriate service by assessing resident needs on admission, a social profile is gathered as is psycho-social needs, spiritual requirements and family/significant other links.

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

There are policies to support cultural and spiritual needs. There is a values and beliefs section in the care plan. Relatives interviewed (two) stated that they felt they were valued, consulted and kept informed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

There are policies and procedures to ensure consumers are not subjected to discrimination, coercion, harassment or sexual harassment. These policies are supported by the code of resident’s rights policy, complaints policy, abuse and neglect policy - all of which are implemented. The policies include support for the resident throughout their engagement with the service. Staff training provided around code of rights in May 2012 with eleven staff attending. Education on Abuse and Neglect was conducted on 07-Mar-13 with eight staff attending.

**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

There is an implemented quality improvement programme that includes performance monitoring.

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

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Policies and procedures cross-reference other policies and appropriate standards. Two family members interviewed spoke positively about the care and support provided.

Staff described a positive atmosphere and stated that they had access to resources that assisted them in providing care to residents.

Assessments and care plans have been documented in all four resident files reviewed.

Caregivers interviewed (three) have a sound understanding of principles of aged care and state that they have been supported by the service for on-going education.

**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

Family members interviewed (two) stated they were given an explanation about services, and procedures prior to entry. Family members report being informed about the locked front door policy and signing the section of the consent form which relates to the environmental restraint. There is an open disclosure policy. The service has access to interpreter services and there is an interpreting policy. Family are welcome at any time and are encouraged to be involved in resident care review. Interpreter services are accessible via the DHB.

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

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

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

D11.3 The information pack is available in large print.

**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

Interviews with three caregivers who have had experience working both morning, afternoon and night shifts, confirmed that they were familiar with the requirements to obtain informed consent. They described asking residents what clothing they wished to wear, choice of food on menu, and if they were ready for personal care requirements. The caregivers interviewed were aware of the residents’ right to decline or refuse. Informed consent education was conducted in 08-Mar-12 with fourteen staff attending. There is a resuscitation policy and resuscitation decision form that is completed appropriately.

D13.1 there were four admission agreements sighted.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

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

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy and informed consent training was provided in March 2012 with fourteen staff attending.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

D3.1h Discussion with the owner/manager registered nurse, three caregivers, diversional therapist and two family members identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e Interviews with the owner/manager and diversional therapist described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. The activity programme includes opportunities to attend events outside of the facility including activities of daily living e.g. shopping. A member from the RSA visits monthly. An RSA member was observed visiting the facility on the day of audit. Entertainers are included in the rest home activities programme. The owner/manager advised that residents are transported to events and appointments in the facility van. The van has a hydraulic lift to allow for wheelchair access. Those driving the van hold a current first aid certificate and copies of driving licences are held by the manager.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation. There is a complaints register. There have been no complaints documented for 2012. One written complaint was observed documented in the complaints register for June 2013. Documentation including follow up letters demonstrates that the complaint has been investigated and results of the investigation have been forwarded to the complainant. The owner/manager is waiting for a response from the complainant as to satisfaction with outcome from investigation. Two family members advised that they are aware of the complaints procedure and how to access forms.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

The manager of Waverley House Rest Home the is owner. She is supported by a registered nurse and care staff. There is a second registered nurse available to cover for annual leave. The rest home provides care for up to 20 rest home residents with 15 residents residing in the facility on the day of audit, one of whom was receiving respite care. The service has a current business plan and quality risk management plan dated April 2013. The quality programme is managed by the owner/manager with assistance from the registered nurse. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. There are measurable goals developed for the business plan and quality plan.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

During a temporary absence of the owner/manager, the facility is managed by a registered nurse.

A review of the documentation, policies and procedures and discussions with staff identified that the service has policies, procedures, processes and systems that support the provision of safe quality care and minimises the risk of unwanted events to residents receiving rest home care.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The service has a business plan and quality risk management plan that are implemented. Progress with the quality plan is monitored through the monthly staff/quality meetings. The staff/quality meeting agenda includes (but is not limited to): occupancy, complaints/concerns, audits, training, health and safety, infection control, incidents/accidents, restraint, client related issues, staffing and general business. Minutes are maintained and easily available to staff. Staff/quality meeting minutes sighted for 25-June-2013. Minutes include actions to achieve compliance where relevant. Discussions with the registered nurse and three caregivers confirm their involvement in the quality programme. Resident/relative meetings take place six monthly. There is an internal audit schedule 2013. Audits include: cleaning, laundry, food service, admission procedures, infection control, care plans, complaints, medication management, personal privacy and safety, continence, cultural safety and spiritual beliefs, wound management, staff training and informed consent. The service has a health and safety management system and the owner/manager is the health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control manual, infection control programme and corresponding policies. The facility uses the "Bug Control" Infection Prevention and Control Manual as a resource. There is a restraint use policy and health and safety policies and procedures.

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

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

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

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

D19.2g Falls prevention strategies such as falls risk assessment, walking aids, use of appropriate footwear, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the registered nurse who completes the follow up. All incident/accident forms are seen by the owner/manager who completes any additional follow up and collates and analyses data to identify trends. Results are discussed with staff through the monthly staff/quality meetings. A resident survey has been completed in 2013, evaluation has not been conducted for follow up and corrective actions required. Therefore an improvement is required. The resident/family survey for 2013 has been sent out in April 2013 and is awaiting return and collation of data.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

The service has policies and procedures that are implemented.

**Finding Statement**

The policies submitted for document review prior to audit evidenced review dates ranging from 2010-2012. However there is no process implemented to ensure that policies are regularly reviewed.

**Corrective Action Required:**

Ensure that polices are reviewed and updated at regular intervals.

**Timeframe:**

6 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

There is an internal audit schedule 2013 and internal audits have been completed as per schedule. A resident survey conducted in February 2013 evidences a low response rate. However, a survey evaluation has not been conducted for follow up and corrective actions identified. Manager advised that a recent family consumer survey has been sent out in July 2013 and is waiting responses to be returned for evaluation.

**Finding Statement**

A resident survey conducted in February 2013 evidences a low response rate. However, a survey evaluation has not been conducted for follow up and corrective actions identified.

**Corrective Action Required:**

Ensure that surveys are evaluated with identified issues managed through the corrective actions process.

**Timeframe:**

6 months

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at monthly management meetings and monthly staff meetings including actions to minimise recurrence. Discussions with the owner/manager and registered nurse confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and two family members interviewed stated they are informed of changes in health status and incidents/accidents. Incident reports for April 2013 were reviewed (9) and include seven falls with no injury, one fall were the resident sustained a bruise and one skin tear. The registered nurse interviewed advised that staff are in regular contact with family and contact with family is documented on family communication sheets sighted. Monthly incident/accident analysis occurs with subsequent annual summary and analysis.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurse, pharmacist and general practitioners is kept. These were sighted on the notice board in the nurse's office. There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one registered nurses, three caregivers, one diversional therapist and one kitchen hand). Reference checks are completed before employment is offered and are in five staff files reviewed. There is an orientation programme in place that provides new staff with relevant information for safe work practice. Three caregivers were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists were evident in five of five staff files reviewed.

Discussion with the owner/manager, one registered nurse and three caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. The registered nurse attends external training including conferences, seminars and sessions provided by the local DHB. The owner/manager has attended education sessions in 2012 and 2013. Education provided in 2012-13 include; restraint, hand washing; oral care in the elderly; infection control; code of rights including advocacy, abuse and neglect, food safety, first aid, diabetes, Epilepsy, documentation and handover; spirituality; teamwork; and medication management. Treaty of Waitangi training conducted in March 2011. Fire evacuation drill last conducted 26-Feb-13. Fire and disaster training occurred April 2012. Training occurs following the monthly staff meetings and records include date, session topic, and names of attendees.

**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

There is a staffing levels and skill mix policy in place. Sufficient staff are rostered on to manage the care requirements of the rest home residents. The owner/manager works Monday-Friday 08.00-17.30 hrs. The registered nurse works 20 hours per week. The owner/manager and registered nurse provide on-call cover. Rosters evidence extra staff can be called on for increased resident requirements. Interviews with three caregivers, and two family members identify that staffing is adequate to meet the needs of residents. There is designated laundry/cleaning staff.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

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

D7.1 entries are legible, dates and signed by the relevant caregiver or registered nurse including designation

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

All residents are assessed by the referring agency prior to entry to the service (confirmed in review of 15 of15 clinical records). The service liaises with assessment services and service coordinators as required. There are entry and admission policies and procedures in place. The service has specific information available for residents/families/whanau at entry and this information includes information such as the Code of Rights. Entry is facilitated in a timely manner. The service has vacancies and therefore is not operating a waiting list. The referring agency is continually aware of the bed occupancy status in the facility.

An internal audit of the admission documentation was last completed on 09-May-13.

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

D14.1 Exclusions from the service are included in Appendix 2 to the admission agreement.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

The service has a process for declining entry should this occur The process includes informing the referring agency of the reasons why the service has been declined. The reason for declining service entry to residents is recorded should this occur and communicated to the resident/family/whanau. Records are kept in a declining entry log book. Review of the log book shows that no persons have been declined entry since the book was implemented.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

Staff are current and up to date with their knowledge and experienced and are considered competent in their role. Long term care plans are developed by the service’s registered nurse, who works 20 hours a week and is on call for the remaining hours when not on site. She has the responsibility for maintaining and reviewing care plans. Caregivers complete progress notes, which are integrated with care plans. Family/whanau are kept informed about the resident's care. An initial assessment and a short term care plan is developed on admission and the full care plan is developed within 3 weeks (confirmed in discussions with the registered nurse and in review of three of three consumer records). There is an appropriate hand-over briefing between shifts (observed) and a handover sheet is used to record issues of more significance (e.g., to draw attention to a newly implemented short term care plan).

Family are involved in planning residents care plan and at evaluation (confirmed in discussions with two of two family members).

Fifteen residents' files were reviewed (four in depth). There is a record of family interaction in the residents clinical records.

D16.2, 3, 4: The four files reviewed in depth identified that in all four residents had an assessment completed within 24 hours and all four files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. All four care plans evidenced evaluations completed at least six monthly.

D16.5e: Four resident files reviewed identified that the GP had seen the resident within two working days. It was noted in three resident files reviewed that the GP has assessed the resident three monthly and the fourth resident (refer Tracer below) is being seen monthly or more frequently as they are not considered medically stable.

A range of assessment tools are completed. A falls risk and pressure area risk is assessed on admission and other assessments are made (e.g., continence if appropriate). Assessments are redone at the time of six monthly evaluations.

Tracer Methodology:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Stages of service provision occur within time frames as outlined in policy. The registered nurse completes the assessments on admission. The RN completes the long term plans of care. She evaluates care at least six monthly or more frequently if needs change. She implements short term care plans on admission to address resident needs and thereafter for acute changes in health changes (e.g., infection, wound, changes to medication, residents condition).

**Finding Statement**

Two residents were observed to be immobile and require assistance with all activities of daily living, were doubly incontinent and needed assistance with food and fluid intake. Files reviewed of these two residents evidenced the date of NASC assessments occurring as 2000 and 2001. Of the fifteen residents, 13 have a medical diagnosis of dementia (link 1.3.9.1). Interview with the RN and review of care plans evidenced that there is a high number of residents residing in the facility who wander and that have diminished awareness and lack of insight around safety and potential/possible dangers/hazards. The RN completed and faxed urgent referrals on the day of audit to the NASC team requesting urgent reassessments for the two residents who are immobile and require assistance with all activities of daily living. There are one grade three and one grade two pressure area wounds currently being treated. The grade two pressure area is almost healed. The grade three pressure area was observed being redressed on the afternoon of audit. The wound had been dressed by the RN two days prior to this dressing change. The wound was observed to be necrotic with signs of infection. The RN stated there had been a deterioration in the wound since it was last dressed. There was evidence of input from DHB wound care nurse specialist and GP. Referral for further input from wound care nurse specialist is required. There was no pressure relieving mattress in place on resident’s bed. A pressure relieving mattress was immediately placed on the bed on day of audit.

**Corrective Action Required:**

Ensure a needs assessment is completed on all residents identified above to ensure a rest home environment is appropriate for their current level of care.

**Timeframe:**

immediate-1 month

**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

Initial assessments are commenced on the day of admission and completed by the registered nurse. An initial assessment is documented in a short term care plan. The initial assessment is completed within three weeks of admission and includes goals of the consumer. Each consumer has a medical assessment completed by the resident's general practitioner of choice within two working days of admission. A dietary profile is prepared and provided to the kitchen staff on the day of admission. The resident's cultural, spiritual and recreational needs are assessed to ensure an holistic approach to planning care. All assessments are completed with input from the resident and family where possible. External specialist input is available, where necessary, providing a co-ordinated, effective multidisciplinary approach to assessment.

Clinical risk assessment tools are used to provide a baseline and identify areas of risk. These assessment tools include a Braden pressure area risk assessments and a Coombes falls risk assessments (evidenced in all four of four resident files reviewed). The RN stated that she will use additional assessment tools as appropriate (e.g., continence, pain).

An internal audit of the assessment and care planning process was last conducted on 08-Apr-13. An internal audit of pain management was last conducted on 29-Nov-12.

All 15 of 15 residents were not able to be interviewed to corroborate evidence due their inability to communicate effectively.

Two of two relatives confirm that information is gathered by staff on their relatives on entry to the service and thereafter as appropriate.

**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

A long term nursing care plan is developed within three weeks of admission that includes a range of care needs covering hygiene, pressure area care, elimination, food/fluids, mobility, oral hygiene, dressing, sleep/rest, communication, mental state, manual handling, spiritual needs, psycho-social and individual daily routine preferences. Each area of the care plan includes; problems/needs, goals and interventions.

D16.3f; Family are encouraged to have input into the planning process were applicable (Of the four files reviewed in depth one file identified that family were involved and the other three residents had no family who could be actively involved.)

D16.3k: Short term support needs plans are used on admission and are used to inform the long term plan changes in health status. Short term care plans are in place for the management of residents with pressure areas, skin tears, infections, pain, and those at risk of falling. The RN uses short term care plans extensively to guide care.

**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

The care being provided is consistent with the needs of residents assessed needs on their referral documentation.

Four resident files were reviewed which included one resident with challenging behaviours and a minor skin tear, one resident with a Grade 3 pressure area on their heel, one resident requiring the use of restraint, and one resident with an early dementia who was transferred from another rest home for safety as they were wandering.

D18.3 and 4 Dressings and supplies used in treatments are provided and are of an appropriate standard as determined by the RN. The RN has a treatment trolley stocked with dressings and supplies and more supplies in a locked cabinet in the locked treatment room (sighted). An internal audit of wound management was last conducted on 25-Jun-12.

A range of continence products are available and resident files include a continence assessment where appropriate. The RN is involved in determining the use of continence products for each resident. She has access to specialist continence advice through the DHB as needed

An internal audit of urinary and faecal continence supplies was last conducted on 09-May-13.

Continence management in-services and wound management in-service have been provided..

Wound assessment and wound management plans are in place for four residents (link 1.3.3.3). The four wounds include one Grade three pressure area (sighted and deteriorating), one Grade two pressure area (nearly healed), and two minor skin tears (link Tracer 1.3.3).

Two of two relatives confirm that staff provide appropriate care for their relatives.

Interview with a GP by telephone confirmed that staff provide a good standard of care.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

Residents are assessed on admission as to their social history and their preferred activities (e.g., hobbies). Likes and dislikes these are entered into the care plan which is then used to identify specific individual needs. The activity programme evidenced on the day of audit and discussed with the diversional therapist covers a variety of activities such as: supervised walking in small groups for those consumers who enjoy walking, quizzes, bingo, outings (the facility has a 6-seater van which can accommodate 2 wheelchairs), exercises, crafts, entertainment, music, other board games and games suitable for indoors and newspaper reading. There is evidence of contact with external community groups such as local schools, SPCA, RSA and churches. A musician was entertaining on the afternoon of the audit.

Activities are planned monthly (confirmed in discussions with the diversional therapist). A copy of the activities plan for each week is displayed on the notice board at the reception/entrance area and in the lounge. Individual activities are provided for residents who do not wish to participate in the group programme. The diversional therapist is employed 22 hours a week to oversee the programme.

D16.5d Individual activity plans are reviewed when care plans are reviewed.

Two of two relatives confirm that the activities programme is well run and appropriate for their relatives.

**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

Care plans are evaluated by the registered nurse 6 monthly or earlier if needed. There is at least a 3 monthly review by the medical practitioner for medically stable consumers. Changes in health status are documented in progress notes and by use of short term care plans. Short term care plans are used widely by the RN. GPs are informed of any changes in residents' health status and medical advice is reflected in interventions (observed in all four of four residents' files reviewed).

An interview with the GP who provides care to the majority of residents confirmed that staff advise the GP in a timely manner of any concerns they have regarding changes in residents’ conditions.

Two of two relatives confirm that they are involved in the review of their relatives care.

D16.3c: All initial short term care plans were developed and documented by the RN within three weeks of admission and care is evaluated by the RN over the initial three weeks of the resident's admission. A long term care plan is developed 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:** PA High

The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs. In managing the referral process the service provides: a) appropriate transfer of relevant information, and b) follow-up occurs where appropriate. The service uses the yellow envelope system when referring residents to Hawke's Bay DHB.

D16.4c; The service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care. Two residents are immobile and requiring full assistance and the other 13 residents require to be nursed in a secure environment for their safety (link 1.3.3.3 and 1.3.9.1).

D 20.1 Discussions with registered nurse identified that the service has access to the needs assessment and service co-ordination service, primary care and district nursing, specialist nurse advisors from the DHB, specialist medical services (including the older persons mental health and allied health service, Hawke's Bay DHB) and laboratory services as well as other service providers as needed.

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

Residents are given a choice of general practitioner or health and disability provider where possible. The RN reported that none of the current residents would be able to make an informed choice (some because they cannot speak and others due to their level of dementia).Both the manager and the RN are involved in discussions with the referring agencies when referrals are actioned.

**Finding Statement**

Two residents are immobile and requiring full assistance (link 1.3.3.3). The digital lock on the front door has been in place for ten years. Historically this has not been identified as an issue in previous audits as residents were more cognitively able and were able to demonstrate that they could access the code which is displayed by the door, and leave and enter the building as they wished. However this audit identified that 13 of fifteen residents residing at the facility have a diagnosis of dementia and two residents a diagnosis of being cognitively impaired. The RN advised that none of the current residents would be able to leave the building independently as they would be unable to understand or work the keypad lock to allow exit. On the informed consent which residents/EPOA sign on admission there is a section which states the "resident to be physically restrained using …in order to maintain safety." In consent forms reviewed the word "physically" had been crossed out and replaced with the word environmentally. The consent forms were evidenced signed by residents and or resident’s representative and registered nurse and GP. There is a Locked Facility policy which documents "all personnel involved in the placement of a client at Waverly House are informed of the locked facility policy, including family members, friends, visitors, social workers, GPs and other related health professionals. It is the policy at Waverly House that all residents and family members/whanau capable of moving freely in and out if the rest home shall be made aware of the combination, and instructed in the operation of the door, so as not to restrict the freedom of movement. The keypad is interfaced with the fire alarms, so that in the event of a fire alarm activation the door lock will automatically be opened." The policy is clearly displayed on the notice board at entrance foyer of the facility. There is a consent for the acceptance of locked facility form which states that the facility “provides a safe secure environment for client who have a tendency to wander.” The forms have a designated area for signatures of next of kin, (relationship to resident stated), GP, Registered Nurse and Manager. Consent forms were evidenced completed in all resident files reviewed. The Consent for the acceptance of a locked facility form does not have a date the form was issued or due for review as per document control policy.

**Corrective Action Required:**

Ensure that referral for reassessment/review is initiated when there is an increase in resident needs within timeframes that safely meet the needs of the resident. This includes those residents that require a secure environment for safety.

**Timeframe:**

immediate-1 month

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

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

ARC D21 ARHSS D21

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

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

The service has discharge procedures in place to guide staff and these are followed in the event of a planned discharge. Discharge procedures include the yellow envelope system for use when discharging residents to Hawke's Bay DHB. The yellow envelope accompanies residents on readmission from Hawke's Bay DHB (the RN reports the system works well).

**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 facility uses the robotics medication management system for packaging regular tablets and the Douglas pharmaceutical system of charting medicines. Tablet packs are delivered monthly along with other medicines. The registered nurse reconciles medicines on delivery and the pharmacist is informed of any discrepancies. The facility's medication policies and procedures cover medication prescribing, dispensing, administration, review, storage, disposal and medication reconciliation. Medications are prescribed by the resident's general practitioner on a medication chart. Photographic identification is included in the medicine charts. Staff sign for the administration of medications on the appropriate medication signing sheet for each resident (confirmed in review of 15 of 15 medicine charts). All care staff are required to be competent to administer medicines due to the need to have an effective roster and the RN oversees this process. Medicines are stored in a locked storage area in a corridor opposite the RN's office. Controlled drugs are stored in a locked safe in a locked cupboard within that locked area. Controlled medications are checked monthly (as opposed to weekly) by the registered nurse and one other medication competent person. Therefore there is an improvement required. Any medications requiring refrigeration are kept in a separate covered box in the fridge in the kitchen (which is able to be secured). Weekly fridge temperature recording sheets were sighted. The lunchtime medication round was observed on the day of audit. No residents were self-administering medicines.

An internal audit of the provision of pharmaceuticals was last conducted on 21 February 2013. Education on medication management was last provided on 18 February 2013 and attended by seven staff.

D16.5.e.i.2; GPs review residents 3 monthly or more frequently and sign their respective medication chart.

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

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

Controlled drugs are in use as injectable PRN pain relief for two residents. A stocktake of controlled medications is carried out monthly. A stocktake was performed with the RN, which confirmed that stock on hand was accurate.

**Finding Statement**

Controlled drugs are stored on site and stocktakes of these medicines have been completed monthly as opposed to weekly.

**Corrective Action Required:**

Perform stocktakes of controlled drugs weekly.

**Timeframe:**

1 month

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

A dietary profile is completed on admission by the registered nurse (confirmed in interviews with the cook and the RN). The cooks and other staff are advised of residents likes and dislikes and any special dietary needs or allergies. There is a small but functional kitchen and two cooks are employed 07.30-13.00hrs daily on a 'four days on-four days off' roster. The kitchen is powered by electricity and gas. The evening meal is cooked during the day and served by caregivers in the evening. Fridge and freezer temperatures are monitored weekly and food temps are monitored daily by the cooks. There is a rotating four weekly seasonal menu which has had dietitian input. The kitchen has a food premises certificate of registration which expires 30 June 2014 which has been issued by the City of Napier. There are a number of manuals to guide practice in the kitchen. An internal audit of food services was last conducted on 13-Mar-13. Education on food safety and kitchen hygiene was last provided on 13-Feb-12 to three staff and safe food handling education was provided on 23-May-12 to two staff.

The lunch time meal was observed on the day of audit and evidenced good food presentation. Two residents required assistance with feeding by staff. There are snacks and beverages available for residents outside of normal meal times which staff can access from the kitchen.

Two of two relatives confirm that they are satisfied with the meal service.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence** **Attainment:** 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

Staff protect consumers and visitors from exposure to hazardous substances. All staff, on orientation to the facility, receive infection prevention and control education covering the management of waste and hazardous substances. This education includes exposure to blood and body fluids. Staff have access to personal protective equipment (observed). Staff have been provided with training in chemical and waste management during orientation. Chemicals are stored safely and locked away when not in use.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The premises has a current warrant of fitness, which expires 1 November 2013. The premises is a totally secure environment, with a code on the front door and fire exits electronically controlled ( refer link 1.3.3.3 & 1.3.9.1). There is a secure internal courtyard with tables and chairs. The external windows have secure stays on them. Reactive and preventative maintenance is carried out by the manager's husband and other contractors as needed. Furniture and fittings are selected with consideration to residents’ abilities and functioning and are clean and functional. Residents rooms were decorated with familiar personal belongings. There is enough room throughout the service for residents to mobilise safely. Floor surfaces are clean and in good repair. There is a transportation of residents policy and drivers licenses are copied and retained in staff files.

D15.3; The following equipment is available, weighing scales (standing only), pressure relieving mattresses, shower chairs, one hoist, heel protectors, thermometers, sphygmomanometer, stethoscope and blood glucose testing equipment.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

There are adequate numbers of toilets and showers with access to hand basins and paper towels. Consumer privacy is able to be respected. Hot water temperatures are monitored and maintained at 45 degrees Celsius by the manager. Communal toilets and showers are well signed and identifiable. There are separate toilets for the public and staff. The showers are spacious and allow for the use of shower chairs. Each toilet has hand washing facilities. Hand sanitizer is available and on display in the facility.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Some rooms are more spacious than others. The corridors are wide enough to permit emergency transfers on a stretcher if needed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

The service has a single lounge and dining area. The majority of residents eat in the dining room although some residents have their meals in the lounge area. Residents are able to access areas for privacy if required. All residents have their own rooms. Furniture is appropriate to the setting and arranged that enables residents to mobilise.

D15.3d: There is a television, newspapers and access to a telephone for private calls available.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

The service has in place policies and procedures for effective management of laundry and cleaning practices. There is a designated area for the storage of cleaning and laundry chemicals. The service has policies and procedures for effective management of laundry and cleaning practices. There are two dedicated cleaners employed (one cleaner was interviewed during audit). There is a closed laundry system. Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. The service has a secure area for the storage of cleaning and laundry chemicals. Chemicals are labelled. Material Safety Data Sheets are displayed in the laundry and chemical storage areas. An internal audit of the cleaning and laundry services was last conducted on 13-Mar-13.

**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

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There is currently a trained person with a first aid certificate on each shift. Waverley House has a NZFS approved fire evacuation scheme. Fire drill last conducted 26-Jun-13. Emergency lighting, extra blankets and alternative cooking facilities (gas barbeque), are available. A civil defence pack is in place with emergency lighting and there is 240 litres of water stored which is accessible in an emergency. Civil defence kits are checked six monthly. A call bell system is in place to alert staff to the area in which residents require assistance.

**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

General living areas and resident rooms are appropriately heated with electric heating and ventilated by windows. Residents have access to natural light in their rooms and there is adequate external light in communal areas. All personal living areas have external windows. The service has a Smoke Free policy. Smoking is only permitted in designated areas. There are no residents who smoke currently. Staff may only smoke outside and out the back of the building in a designated area.

**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

There is a restraint minimisation and safe practice policy that is applicable to the service. This includes a restraint protocol for the steps from assessment, approval and into the support plan. The aim of the policy and protocol is to minimise the use of restraint and any associated risks.

The restraint approval group meets three monthly.

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0

The facility has a locked front door. There is an assessment completed by the registered nurse to assess if the locked front door is an environmental restraint for the resident. There is a consent form for environmental restraint signed by GP, RN and resident and/ or EPOA. These were evidenced completed in 15 resident files reviewed.

There are currently no residents requiring the use of an enabler. There are three residents requiring the use of a restraint.

**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

The registered nurse is the restraint coordinator. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. There are three residents requiring the use of restraint. One resident requiring the use of bedrail and a lap belt and two residents requiring the use of a lap belt. All files for the above residents reviewed evidence a completed assessment, consent for restraint signed by GP, registered nurse and resident's next of kin/EPOA. On-going monitoring was evidenced occurring documented in progress notes when restraint is in use. Files reviewed evidence three monthly review of the continued need for use of restraint is occurring.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

Assessments are undertaken by the registered nurse on consultation with the resident and their family/whanau. The registered nurse is the restraint coordinator. There is a job description in place.  There is a restraint assessment tool available and completed for the residents requiring the use of a restraint. A restraint assessment form is completed for those residents requiring restraint. Three restraint files were reviewed. They included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed three monthly (written evaluation sighted).

There are behavioural monitoring forms completed to monitor challenging behaviours. Care plans of residents with challenging behaviours include de-escalation techniques which staff can use which minimises the need for the use of 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 restraint coordinator is the registered nurse and she is responsible for completing all the documentation. Assessments and care plans identify specific interventions or de-escalation techniques to try (as appropriate) before use of restraint. The consent for restraint is completed in consultation with the residents (as appropriate) or family/EPOA/whanau, GP and the restraint coordinator. Restraint use is reviewed at least three monthly within the facility restraint approval group meeting. Minutes were sighted of restraint approval group meeting which occurred June 2013. All restraint events are discussed at this meeting. Monitoring and observation process is included in the restraint policy. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.

Care plans reviewed of three residents with restraint identified observations and monitoring. Restraint use is reviewed through the six monthly care plan evaluation and three monthly restraint approval group meetings and includes family/whanau input. A restraint register is in place. This has been completed for all residents requiring restraint.

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

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

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

(d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations have occurred six monthly as part of the on-going reassessment for the residents as part of care plan review and at three monthly restraint approval group meetings. Families are included as part of this review. A review of three files identified that evaluations are up to date and have reviewed (but not limited to); a) whether the desired outcome was achieved, b) whether the restraint was the least restrictive option and c) the impact. Evaluation timeframes are determined by risk levels.

**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 actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified.

The restraint approval group completes an analysis of the restraint internal audit tools. The restraint approval group meets three monthly and includes a comprehensive review of all restraint use.

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

Waverley House has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The monthly quality/staff meeting incorporates infection control and health and safety and includes discussion and reporting of infection control matters and consequent review of the programme. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff. Infection control education occurred 22-May-12 with 16 staff attending.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The registered nurse at Waverley House is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains her practice by attending annual infection control updates. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse consultant. The service uses the Bug Control manual as an infection control resource to guide practice.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

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

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by the owner/manager and registered nurse and reviewed annually. The service uses the Bug Control manual to guide best practice. The service is a member of Bug Control and can access external infection control expertise when required. Waverley House infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste disposal and sharps and spills management.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

There is on-going education of staff and residents. This is facilitated by the infection control nurse with expert support from external providers who provide the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. The IC nurse attends training annually. Education for staff last conducted 22-May-12. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. There have been no reported outbreaks of infection in 2012 to present date.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

Infection surveillance is an integral part of the infection control programme and is described in the infection control and surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the registered nurse and owner/manager.

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**