**Heritage Healthcare Limited**

**Current Status:** **05-Aug-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification audit / Verification 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**

Karetu House is owned by Heritage Healthcare Ltd and is located in Greenlane, Auckland. The facility provides rest home level of care, with the current capacity for 38 residents and was fully occupied when audited. The service has reconfigured three single bedrooms to increase bed capacity by another three beds, to make 41 rest home level care beds. Karetu House continues to have predominantly male residents and many of the residents have a history of mental illness and/or alcoholism, along with their associated health problems. Residents are mostly mobile and enjoy participating in planned activities at the rest home, and are supported to maintain links with groups in the community. At the time of audit, there are three younger residents under the age of 65.

There are three areas identified for improvement at the audit, these are related to record management, the installation of call bells in the reconfigured rooms and medicine management.

**Audit Summary AS AT** **05-Aug-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit05-Aug-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 Audit05-Aug-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 Audit05-Aug-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 Audit05-Aug-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit05-Aug-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 Audit05-Aug-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** **05-Aug-13**

**Consumer Rights**

The residents express high satisfaction with the manner in which the service respects their rights and report that they are treated with respect and dignity at all times. As observed at the onsite audit, residents receive services that uphold their rights. Information is provided at the time of admission and displayed throughout the facility regarding consumer rights, access to advocacy services and how to make a complaint. The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), advocacy and complaints information is available in English and Maori languages. Staff demonstrate an understanding of their obligations regarding residents' rights and how to incorporate that knowledge into their day-to-day practices and interactions with residents and family.

The service meets the cultural and religious needs of the residents. The cultural needs of the residents are identified in the care plan and the service meets the cultural, linguistic and specific nutritional needs of residents. Interpreter services are accessible and available for the service providers and residents to access as required. There are three residents who identify as Maori at the service at the time of audit. There are policies and procedures to meet the needs of residents who identify as Maori.

Complaints are managed to meet policy requirements. At the time of audit the service has no outstanding complaints.

**Organisational Management**

The owner/directors and facility manager ensure that services are planned and coordinated to meet consumers' needs. The organisation's strategic and business plans identify their purpose, values, priorities and goals. Planning processes are reviewed annually and evaluated quarterly to measure achievement. Any deficits in service delivery are managed through corrective action planning.

The day to day operation of the facility is undertaken by staff who are appropriately experienced and qualified to undertake the role in a manner that ensures residents' needs are being met in a safe and efficient manner. The owner is a registered nurse and works closely with the facility manager.

All quality and risk management processes are implemented to meet policy requirements. Policies and procedures are supplied and maintained by the owner/director and facility manager. Incidents, accidents and untoward events are recorded, evaluated and discussed with family/whānau in a manner that is reflective of open disclosure principles. All quality actions are recorded and reported at staff and management level. Key components of service are explicitly linked to quality management systems. Quality data collection and findings are used as opportunities for improvements which are well documented. Quality improvements are evaluated to ensure the desired outcomes are reached.

Staffing levels and skill mix are maintained to meet recommendations and contractual requirements. There is a registered nurse on duty Monday to Friday, during normal working hours, and on call as required.

Human resources management processes implemented meet legislative requirements. There is a system in place to identify, plan and facilitate on-going staff education. There are adequate human resources and service provider availability to meet the needs of the residents for the proposed increase in resident numbers.

Residents' information is accurately recorded upon entry to the service, is securely stored, and clinical records areas are not accessible to the public. Archived files are retrievable. There is one required improvement to ensure that each page of the residents file identifies the resident and forms/assessments are consistently dated and/or signed by the staff member.

**Continuum of Service Delivery**

There are clearly documented process for entry to the facility. Admissions are managed in an equitable and timely manner. Adequate information about the rest home is made available. Admission information includes eligibility criteria.

Care and support is provided by a range of health professionals. This includes the registered nurses, trained caregivers, general practitioner and visiting allied health professionals. Clear time frames for service provision are defined and monitored and residents state they are involved in setting goals for independence and wellness. Residents maintain access to additional health services as required. Referrals and transfers are managed in the timely and proficient manner.

Assessments and care plans are fully documented. Interventions are consistent with good practice and desired outcomes are documented. Care plans are reviewed every three months, or as required. Short term care plans are well utilised and reviewed as required.

The activities programme provided at Karetu House is of a high standard and reflects that independence is encouraged and choices are offered. Activity goals are detailed and ensure the provision of relevant and appropriate activities for each resident. Previous interests, hobbies, culture and ability is considered. Sufficient activities and outings are provided.

Karetu House provides an appropriate medication management system in line with current legislation. All medications are stored securely. Medications are monitored by the registered nurse and the authorised prescriber. Administration is conducted by staff who have completed a medication competency. One improvement is required to the process for managing and recording medication refusals.

Food and nutritional needs of residents are assessed and the menu is reviewed by a dietician. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements.

**Safe and Appropriate Environment**

The facility is maintained and furnished to an acceptable level to provide residents with a safe accessible physical environment. With the reconfiguration of three rooms, the service has a mix of shared rooms and single rooms. There are adequate shared bathroom and toilet facilities, ensuite bathroom facilities, dining, lounge and recreational areas which meet residents' needs as confirmed by resident and family/whānau interviews. There is one area for improvement to ensure each bed space in the reconfigured rooms have access to the call bell system. This is being addressed at the time of audit.

The service has an effective cleaning and laundry service. All laundry is undertaken on site. There are appropriate processes for the handling, storage and disposal of waste and hazardous substances.

Emergency education and training and security responses are well documented and understood by all staff, including management of waste and hazardous substances. Six monthly fire evacuations are maintained. There is adequate food, water and emergency supplies, should they be required.

The building has a current warrant of fitness and the service has an approved fire evacuation plan. The reactive maintenance system is well developed and implemented by the service. Annual planning includes long term maintenance and the purchasing of new equipment. The facility has central heating and is naturally ventilated by the opening of doors and windows. There are well kept outdoor areas that have seating and sheltered areas for residents use.

**Restraint Minimisation and Safe Practice**

There are adequately documented guidelines on the use of restraints, enablers and challenging behaviours. There are no restraints or enablers in use.

**Infection Prevention and Control**

The infection control programme is clearly documented and is suitable for a rest home facility with highly independent residents. Infection control responsibilities are clearly documented. Adequate information, resources and on-going training are provided. Annual review of all infection control activities ensures that prevention and control processes are up to date. The infection surveillance program is appropriate for the facility and the level of care provided. Use of antibiotics is monitored and overall infection rates have been minimal. There have been no infection issues or out breaks since the last audit.

Karetu House

Heritage Healthcare Limited

Certification audit & Verification audit - Audit Report

Audit Date: 05-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Heritage Healthcare Limited |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Karetu House | 19 Karetu Street | Greenlane | Auckland |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
| Reconfigure three single rooms to double rooms to increase capacity of the rest home to 41 rooms.  |

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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) Verification audit |
| **Date(s) of Audit** | **Start Date:** 05-Aug-13 **End Date:** 06-Aug-13 |
| **Designated Auditing Agency** | Health Audit (NZ) Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXX | RN, B.Nursing, RABQSA lead auditor | 12.00 | 12.00 | 05-Aug-13 to 06-Aug-13 |
| Auditor 1 |      XXXXXXX |      RN, LA, 8086 | 12.00 | 8.00 | 5-Aug-13 to 6-Aug-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX | Lead Auditor, RN, BN |       | 2.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 24.00 | **Total Audit Hours off site** *(system generated)* | 22.00 | **Total Audit Hours** | 46.00 |
| **Staff Records Reviewed** | 6 of 26 | **Client Records Reviewed** *(numeric)* | 7 of 38 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 7 |
| **Staff Interviewed** | 9 of 26 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 2 |
| **Consumers Interviewed** | 6 of 28 | **Number of Medication Records Reviewed** | 14 of 28 | **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) Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health Audit (NZ) Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 09 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Karetu House | 38 | 38 |       | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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There are three areas identified for improvement at the audit, these are related to record management, the installation of call bells in the reconfigured rooms and medicine management.

1.1 Consumer Rights

The residents express high satisfaction with the manner in which the service respects their rights and report that they are treated with respect and dignity at all times. As observed at the onsite audit, residents receive services that uphold their rights. Information is provided at the time of admission and displayed throughout the facility regarding consumer rights, access to advocacy services and how to make a complaint. The Health and Disability Commissioner’s Code of Health and Disability Services Consumers' Rights (the Code), advocacy and complaints information is available in English and Maori languages. Staff demonstrate an understanding of their obligations regarding residents' rights and how to incorporate that knowledge into their day-to-day practices and interactions with residents and family.

The service meets the cultural and religious needs of the residents. The cultural needs of the residents are identified in the care plan and the service meets the cultural, linguistic and specific nutritional needs of residents. Interpreter services are accessible and available for the service providers and residents to access as required. There are three residents who identify as Maori at the service at the time of audit. There are policies and procedures to meet the needs of residents who identify as Maori.

Complaints are managed to meet policy requirements. At the time of audit the service has no outstanding complaints.

1.2 Organisational Management

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1.3 Continuum of Service Delivery

There are clearly documented process for entry to the facility. Admissions are managed in an equitable and timely manner. Adequate information about the rest home is made available. Admission information includes eligibility criteria.

Care and support is provided by a range of health professionals. This includes the registered nurses, trained caregivers, general practitioner and visiting allied health professionals. Clear time frames for service provision are defined and monitored and residents state they are involved in setting goals for independence and wellness. Residents maintain access to additional health services as required. Referrals and transfers are managed in the timely and proficient manner. Assessments and care plans are fully documented. Interventions are consistent with good practice and desired outcomes are documented. Care plans are reviewed every three months, or as required. Short term care plans are well utilised and reviewed as required.

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Food and nutritional needs of residents are assessed and the menu is reviewed by a dietician. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements.

1.4 Safe and Appropriate Environment

The facility is maintained and furnished to an acceptable level to provide residents with a safe accessible physical environment. With the reconfiguration of three rooms, the service has a mix of shared rooms and single rooms. There are adequate shared bathroom and toilet facilities, ensuite bathroom facilities, dining, lounge and recreational areas which meet residents' needs as confirmed by resident and family/whānau interviews. There is one area for improvement to ensure each bed space in the reconfigured rooms have access to the call bell system. This is being addressed at the time of audit.

The service has an effective cleaning and laundry service. All laundry is undertaken on site. There are appropriate processes for the handling, storage and disposal of waste and hazardous substances.

Emergency education and training and security responses are well documented and understood by all staff, including management of waste and hazardous substances. Six monthly fire evacuations are maintained. There is adequate food, water and emergency supplies, should they be required. The building has a current warrant of fitness and the service has an approved fire evacuation plan. The reactive maintenance system is well developed and implemented by the service. Annual planning includes long term maintenance and the purchasing of new equipment. The facility has central heating and is naturally ventilated by the opening of doors and windows. There are well kept outdoor areas that have seating and sheltered areas for residents use.

2 Restraint Minimisation and Safe Practice

 There are adequately documented guidelines on the use of restraints, enablers and challenging behaviours. There are no restraints or enablers in use.

3. Infection Prevention and Control

The infection control programme is clearly documented and is suitable for a rest home facility with highly independent residents. Infection control responsibilities are clearly documented. Adequate information, resources and on-going training are provided. Annual review of all infection control activities ensures that prevention and control processes are up to date. The infection surveillance program is appropriate for the facility and the level of care provided. Use of antibiotics is monitored and overall infection rates have been minimal. There have been no infection issues or out breaks since the last audit.

Summary of Attainment

* 1. Consumer Rights

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

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

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | PA Low | 0 | 3 | 1 | 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: 0Criteria (of 34): CI:0 FA:21 PA:1 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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

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

* 1. Safe and Appropriate Environment

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | FA | 0 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | 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 | PA Low | 0 | 4 | 1 | 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: 7 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:16 PA:1 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

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

1. Infection Prevention and Control

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

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

|  |
| --- |
| **Total Standards (of 50) N/A:** 5 **CI:** 0 **FA:** 42 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 90 **PA:** 3 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Heritage Healthcare Limited

Type of Audit: Certification audit

 Verification audit

Date(s) of Audit Report: Start Date:05-Aug-13 End Date: 06-Aug-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.9 | 1.2.9.1 | PALow | **Finding:**There is inconsistent recording of client information and recording of dates on the clinical tools, assessments and care plans sighted. **Action:**Ensure there is consistent recording of patient identification on each page of their record and ensure forms are consistently dated and/or signed.  | 6 months.  |
| 1.3.12 | 1.3.12.6 | PAModerate | **Finding:**Not all medication refusals are recorded. For example: there is one resident who is not taking his second daily dose of regular medication (xxxxxx).**Action:**Provide evidence that the resident is taking his medication as prescribed and that all refusals are recorded and collated through the medication error process. | 3 months |
| 1.4.7 | 1.4.7.5 | PALow | **Finding:**Call bells are not yet installed for the extra beds in the reconfigured rooms at the time of audit.**Action:**Ensure there is an appropriate call system in the reconfigured rooms. | Prior to occupation of the beds.  |

# Continuous Improvement (CI) Report

Provider Name: Heritage Healthcare Limited

Type of Audit: Certification audit

 Verification audit

Date(s) of Audit Report: Start Date:05-Aug-13 End Date: 06-Aug-13

DAA: Health Audit (NZ) 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

The facility manager, the owner/director (who is a registered nurse (RN)) and nine staff interviewed (one RN, five caregivers, one cook staff, one cleaner and one diversional therapist), demonstrate knowledge and understanding of consumer rights, obligations and how to incorporate them into their everyday practice. The Code is available in English and Te Reo and other languages as required. As observed at the onsite audit, staff are seen to be addressing residents with respect, knocking on doors and asking to enter rooms prior to entering, and providing the residents with choices. Education on consumer rights is last conducted in April 2013.

The Aged Related Residential Care (ARC) service agreement requirements for rest home level of care are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

Policy and procedures identify that opportunities are provided for explanations, discussions and clarification of the Code of Health and Disability Services Consumers' Rights (the Code) upon admission. A copy of the Code is included in the resident welcome pack. The resident information booklet contains contact phone numbers for advocacy services.

The Code is displayed in English and Te Reo languages in communal areas and is also available to residents and family in the information booklet. The six of six of residents and two of two family/whanau interviewed report they are provided with information on the Code on admission, the information is in the admission pack and information brochure and the admitting staff provide verbal information on the Code. The advocacy brochure is provided in the welcome pack and available at reception. The six residents and two family interviewed report they are treated with respect and dignity.

The relevant ARC requirements are met.

**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

Policy and procedures outline how service providers provide privacy and meet residents' needs, values and beliefs. There is a mix of shared and single rooms. Three residents interviewed who live in the shared rooms confirm their personal privacy is maintained. The six of six residents and two of two family/whanau interviewed expressed high satisfaction with the way they are treated by all staff (care, allied health, medical, domestic services and activities staff) and report that the residents' dignity, privacy and independence is always respected and they have no concerns regarding abuse or neglect. The nine staff interviewed also confirmed they have no concerns regarding abuse or neglect. Education regarding preventing abuse and neglect is sighted on the training calendar for April 2013.

Information on the Nationwide Health and Disability Advocacy Services is provided in the appropriate language in admission information, with the poster and brochures displayed and available at the entrance. The advocate last provided education on the Code in April 2013.

The relevant ARC rest home requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service has a Maori Health Plan and standards and Tikanga Best Practice to guide staff actions. At the time of audit there are three residents who identify as Maori. The service's protocols and practices for welcoming new/prospective Maori residents clearly identifies the organisation's commitment to providing culturally appropriate services and ensuring an atmosphere of cultural safety within the facility. Prospective residents are asked to identify any cultural beliefs and values which they choose to have acknowledged as part of the initial meeting and information gathering. Policy states Maori residents’ wellbeing and satisfaction will be monitored using an interpersonal approach and through a client questionnaire to determine the satisfaction of the resident and their whānau with the services provided. Wherever gaps are found in service delivery as a result of such monitoring the service will take action to improve the services provided to the necessary standard. The external cultural advisor last conducted education in April 2013, this include the Treaty of Waitangi, Maori health and cultural needs during death and dying.

Protocols identify that when requested, the service will provide Kaumatua from the local marae to liaise and speak in te reo Maori with the resident and their whānau. The cultural pan is sighted for one of the residents who identify as Maori, this plan identifies the resident’s Iwi, tribe and the contact if a Kaumatua is needed for advice and support. The cultural plan has the patient's cultural wishes for when they die.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The cultural safety policy states assessment of significant cultural beliefs, values and practices are undertaken. During the pre-admission process and assessment on admission the RN ascertains the impact of the person’s cultural beliefs, values and practices on the provision of services to them and their families. There is in-depth information related to Asian and Pacific people’s cultural requirements to guide staff.

The seven residents' files reviewed record the resident's individual values and beliefs. Interviews with the residents report they are treated with respect and dignity that is appropriate to their cultural needs. All residents and family interviewed expressed satisfaction with the care provided which reflects their individual values and beliefs.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

The facility manager, owner/director and RN report that discrimination and harassment of any nature will not be tolerated in the service. Any harassment that comes to their attention will be taken seriously and appropriate action will be taken. Harassment may be considered serious misconduct. The organisation's policy clearly identifies the procedures to be taken should a complaint related to any form of discrimination or harassment occur.

The five of five caregivers interviewed demonstrate knowledge on the signs of abuse, neglect and discrimination. The six of six staff records (one RN, three caregivers, one cook and one cleaner) reviewed have position descriptions that include professional boundaries. There are no instances recorded of discrimination. As observed on the day of audit professional boundaries are maintained for the well-being of the residents that still encourages a friendly and home like environment. The six of six residents and two of two family interviewed have no concerns with discrimination and speak highly of how they are treated by all staff.

The relevant ARC requirements are met.

**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

The service identifies actions taken to ensure residents receive appropriate services in an environment that encourages good practice. This includes evidence based practice as per policies and procedures. Evidence-based practice is observed, promoting and encouraging good practice (evidenced in interviews with the facility manager, owner/director, RN and five of five caregivers). Examples include policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services, gerontology and palliative care services. The gerontological nurse practitioner and mental health team are available for consultation regarding residents who are referred for additional care advice. There is regular in-service education and staff access external education that is focused on aged care and best practice. The service accesses aged care education through the DHB study days. The six residents, two family and GP interviewed expressed high satisfaction with the care delivered.

The relevant ARC requirements are met.

**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

The Open Disclosure policy is easy to read and available to all staff. The cultural policies identify that wherever necessary interpreter services will be provided. There is a list on approved interpreters displayed in the entrance corridor.

The two of two family member interviews confirm they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure is documented in the family communication sheets, on the accident/incident form and in the residents' progress notes (evidenced in seven of seven residents' files). The family member of the past resident for whom a coroner’s inquest is to be undertaken, reports high praise for the actions of the service in keeping them informed.

The relevant ARC requirements are met.

**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

The informed consent policy is clearly documented and in accord with the rights six and seven of the Code of Health and Disability Services Consumers' Rights. The situation where general written consent is required is defined and includes outings, photos, treatments, and sharing of information with other health professionals.

Advance directives allow for the quick identification of competency and resuscitation status of all residents. One advance directive sighted has not been signed by the resident, however this was completed on the day of the audit (refer # 1.3.3).

 Residents' records, and interviews, confirm they receive good information, choice is given and the required general consent forms are sighted in the seven out of seven records sampled. Resident choices regarding day to day care and support are well documented in the care plan.

The relevant ARC requirements is met.

**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

 Advocacy and support service information is shown in policy and procedures. The service actively encourages residents to participate fully in determining how their health and welfare is managed. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client information booklet and with the brochure available at reception/entrance to the service. The six of six residents interviewed confirms they are informed about the advocacy service and their rights. The five of five caregivers interviewed confirm the advocate visits the service, with education last provided by the advocate in April 2013.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Several of the residents are observed independently and/or with the accompaniment of visitors going out into the community. There are no set visiting hours and family are encouraged to visit or have their family member visit home if possible. The six of six residents and two of two family confirm unrestricted visiting hours. There are church services conducted at the facility and residents are welcomed to access their own spiritual advisors.

The relevant ARC requirements are met.

**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

Complaints management is explained as part of the admission process. It is fully described in policy and shown in the resident welcome book. The facility manager includes the right to complain as part of the admission discussion and the service respects the resident's right to make a complaint. A copy of the complaints forms are located at the sitting area near the entrance.

The complaints register identifies that in 2012 and 2013 there have been three complaints made of a minor nature in 2012 and nil recorded for 2013. All complaints show in detail the corrective actions taken, by whom and that they have been resolved to the complainant's satisfaction. Corrective actions are put in place as required. The complaints register has the dates, complaint advocacy offered, nature of complaint, resolution and the date the complaint is closed.

The facility manager reports there is currently a coroner’s inquest into the sudden and unexpected death of a resident. The facility manager reports the service has yet to receive any feedback from the coroner. The family report that they have high praise for the manner in which the service cared for their mother, how the staff have kept them informed of the sudden death and the support that the service has provided to them.

Interviews with two family and six residents confirm their understanding of the right to make a complaint. Monthly resident meetings are used as a forum for residents to voice any concerns. The standing agenda for the residents meetings includes suggestions and complaints (minutes sighted).

The relevant ARC requirements are met.

**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

There is a current 2013-2014 business plan which describes the mission, philosophy and annual goals which are also reflected in the quality management system sighted. The plan documents the organisations goal to add hospital level of care to the service delivery.

The owner/director is a New Zealand registered nurse (RN) who has many years’ experience in the sector. They have full authority and accountability and oversees all business decisions.

The owner/director (RN) is supported by a facility manager. There is an organisational chart and documented delegation of authority. The facility manager is a full time position with responsibilities for day to day service delivery. The facility manager has previous and current experience in the management and the personal care of older residents. The facility manager is supported by registered nurses to provide the direction and authority for the clinical care. The facility manager has over 16 years of aged care/mental health experience and has been managing this rest home since it opened seven years ago. Interviews with the owner/director, RN on duty and with four caregivers confirm that the manager is competent and very supportive of staff at the facility. The facility manager has a job description and maintains individual training records. The facility manager has a current first aid certificate and participates in on-going education in the management of care services (over 8 hours in the past 12 months). The roles of the facility manager, owner/director and RN are clearly defined

Interviews with five of five caregivers confirm that residents are adequately cared for in respect of their everyday needs and services. The GP also expressed high satisfaction with the quality of care proved at Karetu House and expressed the staff have a 'high level' of clinical skills and knowledge.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

 When the facility manager is away the owner/directors and the RN undertake all requirements of the role. The RNs have experience in the management of residents with mental health issues. The facility manager ensures the RN has adequate training, skill and experience to undertake the role. The owner/director (RN) and nine staff interviewed confirm there are suitably qualified staff who perform the facility manager's role in temporary absences. The management team are suitably qualified to manage services to meet the needs of rest home level of care with a focus on residents with a history of mental health issues and/or diagnosis.

The six of six resident and two of two family/whānau interviews confirm that all services are delivered in an efficient manner that meets all their needs.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The quality plan and policies and procedures sighted identify the organisation's quality and risk management systems. The quality and risk programme for 2013 includes:

-Incident/Accident Review

-Risk Management Plan Review

-Business Plan Review

- Internal audit programme into key aspects of service delivery, resident care, health and safety, and infection control

- Medication Competencies

- Annual Complaints Review

- Dietitian Report

- Annual Infection Control Review

- Annual Restraint Minimisation Review

- Family Satisfaction Survey

- Complaints Residents Feedback

- Resident Food Satisfaction Survey

This policy and associated risk management plan provides a framework for the identification and management of risk exposure to the overall operations of the service. There are systems and processes in place to minimise risk exposure. Interviews with staff and management identify their understanding and implementation of the quality and risk systems as stated above. All actions taken are used as opportunities for improvement and staff are kept well informed of corrective actions put in place.

The quality programme includes the scheduled internal audit programme. Where areas for improvement are identified from the internal audit the service completes a quality improvement report form (corrective action). The quality improvement report includes the area for improvement, corrective actions already undertaken, further action planned and the name of the person to complete the action, the review of the corrective action and if further improvement/actions are required.

The service has a system in place which ensures policies and procedures are kept up to date and that they are reflective of current good practice and meet legislative requirements as confirmed in policies sighted. The system includes the removal of obsolete documentation. When new policies or procedures are introduced staff are informed and educated as required.

Key components of service delivery are discussed at staff and management meetings and include overall resident care, restraint, health and safety which incorporates incidents and accidents and any newly identified hazards, audit results, infection control, compliments and complaints, quality improvements, policy reviews, education and general business. This is confirmed in meeting minutes sighted and at interview with the five of five caregivers.

The service has a current risk and hazard register which covers all aspects of service delivery. The documentation includes the date a hazard or risk is located, the significance and the rating of the hazard, if it has been eliminated, isolated or minimised and the actions put in place to ensure consumer and staff safety. The frequency of monitoring risks is well documented and the facility manager has a system in place to ensure reviews are undertaken to meet timelines. There is a three monthly environmental, infection control and health and safety inspection of the service. All issues are discussed at monthly staff meetings as confirmed in minutes sighted. Significant hazards are reported to the owner/manager.

Quality improvement data is analysed, evaluated and used as an opportunity for service improvement. Residents and staff are kept very well informed and involved in this process. Quality improvement data is very well documented and identifies that all corrective actions are monitored for effectiveness and outcomes are measured prior to any completion sign off. Documentation identifies that this process is reported at all levels of the service.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

Documentation, policy and procedures are up to date and cover all required aspects of adverse event reporting. The facility manager and owner/director and management can verbalise their understanding of their responsibilities with regard to reporting adverse or unplanned events and who notification must be made to for a serious adverse event, such as an infection control outbreak or a serious injury event.

The nine staff interviews identify that incident and accident forms are used to report any adverse event and that they are reported to the RN and/or manager. A review of 2013 incident and accident forms shows that incident and accident information is used as an opportunity for improvement. The accident/incident forms sighted for March 2013 indicates and increase in falls, with the analysis indicating that two residents had multiple falls over this time. The falls prevention strategies are recorded in the accident/incident report for March 2013. There is an additional quarterly report and analysis of the accidents and incidents. The January to March 2013 quarter reviews the falls and the preventative strategies that are implemented.

The relevant ARC requirements are met.

**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 human resources documents and policies sighted meet legislative requirements. Job descriptions are sighted for the privacy officer, manager, registered nurse, caregiver, diversional therapist/activities coordinator, cook and cleaner. They all identify role, responsibility, accountability and scope of practice. The induction/orientation for new staff includes health and safety, incident reporting, hazard identification, safe use of gloves, medicine management, infection control, managing challenging behaviour and communication. The service has a comprehensive plan for on-going education for staff over a two yearly cycle.

There is a system in place to record annual practising certificates for staff who require them. The service has due dates recorded for staff practising certificates noted for all staff and contracted professionals that require a practising certificate. A review of six of six staff files and staff interviews confirm that the orientation process prepares staff for the roles they undertake. First aid qualification is part of the on-going education programme. The aging process is part of the induction handbook and there are refreshers annually. There are on-going study days that the service accesses through the DHB. Medication competencies are undertaken annually and new staff are orientated to the role and unable to give medications till they are confident and assessed as competent. The five of five caregivers interiewed report they receive good support for ongoing education. The six of six residents report they recieve a good quality of care.

Staff file reviews and the training schedule sighted for 2012 and 2013 identifies the services education plans and records all education provided. Education is undertaken onsite and offsite and is presented by specialist providers as is appropriate. Staff are encouraged to attend education both in-house and off site related to the roles they perform. The annual infection control programme covers hand washing, standard precautions, transmission based precautions, PPE, needle stick injuries, staff illness, hazardous materials, waste management and specimen collection. The infection control education is last conducted in February 2013. Restraint minimisation, challenging behaviours, mental health issues, dementia and de-escalation techniques is last conducted in August 2012.

The relevant ARC requirements are met.

**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

Policy clearly sets out the process to determine service provider levels and skill mix to ensure safe service delivery. There is a RN on duty morning shift Monday to Friday. The RNs share an on call roster for clinical issues, with the facility manager on call for non-clinical issues. The review of six weeks rosters confirm that the following numbers of care staff are on duty each shift:

- morning shift (7am to 3pm) : three caregivers (one who finishes at 1 pm), with one extra caregiver on duty Tuesdays and Thursdays

-afternoon shift (3pm to 11pm): three caregivers (one who finishes at 8pm

-night shift (11pm to 7am): two caregivers.

 There are adequate housekeeping, kitchen staff and a diversional therapist to meet the needs of the residents. All shifts are covered by at least one staff member who holds a current first aid certificate, with all but one new staff member not having a current first aid qualification. All staff undertake appropriate education and training to undertake their roles. If staff are off work for any reason the person is replaced.

The six of six residents interviewed report that there are adequate staff rostered that meets their needs.

Verification:

There are adequate staffing levels to provide care to the proposed increase of three residents.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

The Document Control policy identifies how health information meets legislative requirements and relevant professional and sector Standards.

As observed, resident information is stored and filed to ensure it is not on public display. The caregivers complete progress note entries each shift (confirmed in the seven of seven residents files reviewed and interview with the five of five caregivers). The progress notes record the date, name, signature and designation of the staff member. There is a corrective action request made at 1.2.9.1 regarding the consistency in the identification, dates and signatures on forms.

The Aged Related Residential Care (ARC) service agreements of D7.1 are partially met. The other ARC requirements for rest home level of care are met.

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

The seven resident files reviewed have resident information that is managed in an accurate and timely manner. In the seven files there is inconsistent recording of the resident's identification on each page. For example the front page of the care plan has the patient identification recorded, with the other pages not recording the resident’s identification. There are a number of forms and assessments that do not record the date that the assessment has been conducted and or/have a signature. The progress note entries do record the date, time, name, signature and designation of the staff member.

**Finding Statement**

There is inconsistent recording of client information and recording of dates on the clinical tools, assessments and care plans sighted.

**Corrective Action Required:**

Ensure there is consistent recording of patient identification on each page of their record and ensure forms are consistently dated and/or signed.

**Timeframe:**

6 months.

**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

The service operates twenty four (24) hours per day seven days per week. The entry criteria, assessment and entry screening processes are clearly documented. Information about the service is readily available on the Ministry of Health and Eldernet web sites. Referring agencies are fully informed of bed availability and the uniqueness of the resident group.

All residents are required to be assessed as requiring rest home level care only and this is evident in resident records sampled. Evidence of the completed admission documents is also sighted.

The related ARC requirements are met. Full details regarding the resident's right to receive additional services is included in the resident agreement.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

There is an adequately documented process for the management of any declines to entry and waiting lists. There is currently five potential residents on the waiting list. Records of enquiries are maintained and, in the event of decline, information is given regarding alternative services. Pre-entry criteria forms are used to assess eligibility. Prioritisation is based on the best fit with the service and the needs of the other residents. Reasons for refusal are clearly stated. The Facility Manager is observed in discussion with a referrer on the day of the audit, and confirms sufficient communication is provided regarding eligibility and 'best fit' with the service.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

Residents' and staff files sampled confirm that each stage of service provision is completed by a suitably qualified person. All assessments and care plans are developed and reviewed by a registered nurse. Daily interventions and support with activities of daily living are implemented with the help of trained caregivers and the diversional therapist.

Timeframes for service delivery are defined and met as evident in seven out of seven residents' files sampled. An initial assessment is performed on admission by the registered nurse and a medical assessment conducted by the GP within forty eight hours, unless the resident has been discharged directly from an inpatient setting. An initial care plan is developed and implemented for the first week to guide staff. Following this the long term care plan is developed and implemented to meet the identified needs and goals of the resident. Behaviour management plans and short term care plans are also developed as and when required and care plan reviews are completed (at a minimum) every three months. GP reviews are also completed every three months. The GP interviewed confirms his involvement in specialist referrals and medication reviews and states that he is always contacted regarding any concerns in a timely and proficient manner.

Continuity of care is maintained. For example, GP entries and visits from allied health providers are sighted. A number of residents (16) have a mental health diagnosis so the service works closely with mental health services. This is evident on the day of the audit. Two staff from mental health services are visiting to review the psychiatric needs of one resident and assess for possible discharge. Daily handovers between staff also ensures continuity. During the audit one handover is observed and confirms accurate and comprehensive information is communicated. In addition, the two registered nurses maintain a communication book and both share a morning duty once per week to ensure continuity of information. Residents' files are integrated and contain a section for allied health reporting.

The relevant ARC requirements are met. Care plans are comprehensive and include physical, spiritual and cultural abilities, deficits and expected outcomes.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

The registered nurse completes a number of assessments on admission inclusive of falls, pressure, risk, behaviour, nutritional, continence (where applicable), pain (where applicable) and a values and beliefs assessment. Additional assessments sighted within the file sample include the medical assessment completed by the GP, the activities assessment completed by the diversional therapist, a mini mental state assessment (completed where applicable) and a response to medication assessment (as requested by mental health services). Base line observations are also recorded on admission, and there after monthly (or more frequently if required).

The required (and appropriate) assessments are sighted in seven out of seven files sampled. The results of the assessment process are transferred onto the long term care plan with outcomes and goals documented. Assessments are reviewed by the nurse and updated, as required, to reflect the current status of the resident (refer # 1.3.3). Residents interviewed report involvement in the assessment process and there are adequate areas within the facility to ensure assessments are conducted in private.

The relevant ARC requirements are met. Long term care plans sighted have been completed within three weeks of entry. Assessments sighted are commensurate with that of the needs resident.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

An initial care plan is developed on admission and a long term care plan developed within two weeks. The long term care plan is developed by the registered nurse and includes individualised goals and related interventions. A new care planning format has recently been implemented (May 2013) and is an improvement on the previous version, which tended to document by exception only. The new format is more comprehensive and goal focused, and includes the required domains as specified within ARC.

 Interventions sighted are consistent with assessed need and good practice. The required level of dependence is documented for each goal. Current care plans are sighted in all seven residents' files, including four from the new format. Short term care plans are developed when required. A number of short term care plans are sighted within the sample. For example, in the event of infections, wounds or escalating behaviour. Short term care plans are reviewed regularly and closed out when discontinued.

Residents' files sampled evidence integration. Currently sections exist for care, progress, correspondence, medical notes, adverse events, consents, laboratory results, NASC correspondence, referral agencies, DHB letters and medical specialists records. Staff interviewed confirm they have access to residents' records and were sighted completing their progress notes on the day of the audit.

The relevant ARC requirements are met. Initial assessments are completed on admission and residents and family confirm input in the development of health care plans.

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

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

Interventions are documented for each goal on the care plan. Interventions sighted are commensurate with current needs and desired goals. Interventions are detailed and documented clearly to guide staff. The GP interviewed is satisfied that clinical interventions are based on good practice and implemented in a timely and competent manner. For example, a review of wound management confirms good success with healing and behaviour management plans confirm appropriate actions in the event of escalating behaviour. The required blood tests are conducted to assess for toxicity and nursing 'alerts' highlight any specific interventions for clinical risk.

Interventions from allied health providers are also included in care planning. For example the six weekly visits from the DHB podiatrist and instructions on blood sugar monitoring as requested by the diabetes specialist nurse.

Residents are encouraged to be involved in developing realistic and optimal levels of functioning to meet their own everyday living needs/goals and to maintain independence. (refer # 1.3.3).

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The activities programme provided at Karetu House is of a high standard and reflects that independence is encouraged and choices are offered. The diversional therapist coordinates the programme and is on site three days per week. In her absence, the programme is fully implemented by management, staff and volunteers. A range of relevant resources has been developed and is accessible for all staff. This provides evidence based programmes and information which ensures the programme is implemented in an effective, efficient and continuous manner.

The diversional therapist completes a case study for each resident, which identifies personal interests and hobbies, from which a goal plan is developed. Activities are then planned to help maintain skills and interests. Individual activity goals are reviewed every three months with a comment regarding achievement and outcome.

Residents interviewed speak highly regarding the variety of activities and outings that are provided. Preferences are considered and interests maintained. For example residents are observed participating in a wide range of in house activities during the audit, a number of residents attend regular community day groups, there is 98% participation in the Tai Chi group and two bus outings occur every week. Residents are also fully supported to access the community independently and continue with personal interests.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Three monthly care plan reviews, as stipulated in the care planning policy, are occurring routinely as required. Reviews are documented on the long term care plan, which is then updated if required. In addition, daily progress notes are completed by the caregivers which assess daily response to interventions. Any changes to support interventions are documented to enable the resident to attain their goals or to work towards goals if not already attained. Short term care plans are also evaluated as required. Additional reviews include the three monthly medication review by the GP and psychiatric reviews by the community mental health team, as required. Residents interviewed and two family members state they can are involved in the care planning and review process (as appropriate).

The relevant ARC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The GP interviewed states that resident support for access or referral to another health and disability provider is facilitated in a timely and proficient manner. The GP confirms his involvement in the referral process.

The Facility Manager states that a formal referral process exists which includes the identification of risk and involvement of family (if available). Evidence of recent referrals is included in the sample. Examples include a referral to the diabetes specialist nurse, discussions regarding the involvement of community nursing for the management of ascites and involvement with the Community Alcohol and Drug Service (CADS) .There is also evidence of involvement with crisis mental health services as required.

The ARC requirements are met. Residents interviewed state they have access to the community and allied health services of their choice.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

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

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

Planned discharges or transfers are preferable and conducted in collaboration with the resident and family (if available) to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner and that the needs of residents are paramount. There is also a defined, and well implemented process, for the management of emergency transfers to inpatient services. An example of which occurred the day before the audit.

In the event of a discharge/transfer the resident's records are copied and necessary data transferred with the resident. The GP interviewed confirms his involvement in the discharge/transfer process.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

There are adequately documented policies and procedures for all stages of medicine management. Policies reflect current legislative requirements and safe practice guidelines. Standing orders meet the 2012 guidelines.

A blister pack medication system is implemented. All medicines are prescribed by the GP using the pharmacy generated medication chart. The service has one prescribing GP for medical needs. Additional medications (for example those under psychiatric or alcohol and other drug services) are prescribed by the appropriate authority. All medication charts include photo identification and allergies. Three monthly medication reviews are evident in all 14 medication records sampled.

Medications are checked by the registered nurse on entry to the facility. This includes blister packs, non-packaged medication and intramuscular injections. Records are maintained, including the use of an IM medications signing sheet for traceability.

Non-packaged medications is safely stored in a locked medication cabinet in the nurses office. A small medication fridge is provided and the temperature maintained in line with storage recommendations. Daily medications are administered from a secure medication trolley. There is a small locked and secure metal box in the medication cupboard which is used to store controlled drugs. There is currently one resident on controlled drugs. The required drug checks of controlled drugs are evident, including the six monthly check conducted by the pharmacist.

All medications are labelled per person. On the day of the audit there is a small supply of left over paracare and laxsol which is yet to be returned to the pharmacy. These are bagged up and removed from circulation to avoid usage.

Medications are administered by staff assessed as competent. Competencies for medicine management and administration are monitored by the registered nurse and include the administration of insulin. Records are sighted to verify the process and a lunch time medication round is observed which confirms administration is safely maintained. Administration records are complete and signed as required. Signatures are checked against the current specimen signature list. Records of response to medication are also maintained. This includes a checklist for monitoring anti-psychotic side effects which is completed when requested by the community mental health key worker.

There are a number of residents who are self-administering lotions/creams. A copy of the required competencies is evident, including GP approval.

Medication errors are reported and investigated. Records of the past three months of medication errors are sampled. This includes the process for recording refusals to take medication. It is noted there is one resident who is consistently not taking his full dose of daily medication, and this has not been included within the medication errors process. An improvement is required.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

One recently admitted resident is not taking his full dose of medication as prescribed. The resident is prescribed xxxxxxxxx to be administered in the morning and in the evening. The xxxxxx is prescribed by CADS. In addition the GP has prescribed the resident xxxxxx for pain. The resident is taking the morning xxxxx as prescribed, but does not present to staff for his evening dose. Instead he is requesting, and receiving, prn xxxxx. Failure to request, and be administered, his evening xxxxx is not being recorded as a medication refusal and is resulting in a large supply of stored xxxxxx.

**Finding Statement**

Not all medication refusals are recorded. For example: there is one resident who is not taking his second daily dose of regular medication).

**Corrective Action Required:**

Provide evidence that the resident is taking his medication as prescribed and that all refusals are recorded and collated through the medication error process.

**Timeframe:**

3 months

**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

Residents are provided with a well-balanced diet which meets their cultural and nutritional needs. The menus have been reviewed by a registered dietician and confirm they are appropriate for the needs of the older person. Deviations from the menu, occurring as a result of the availability of fresh produce, are recorded.

Nutritional assessments are completed on entry. Special dietary needs are identified and the cook confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident. Residents are weighed monthly and confirm nutritional needs are being sufficiently addressed. Where required, any additional nutritional support is clearly documented in care plans and appropriate interventions implemented. This includes referrals to the diabetic specialist nurse regarding the one insulin dependent resident. There are no residents requiring nutritional supplements and the GP monitors health needs at each review. All residents interviewed are very satisfied with the food. The meal service is observed on both days of the audit. Meals are well presented and sufficient in quantity.

The cook is interviewed and has the required food safety qualifications. Nutrition and safe food management policies define the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers and records of temperature monitoring are maintained. Guidance is provided for staff on defrosting, environmental cleaning, storage, minimising risk of contamination and food hygiene principals.

The ARC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

Safety data sheets are visible in all areas in which chemicals are kept. Chemicals are stored in secure areas when not in use. All chemicals sighted are in their original chemical bottles which have labels that show appropriate first aid instructions.

Disposable gloves, masks, and goggles are sighted. Interview with the housekeeper confirms they can access PPE at any time and they can verbalise appropriate use. Staff are observed using disposable gloves as required. Management of waste and chemical spill management is included in the infection control and hazard management education, last conducted December 2012.

Waste is removed from the facility by a contracted company on a weekly basis as well as by the council rubbish collection service. Approved yellow sharp bins are available for the safe disposal of sharps. They are kept in a locked cupboard that can be accessed by staff when required.

 The relevant ARC requirements are met.

**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

All processes are undertaken as required to maintain the service building warrant of fitness. The current warrant of fitness expires 25 June 2014. Electrical safety and medical calibration checks sighted, last conducted March 2013. Carpet cleaning is undertaken by the housekeeping staff on a scheduled basis. Biomedical equipment is either purchased new within the last 12 months (March 2013) or has a verification/calibration inspection that is conducted at least annually (last conducted March 2013).

The physical environment minimises risk of harm and provides safe mobility by ensuring the flooring is in good condition, the correct use of mobile aids and walking areas not being cluttered. There is a three monthly environmental, health and safety and infection control inspection and a hazard register. There is a planned and reactive maintenance plan, in which staff identify areas that require maintenance (maintenance folder sighted).

The hot water in resident areas is checked monthly, the temperature recordings sighted are 45 degrees Celsius or below.

Residents have access to outdoor areas with seating and shaded areas. Interviews with six residents and two family/whānau members confirm the environment is suitable to meet their needs. Residents are observed walking around safety both independently and with the use of walking aids.

Verification:

The three single rooms have been converted to double rooms. There are two beds in each of these rooms (room numbers 1, 19 and 21). There are privacy curtains to provide visual privacy for each resident. At the time of audit the call bells are being installed in the additional bed room spaces. Refer to CAR at 1.4.7.5.

The relevant ARC requirements are met.

**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

The facility has adequate numbers of accessible toilets and showers located centrally on both levels. There are separate staff and visitor toilets. Doors can be locked for personal privacy and to indicate the room is in use. There are signed male and female toilets in shared areas. The service have seven double rooms with ensuites and an additional six toilets and four showers. The six of six residents report there are adequate toilet and showering facilities that meets their needs.

The relevant ARC requirements are met.

**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

The service currently has a mix of double and single occupancy rooms. This includes the recent conversion of three of the single rooms to double rooms, each of these rooms have sufficient room for each residents' personal effects and bed space. Each of these rooms has dividing curtains and call bells in each resident’s' sections. Bedrooms sighted allow residents, with or without mobility aids, to move around safety. Interviews with six of six residents and two of two family/whānau confirm they are happy with and can personalise their personal bedroom space.

**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 physical environment is looking tired but it provides safe, age appropriate and accessible areas to meet residents' needs. Residents are free to move around the facility as they wish. There are two dining areas and three lounge areas. Activities are undertaken in the lounge and dining areas as observed on the days of audit. The six of six residents and two of two family/whānau interviews confirm their satisfaction with the facilities provided.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

All cleaning and laundry processes are set out in policy. Cleaning materials are stored in secure areas. Mops are placed outside to dry in an area that is not used by residents.

The main laundry has a clean to dirty flow. The laundry audit undertaken in March 2013 has no areas identified for improvement. The cleaning audit conducted March 2013 had areas of improvement, with the corrective actions identified, implemented and signed off as completed.

Interviews with six of six residents and two of two family/whānau confirm they are satisfied with laundry and cleaning services.

The relevant ARC requirements are met.

**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:** PA Low

 A review of six of six staff files and education documentation identifies that fire evacuation and emergency training is undertaken six monthly. All current staff attended the education and fire evacuation undertaken in December 2012. The approved evacuation scheme is dated 24 July 2000. Inspection of emergency equipment and lighting, fire alarms and sprinklers are carried out monthly by a contracted company. Emergency lighting lasts up to three hours. This meets legislative requirements for the building warrant of fitness requirements. Fire equipment was checked in October 2012. Smoke detectors are linked to a fire panel located in the manager’s office and sprinklers are linked directly to the fire service. The facility manager confirms there is a gas BBQ available if required. All staff have current first aid certificates.

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

The call bell system is audible throughout the facility and there is a panel to identify where the call has been made. Interviews with six of six residents confirm staff respond in an appropriate timeframe if the call bell is activated. Monthly call bell audits are undertaken to ensure all call bells are working. There are security cameras located in the external areas of the building.

Verification:

The call bells are not installed into the reconfigured rooms at the time of audit. Written communication with the electrician evidenced that these are planned to be installed in the week commencing 12 August 2013. A corrective action request is made to ensure each resident in the reconfigured rooms have access to a call bell.

The relevant ARC requirements are met.

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

The call bells are not installed into the reconfigured rooms at the time of audit. Written communication with the electrician evidenced that these are planned to be installed in the week commencing 12 August 2013. A corrective action request is made to ensure each resident in the reconfigured rooms have access to a call bell.

**Finding Statement**

Call bells are not yet installed for the extra beds in the reconfigured rooms at the time of audit.

**Corrective Action Required:**

Ensure there is an appropriate call system in the reconfigured rooms.

**Timeframe:**

Prior to occupation of the beds.

**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

All residents' bedrooms have large opening windows that allow natural light and ventilation. The facility is centrally heated. Interviews with staff, six of six residents and two of two family/whānau confirm the facility is kept at an even temperature throughout the year. There are designated smoking areas outside. The inside of the facility is smoke free.

The relevant ARC requirements are met.

**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

Karetu House uses no restraints and no enablers. There is no evidence of restraint or enabler use during the audit. There are adequately documented guidelines on the use of restraints and enablers if needed. Definitions are congruent with the requirements of the Health and Disability Sector Standards and staff interviewed are aware of the correct definitions. There are also guidelines on the management of challenging behaviours and staff receive adequate training. An annual review of restraint and enabler use has been conducted in 2013.

The ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control programme is clearly documented and is suitable for the facility and the level of care provided. There is a designated infection control coordinator (registered nurse) and the responsibilities are clearly documented. Interview with the infection control coordinator and review of resident records indicate that an infection record is maintained for each resident documenting type, treatment and duration.

Adequate information, resources and on-going training are provided. The annual review of the programme ensures that infection prevention and control activities and processes are up to date. Infection control data is communicated to senior management. Residents, visitors and staff are protected from the spread of infection by use of signage, available protection equipment and alcohol based hand sanitizer, adequate outbreak management and pandemic planning and communicating relevant information and education at staff and resident meetings. In addition, flu vaccinations are offered to residents (35 out of 40 residents consented to a flu vaccination this winter).

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control programme defines appropriate responsibilities for the infection control coordinator and team that are appropriate for a rest home service. The coordinator confirms that designated space and time are provided for infection control management activities and resources. The infection control coordinator is a registered nurse with relevant skills and expertise to implement the programme. She reports to the Facility Manager and has access to current information relevant to the size and complexity of the facility including infection control manuals, internet and expert advice (as required). The Owner/Director is also a registered nurse who has a relevant infection control qualification.

ARC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

Documented policies and procedures are in place for the prevention and control of infection. The policies are appropriate for the facility and reflect current accepted good practice and legislative requirements. Policies and procedures are written in a user friendly format, contain appropriate level of information and are developed and reviewed annually in consultation relevant stakeholders. Policies are readily accessible to staff in service areas and identify links to other documentation in the organisation e.g. health and safety and quality and risk.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

Infection control education and training is provided during orientation and again in an on-going manner. The orientation training is provided by the registered nurse and external training provided by the DHB Infection Prevention and Control Specialist Nurse. The next training is scheduled for this month (August 2013). Records of attendance at the required training are sighted (refer # 1.2.7).

Adequate and appropriate information on hand washing and standard precautions is displayed in resident toilets and bathrooms.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

The infection surveillance programme is appropriate for the facility and the level of care provided. The surveillance programme has recently been extended to include standardised definitions and microorganisms. The use of antibiotics is monitored and infection rates are graphed to enable useful analysis. Additional data includes the identification and classification of infection events, indicators and outcomes. Surveillance data is collated both monthly and quarterly and confirm very minimal infections. Where a preventative response or corrective action is required, it is recorded and implemented. This is evident in the records regarding the management of cellulitis. Staff interviewed report they are made aware of any infections of individual residents by way of feedback from registered nurse and staff meetings. The Doctor is also informed if their resident has an infection.

**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:**