**Sandringham House Limited**

**Current Status:** **04-Mar-13**

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

**General overview**

Sandringham House in Oamaru is owned by a husband and wife team with one owner as manager and the other owner provides maintenance and resident support. Sandringham House is certified to provide rest home level care for up to 21 rest home residents. On the day of the audit, there were 19 residents. The service continues to implement a quality and risk management system and continues to apply the principles of continuous improvement. The owners are supported by a registered nurse with experience in aged care who provides clinical oversight to the facility. There is an implemented quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided. Improvements are required whereby: complaints and concerns are documented on a complaints register, corrective actions are developed around audit outcomes, initial care plans are completed by the registered nurse and within expected timeframes, aspects of medication management comply with best practice, decanted foods are dated and food temperatures are recorded, hot water temperatures are within expected limits and chemicals are stored securely.

The prospective new owners (husband and wife) are planning to manage the facility following transition into the service by the current owners/managers. One of the new owners is a registered nurse who has worked as a registered nurse at Sandringham for four years with many years' experience in community nursing. The other will work as a handyman and provide administration support. The new owners advised that they intend to run the home as a very family orientated rest home like the current owners. There is a plan to maintain current staffing, policies, procedures, quality systems and no environmental changes are envisaged at this time.

Taurima Resthome

Scovan Healthcare Limited

Surveillance audit - Audit Report

Audit Date: 16-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

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| **Provider Name** | Scovan Healthcare Limited |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Taurima Resthome | 85 B Clawton Street |       | New Plymouth |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| **Type of Audit** | Surveillance audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 16-Jul-13 **End Date:** 17-Jul-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXX | MBA MN B Ed, Lead auditor, RGON, Dip Tchg, Adv Dip Child and Family | 12.00 | 8.00 | 16-Jul-13 to 17-Jul-13 |
| Auditor 1 |       |       |       |       |       |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 1.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 12.00 | **Total Audit Hours off site** *(system generated)* | 9.00 | **Total Audit Hours** | 21.00 |
| **Staff Records Reviewed** | 3 of 14 | **Client Records Reviewed** *(numeric)* | 3 of 15 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 3 |
| **Staff Interviewed** | 6 of 14 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 3 of 15 | **Number of Medication Records Reviewed** | 10 of 15 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

# Declaration

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

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

Dated this 21 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Taurima Resthome | 30 | 15 |       | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Taurima provides rest home level care for up to 30 residents with 15 residents on the day of audit. The service no longer offers hospital care.

Residents and family members interviewed state that they are informed of key staff involved in the residents' care and all residents and family members spoke highly of the service.

The quality and risk management programme is implemented with management of complaints, incidents and accidents, monitoring of infections, implementation of an internal audit schedule surveillance of infections. The new owners have put new policies in place and these are being implemented.

Taurima is managed by the owner who is supported by an experienced registered nurse. The owner/registered nurse is on site three days a week and the clinical manager (registered nurse) is on site for the other days in the week. Staffing is stable and there is an implemented orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There are assessments and care plans completed for residents that document expected care and support. These are reviewed six monthly or as required when resident needs change.

Improvements required at the previous audit have been addressed. These include improvements to addressing issues raised by family, information for family, complaints, governance, the quality and risk management programme including new policies, human resources including training, assessment, care planning and review, medication, enablers and restraint.

One improvement continues to be required around review of the menu by the dietitian.

1.1 Consumer Rights

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs and family state that they are fully informed at all times. An interpreters policy is in place and external assistance is available if necessary.

The complaints procedure is provided to residents and relatives as part of the admission process. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed.Family state that they receive good information and that any concerns are addressed promptly.

Improvements required at the previous audit around addressing issues raised by family, information for family and complaints have been addressed.

1.2 Organisational Management

Taurima provides a quality and risk management programme that includes monitoring of incidents and accidents, review of complaints, implementation of an internal audit schedule and surveillance of infections. The service has new policies and procedures that are reviewed annually and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards.

The service has human resources procedures for staff recruitment. The orientation programme provides new staff with relevant information for safe work practice. There is an annual education schedule that is being implemented.

Staffing levels safely meet the needs of the residents with a clinical manager who is well known in the service providing 30 hours a week support and the owner/manager/registered nurse providing three days a week on site support and oversight.

Improvements required at the previous audit have been addressed. These include improvements to governance, the quality and risk management programme including introduction of new policies, human resources including training, contracts, performance appraisals and job descriptions.

1.3 Continuum of Service Delivery

The service has a documented assessment process and resident’s needs are assessed prior to entry. Assessments including use of specialised assessment tools and care plans and evaluations are completed by the clinical manager (registered nurse). Service delivery plans demonstrate service integration and are individualised.

Care plans are evaluated six monthly and the service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.

The activities coordinator provides an activities programme with activities are planned to cover five days of the week. The programme is varied and residents and family members praised the service for the activities provided.

The service medication management system follows the new policy and the GP monitors and prescribes medications.

Meals are prepared on site with a cook preparing all meals. Food and fridge temperatures are recorded weekly. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

Improvements required at the previous audit have been addressed. These include improvements to assessment, care planning and review and to medication.

An improvement continues to be required to dietitian review of the menu.

1.4 Safe and Appropriate Environment

There is a current building warrant of fitness. The facility is maintained by the new owner with no obvious improvements required to the building.

2 Restraint Minimisation and Safe Practice

There are clear guidelines in the new policy to determine what is a restraint and what is an enabler. The process of assessment and evaluation of enabler use is documented and implemented for residents using enablers. The service does not use restraint.

Improvements required at the previous audit around enablers and restraint are addressed.

3. Infection Prevention and Control

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the service. There are audits of the environment and health and safety audits. Infection control is linked into the quality improvement programme and there are improvements made to service delivery if required using surveillance data.

Summary of Attainment

* 1. Consumer Rights

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 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 | Not Applicable | 0 | 0 | 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 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:9 CI:0 FA: 3 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:8 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 | Not Applicable | 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 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 34): CI:0 FA:18 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 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 | Not Applicable | 0 | 0 | 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) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 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 | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Low | 0 | 2 | 1 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:5 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 51): CI:0 FA:14 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 | Not Applicable | 0 | 0 | 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 1 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:7 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 36): CI:0 FA:4 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 1 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 21): CI:0 FA:8 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 4 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 29): CI:0 FA:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 28 **CI:** 0 **FA:** 21 **PA Neg:** 0 **PA Low:** 1 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 54 **PA:** 1 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Scovan Healthcare Limited

Type of Audit: Surveillance audit

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

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.13 | 1.3.13.1 | PALow | **Finding:**The menu has not been reviewed by a dietitian for three years. **Action:**Provide dietitian review of the menu as planned.  | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Scovan Healthcare Limited

Type of Audit: Surveillance audit

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

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.3 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

D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. New policies have been put in place around privacy, confidentiality, dignity, respect and around laundry services noting the previous issues identified related to laundry services.

D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. Three of three family members state that laundry is better organised and that their family members clothing is with the resident. There have been no incidents or complaints since the new ownership. Residents state that they have a timely and accurate laundry service. All clothes are named. There is also a system including a designated area for any clothes that are not named and staff work to identify who these belong to.

Staff were observed respecting residents privacy and could describe how they manage maintaining privacy and respect of personal property.

Three of three residents interviewed and three family members state that staff are respectful and maintain resident’s privacy. Privacy training as part of code of rights training occurred in July 2012 and eight staff attended. This is booked for November 2013 with the Health and Disability Advocacy Service.

The resident initial assessments and care plans detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information on these documents and practice accordingly. All residents interviewed stated their needs were met. Cultural training occurred in March 2012 and twelve staff members attended. A Maori resident passed away in May 2013 and staff had training in conjunction with the passing of the resident. Staff and the owner/manager/registered nurse describe cultural awareness in practice with examples of cultural sensitivity e.g. the lounge was turned into a meeting /sleeping place, a spare room was the kai room, kawa kawa leaves were put up as a symbol of respect and staff who identify as Maori led the education for other staff. Pictures sighted demonstrate the adherence to cultural needs with the room and service blessed by the kaumatua.

Three of three resident files reviewed have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this.

There are various churches locally and residents are encouraged to attend these. Two residents attend their own church services. Multi-denominational services are conducted in the facility at least once monthly. All residents and family members interviewed indicated that resident’s spiritual need are being met when required.

D4.1a Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered. On interview three residents state they are regularly consulted by staff about their care and preferences and feel this promotes their independence. Three of three caregivers described how they encourage residents to engage in activities in the facility and to link with community activities including RSA and church groups.

There is a policy on abuse and the topic is covered at orientation and has been addressed at staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Abuse and neglect training last occurred as part of the code of rights training in July 2012 and the owner/manager/registered nurse states that Aged Concern is being booked for a workshop. Discussions with staff identified that there have been no incidents of abuse of neglect at the facility and three of three family members and three of three family members state staff are very approachable and friendly.

Improvements identified at the previous audit around investigating issues identified by family have been addressed and family also state that there is no evidence that clothing goes missing.

**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 1.1.9 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

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

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

D16.4b Three of three relatives state that they are always informed when their family members health status changes.

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

Accident/incidents, complaints procedure and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.

The registered nurse interviewed state that they record contact with family in the progress notes and this is documented in three of three files reviewed.

There is an interpreter policy and staff are able to access interpreting services if required. There are no residents currently requiring interpreting services.

Three of three resident’s state that they are kept informed and engaged at all times.

Improvements identified in 1.1.9.1 at the previous audit are as follows with evidence of completion of actions documented: a) Family not invited to residents review of care plans. Actions completed: In the three files reviewed, all have included resident’s participation in care planning and they decide if they wish family to be involved. b) Family not updated regarding doctors instructions and are not contacted regarding changes, issues or incidents. Actions completed: Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. 13 of 13 completed incident forms were selected for audit. The forms identify that family are notified of any incidents in 10 of the incident forms and the others do not have family or the incident was described as not requiring family being contacted as identified in the family signed list that indicates what they want to be contacted about. A page has been introduced into each resident file documenting significant issues and at each event, family are notified with this documented as sighted in three of three files. c) Resident and relative survey forms do not include dates on the forms, no evidence of corrective actions arising from forms and no documented analysis of the forms to determine if residents or relatives are satisfied with the service. Actions completed: The owner/manager/registered nurse states that the issues identified related to the previous ownership and the onsite and hands on addressing of issues that is currently taking place by the owners is already addressing the issues informally. The intention is to undertake a satisfaction survey by September 2013 and the intention is also to ensure that the new survey asks residents if the previous issues have been addressed. The survey form to be used has been sighted and includes privacy, dignity, rights, activities, food services, safety and security. d) The information pack does not contain the pricing of the service. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know,” is not included in the information pack. Actions completed: The MoH booklet is now included in the welcome pack as sighted for the new resident admitted. The agreement has been updated and the schedule includes all services covered and not covered by the service.

Improvements identified at the previous audit have been addressed including informing family members of incidents, analysis of resident and relative feedback and provision of the Ministry of Health booklet “Long-term Residential Care in a Rest Home or Hospital – what you need to know” with pricing of the service within the information pack.

**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 1.1.13 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

D13.3h. A complaints procedure is provided to residents within the information pack at entry. A new policy has been put in place that aligns with the code of rights. This includes information and a process to manage written and verbal complaints.

There is a complaints flowchart. Information around the complaints procedure is provided to resident/relatives at entry. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented.

Discussion with three of three residents and three of three relatives confirm they are provided with information on complaints and complaints forms. Three of three caregivers are able to describe the complaints process.

Three of three caregivers, the owner/manager/registered nurse and the clinical manager state that verbal complaints would now be documented noting that all state that there have been raised since March when the new owners took over. Issues raised in the previous audit relating to specific complaints include staff discussing medical information by phone with relatives with medical issues documented and if a GP was informed. Staff have been reminded in a staff meeting as confirmed the clinical manager, cook and two caregivers specifically asked.

The owner/manager/registered nurse states that the new complaints policy and process is in place and while there have been no complaints to date under the new ownership states that she is on site three days a week and provides oversight of the programme.

The improvements identified at the previous audit around documentation of verbal complaints, ensuring that the clinical manager informs family of key changes and addressing of complaints as per policy have been addressed.

**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

Taurima has capacity for 30 residents (noting that the only double room has been converted into a second small lounge) with 15 rest home residents currently in the service. The new owners have developed a business plan that includes goals, objectives and actions with identified responsibilities and timeframes. Currently they are working through the initial phases of identifying issues for improvement and are beginning to work through the plan.

The new philosophy is 'yes, we can do that for you'. This is documented in the policy manual.

Management meetings have been established with one already held in May 2013 and one scheduled for the week of the audit. All aspects of the quality programme are reviewed and a risk management plan documented is also reviewed through these meetings. The management meeting is attended by the owners and the clinical manager and any key staff as required. The May 2013 meeting minutes indicate comprehensive review. The owners also own a second rest home in Fielding and are following a standard process that includes follow up documented on the following meeting minutes (other rest home meeting minutes sighted as a model).

The service is managed by the owners with one of the owners (registered nurse) on site three days a week and the other providing support as required. She is supported by the clinical manager (registered nurse) who is designated as the manager for the other days of the week with the two taking the on call role.

Improvements required at the previous audit with corrective actions documented as follows: a) A long term governance framework is not documented. Actions completed: The governance framework is documented in the new policy manual with the structure described. b) Business plans and business risk management plan not current. Actions completed: The business plan which is the quality plan has now been documented and is reviewed through the management meeting.

ARC,D17.3di (rest home) The owner/manager/registered nurse states that she has maintained at least eight hours annually of professional development activities related to managing a rest home. The owner/manager/registered nurse states that she is supported by the clinical manager (registered nurse) who provides 30 hours a week support. She has maintained at least eight hours annually of professional development activities related to managing a rest home.

Improvements identified at the previous audit around governance and the review of the business plan and business risk quality management plan have been addressed.

**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:** Not Applicable

**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

Taurima has a newly established quality and risk management system. Interviews with the owner/manager/registered nurse, clinical manager, three caregivers, one cook, a recreation officer and a review of meeting minutes demonstrate a culture of quality improvements that have started with the new management. The owners have already put in place new policies and procedures based around eight service goals (actions and ways these will be monitored). Any internal audit is linked to the service goals. Quality indicators are reviewed at each monthly staff meeting and bi-monthly management meeting.

 Resident/family meetings are held monthly and allow residents to express any concerns.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The policies are ones used at the other rest home owned by the same owners and adapted to fit the service. Policies include the following: continence assessment and management, pain management and pain assessment form, skin management, wound care, a transport and transportation of resident's policy and death of a resident.

The service has a health and safety system. There is an internal audit schedule and internal audits are completed as per schedule. Action plans are documented on the form and these will be signed off by the owner/manager/registered nurse and/or clinical manager. The process is newly implemented and there has not been an opportunity to sign off corrective actions at this point. The set agenda for the meeting minutes indicates that there is a process for review of corrective actions and sign of resolution (meeting minutes sighted for the sister site include resolution of corrective actions). Audits are re-diarised if follow up is required. Resident/relative surveys are to be completed annually noting that the survey is documented to be offered by September 2013.

D19.3 There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. The hazard manager is up to date with evidence of resolution of issues.

D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and managing this population appropriately.

There is monthly accident/incident collation of data and monthly surveillance of infection reports. The service has linked the complaints process with its quality management system through the staff meetings.

Improvements identified at the previous audit around policies, review of the quality programme, corrective actions, hazard register and documentation and audit processes have been addressed.

**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

D19.3b; There is a newly implemented incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. A new form has also been introduced with sign off by the clinical manager and owner/manager/registered nurse.

The service collects incident and accident data. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the service quality programme and staff meeting minutes reflect a discussion of results.

13 incident forms were reviewed across the service and all demonstrated follow up by the managers.

There have been no serious incidents that have been required to be reported to specific authorities e.g. DHB, police, coroner since the new owners have taken over the service in March 2013. The owner/manager is able to describe the service responsibility in reporting incidents.

**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

D17.7d: There is an orientation programme that is relevant to the rest home and all files reviewed (three of three staff files) have signed orientation completed. All staff including the three caregivers state that they receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency. The clinical manager and the owners facilitate the workshops with some topics outsourced e.g. the Health and Disability Advocate and CPR training. A copy of the content and attendance records are retained.

Practicing certificates are sighted as being current for the clinical manager and owner/manager/registered nurse.

There are new recruitment policies in place including referee and police checks. Copies of interviews are kept on file.

Three of three residents and three of three relatives state that staff are knowledgeable and competent.

Three of the seven caregivers have completed ACE and two other staff are training.

Since the change of ownership the service has completed a significant number of training sessions including cultural awareness, privacy, confidentiality, documentation, CPR, medication competencies, a skills marathon with restraint, infection control, first aid, emergencies, health and safety, resident rights, medications. 90% of staff have completed all training.

Improvements identified at the previous audit are as follows with evidence of corrective actions: a) Job descriptions have been newly developed and are appropriate for staff roles. b) Two new staff (files reviewed) have documented orientation. c) All staff have copies of their current contract in their staff files. d) All performance appraisals are up to date including a three month appraisal for two new staff sighted. The clinical manager is working through a training programme relevant to her role. e) Training has been completed around wounds, pain, continence, restraint including challenging behaviour. f) There are implemented competencies for staff for medication - completed annually and these have all been redone since the new owners have taken over in March 2013.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

The new owners have established policies around the management of staff skill mix including contractual obligations and the acuity of residents within the service.

The owner/manager/registered nurse is supported by a clinical manager (30 hours a week). The owner/manager/registered nurse states that is on site three days a week with overlap of the two registered nurses. There is a recreation officer (25 hours a week), three cooks who cook all meals, one cleaner, one maintenance and seven caregivers. The clinical manager and owner/manager/registered nurse are on call. Staff are replaced if on leave as sighted on the roster.

Currently there are two staff on morning and afternoon shift (one full and one half shift) and one staff overnight. This meets the acuity needs and number of residents currently in the service. Three caregivers interviewed and the clinical manager state that there are sufficient staff on at all times.

Three of three residents and three of three relatives report staff are available to meet their needs and there are sufficient staff to provide support at all times.

Physiotherapy services are provided by an external provider when required.

**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:**

**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 1.3.3 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

D16.2, 3, 4: The three rest home files reviewed identified that in all three files an assessment was completed within 24 hours and files identify that the long term care plan was completed within the three weeks of admission as per policy. There is documented evidence that the care plan is reviewed by the clinical manager and all residents have a new care plan documented on the new care plan template. All care plans evidenced evaluations completed at least six monthly with evidence that they are reviewed more frequently when required.

D16.5e: Three of three resident files reviewed identified that the GP had seen the resident within two working days of admission following entry to the service.

A range of assessment tools are completed in resident files (new templates in place) on admission and completed at least six monthly including a pressure area assessment and falls risk assessment and management plan. A pain assessment is completed if required and there is a dietary assessment if there are specific needs. Dietary needs are documented on the initial assessment form and as part of the assessment completed with the care plan and review.

There is a new policy around monitoring food and fluid intake with clear strategies that would be documented as described by the clinical manager and the owner/manager/registered nurse. There are no residents losing weight on the days of the audit. the cook also described giving high calorie foods to residents losing weight if required.

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

Assessment documentation includes medical assessment and a holistic assessment that includes hygiene, pressure area care, elimination, fluid and food, mobility, oral hygiene, dressing, sleep/rest, communication, mental state/behaviour, manual handling, spiritual, psycho-social behaviour, pain management, cultural needs. There is an activities assessment including social history.

All files include assessment of pressure risks, falls risk, dietary assessment and continence assessment. Pain assessments are used if required and as described by the clinical manager. There are no residents currently using controlled drugs.

Three of three files reviewed have a nursing and medical assessment documented on admission that is completed in a timely manner as per policy.

The clinical manager and owner/manager/registered nurse have a sound understanding around the use of assessment tools and are both able to describe use of these.

Improvements identified at the previous audit around the use of specific assessment tools to identify risk of pressure areas and pain assessments have been addressed.

**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 1.3.6 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

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available with individualised products and resident files include a continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed through the DHB and this can be described. Continence management in-services and wound management in-service have been provided last in Feb 2013.

Wound assessment and wound management plans are not required currently in the service however a wound assessment and plan for a resident was sighted in the past as being well completed.

The clinical nurse manager interviewed describes the referral process and related form should a resident require assistance from a wound specialist or continence nurse.

Strategies to manage care requirements for all residents reviewed are documented.

The three caregivers and clinical manager interviewed state that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies and any miscellaneous items. On the day of the audit plentiful supplies of these products were sighted. Three of three residents and three of three relatives interviewed were complimentary of care received at the facility.

**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 programme is developed monthly and is normally displayed in the lounge after it has been completed (note that the activities coordinator has not been able to access a printer for the last month).

Residents have an activities assessment completed over the first few weeks after admission which includes identifying social relationships and behaviours as part of the nursing assessment, an assessment of resident abilities, special interests or hobbies, musical abilities, outside groups/activities.

D16.5d Three of three resident files reviewed identified that the individual activity assessment is completed and an attendance of residents at activities retained.

There is an activities coordinator who has been providing a programme in the service for 17 years.

Activities are age appropriate and are planned and reviewed by the activities coordinator with input from residents. There are programmes running that are meaningful and reflect ordinary patterns of life. There are also visits from community groups, engagement in the community, special events celebrated, physical exercises, intellectual activities etc.

On the day of audit, residents were observed being actively involved with a variety of activities in the rest home.

Three relatives state that residents can chose to engage in activities and those who do state that the activities are appropriate and engaging.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. This was sighted as being completed in three of three files reviewed.

There are short term care plans to focus on acute and short-term issues as sighted in files reviewed. Changes to the long term and daily care plans are made as required.

Three of three resident’s state that the care plans reflect their needs as noted when they talked about the cares they require.

Progress notes are documented at least at the end of each shift and as changes occur.

Residents state that they are involved in care planning and review.

**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 1.3.12 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:** FA

Medications are managed appropriately in line with accepted guidelines. There are medication management policies. These are comprehensive and clearly direct staff to their responsibilities in each stage of medication management. Six of six medication files reviewed indicate that all documentation is well completed. The lunch time medication round showed that the staff administer medication as per the policy.

Caregivers, the clinical manager and owner/manager/registered nurse administer medications in the rest home. Competencies are completed annually for caregivers and registered nurses who administer medications (all records sighted as being completed).

Medication profiles are legible, up to date and reviewed three monthly or earlier by the general practitioner and as needs arise with documentation in the medical notes indicating frequency of review.

Medications are stored in a locked room and a trolley is used to take medications out at lunch time as sighted on the day of the audit. Controlled drugs (CD) are stored in a locked safe in the locked cupboard - none currently in use in the service.

Medication charts have photo identification. There is a medication fridge and temperatures are checked (within range for 2013).

There is no evidence of transcribing in six of six medication files reviewed. There are no residents who self-administer medication.

Any expired or unused medication is sent back to pharmacy. Residents interviewed (three of three) state that they are given medications in a timely manner as per their prescription.

Eye drops are dated.

Improvements identified at the previous audit around fridge temperatures, individual bottles of liquid medication, medication checked on arrival, medication policies, controlled drugs, dating of eye drops and staff competencies around medication have been addressed. Ensure that staff competencies around medication are completed annually.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Policies on food service is developed and implemented. The cooking is completed by a one of three cook. Meals supplied include breakfast, lunch, dinner, morning tea, afternoon tea and supper. These meals are served at times that reflect community norms. Outside of regular meal times staff will provide a nutritious snack or drink if residents are hungry or thirsty. Extra snacks are provided when needed.

All residents (three of three) and family members (three of three) praised the meals which looked appetising and well presented on the day of the audit.

There are no food allergies at present and likes and dislikes are recorded on a white board in the kitchen. There is one vegetarian who is stated by the cook as asking for meat. The cook states that she gives the resident what she requests.

The cook takes the temperatures of fridge, freezers and cooked meats and these are within normal range for 2013.

There are adequate supplies of food in the event of an emergency for a month and the cook ensures that food is rotated.

The dietitian is booked to visit the service and review the menus. In the meantime, the owner/manager/registered nurse is providing oversight to the menu and ensuring that the cook cooks meals as per the menu. An improvement around dietitian review of the menu continues to be required.

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

Policies on food service are developed and implemented.

The cooking is completed by a one of three cook. Meals supplied include breakfast, lunch, dinner, morning tea, afternoon tea and supper. These meals are served at times that reflect community norms. Outside of regular meal times staff will provide a nutritious snack or drink if residents are hungry or thirsty. Extra snacks are provided when needed.

All residents (three of three) and family members (three of three) praised the meals which looked appetising and well presented on the day of the audit.

The dietician is booked to visit the service and review the menus. In the meantime, the owner/manager/registered nurse is providing oversight to the menu and ensuring that the cook cooks meals as per the menu.

**Finding Statement**

The menu has not been reviewed by a dietitian for three years.

**Corrective Action Required:**

Provide dietitian review of the menu as planned.

**Timeframe:**

3 months

**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 1.4.2 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

There is a current Building Warrant of Fitness was sighted as being displayed (expiry 29 September 2013). The lounge area is designed so that space and seating arrangements provide for individual and group activities and there are spaces for residents to have private conversations.

There is a safe and secure outside area that is easy to access. Three of three residents and the three family members state that the environment is well maintained and there are no obvious signs of areas requiring maintenance on the day of the audit.

**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 1.4.8 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:** Not Applicable

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The restraint management policy and staff state that enablers should be voluntary and the least restrictive option. There are three residents that chose to use enablers (bedrails) and restraint is not used in the service. Training around restraint and enablers was last held in March 2013 - training records sighted.

The new owner/manager/registered nurse has introduced new policies and these include a process for assessing the need for enablers. This is in use for residents using enablers.

The service no longer provides hospital level care and there are no restraints used in the service. At the previous audit, a cocoon was used as a restraint. This is no longer used. The new policies and procedures contain a comprehensive process for assessing, planning and review of any restraint used.

The previous improvement around enablers is addressed.

The previous improvements around restraint are addressed (2.2.2.1, 2.2.3.2, 2.2.3.4, 2.2.4.1, 2.2.5.1).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

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

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

The service no longer provides hospital level care and there are no restraints used in the service. At the previous audit, a cocoon was used as a restraint. This is no longer used. The new policies and procedures contain a comprehensive process for assessing, planning and review of any restraint used.

The previous improvements around restraint are addressed (2.2.2.1, 2.2.3.2, 2.2.3.4, 2.2.4.1, 2.2.5.1).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

The service no longer provides hospital level care and there are no restraints used in the service. At the previous audit, a cocoon was used as a restraint. This is no longer used. The new policies and procedures contain a comprehensive process for assessing, planning and review of any restraint used.

The previous improvement around enablers is addressed.

The previous improvements around restraint are addressed (2.2.2.1, 2.2.3.2, 2.2.3.4, 2.2.4.1, 2.2.5.1).

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

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

 (b) Following appropriate planning and preparation;

 (c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

 (d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

The service no longer provides hospital level care and there are no restraints used in the service. At the previous audit, a cocoon was used as a restraint. This is no longer used. The new policies and procedures contain a comprehensive process for assessing, planning and review of any restraint used.

The previous improvement around enablers is addressed.

The previous improvements around restraint are addressed (2.2.2.1, 2.2.3.2, 2.2.3.4, 2.2.4.1, 2.2.5.1).

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

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

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

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

 (d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

The service no longer provides hospital level care and there are no restraints used in the service. At the previous audit, a cocoon was used as a restraint. This is no longer used. The new policies and procedures contain a comprehensive process for assessing, planning and review of any restraint used.

The previous improvement around enablers is addressed.

The previous improvements around restraint are addressed (2.2.2.1, 2.2.3.2, 2.2.3.4, 2.2.4.1, 2.2.5.1).

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

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

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

 (c) Adverse outcomes;

 (d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 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 control policy includes surveillance and this describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control co-ordinator with support from the GP as required.

Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation includes graphs of incidents and results.

The staff meeting is the infection control meeting and this is appropriate to the size of the service.

Three caregivers and the clinical manager are familiar with how many residents have infections and improvements made as a result as required.

**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:**