**Avonlea Dementia Care Limited**

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

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

**General overview**

Avonlea Dementia Care provides dedicated dementia rest home level care for up to 54 residents and hospital level care in a small 10 hospital bed unit. On the day of audit, there were 47 residents across the five dementia homes and six residents in the hospital area.

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings. The service continues to maintain a continued improvement focus since previous audit. A number of education initiatives are implemented at Avonlea included specialist dementia training for staff and families.

The service is managed by an experienced aged care operations manager. She is supported by a clinical nurse manager, a stable staff and the management team at Dementia Care NZ.

There is one improvement required by the service around the medication fridge temperature.

The service is commended for achieving seven continual improvement ratings relating to family information and support, good practice, quality goals and quality initiatives, implementation of a comprehensive education programme and the activities programme.

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

Standards have been assessed and summarised below:

**Key**

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

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

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

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

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

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

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

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

**Consumer Rights**

Avonlea Dementia Care strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. Complaints processes are implemented and complaints and concerns are actively managed and well documented. A complaints register is maintained.

**Organisational Management**

Dementia Care NZ Ltd is the proprietors/directors of Avonlea Dementia Care. The operations manager of Avonlea reports to the directors on a monthly basis against the quality and risk management plan and also the vision and values which are embedded into practice. The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and other staff meetings. The service is active in analysing data and comprehensive reports, trends and action plans are completed. Corrective actions are identified and implemented and show follow up and review. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status.

Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. Friends and family satisfaction surveys are completed and regular resident/relative meetings are held.

There are comprehensive policies/procedures to provide hospital and dementia specific care. There are appropriate clinical procedures for the introduction of hospital residents. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. The training programme for staff also includes specific training based around the service's, "Best Friends Approach to Dementia Care" (putting yourself in their shoes). This is carried out for all staff regularly and is key to living their values and philosophy.

Families are provided with two programmes called 'sharing the journey' and 'orientation for families'. These provide information and support for family members in understanding dementia. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

**Continuum of Service Delivery**

There are pre-entry and admission procedures in place. The service is pro-active in the community and meets with groups such as Alzheimer's Society. There is a well presented information booklet for residents/families/whanau at entry that includes information on the service philosophy and practices particular to the secure units. Care plans are developed by the services registered nurses and are reviewed six monthly in the facility. Families are involved in the development and review of the care plan. A multi-disciplinary meeting occurs six monthly. The service has strong vision that is reflected in a team approach with a comprehensive mentoring programme that assists with support and values.

All staff are highly qualified in their roles and complete on-going training around the specific needs of people with dementia. All assessments linked into the comprehensive care plan.

Care plans are individually developed, holistic and meet resident's needs. Other specific needs of residents such as medical conditions are also included. There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes. There is a planned seven days activities programme that is developed by recreation staff and daily household activities are completed. They are supported by an organisational Diversional Therapy Coordinator that supports the team and monthly teleconferences are provided.

The medication management system includes medication policy and procedures and there is on-going education and training of staff in relation to medicine management.

The main kitchen provides food to each unit. The service also has access to a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files. Improvement is required around medication fridge temperature.

**Safe and Appropriate Environment**

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness displayed in the foyer. Residents were able to move freely inside and within the secure outside environments off the dementia units.

Avonlea is divided into six small homes. Their philosophy of the 'small homes' mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel. The smaller homes also have a higher staff ratio. Each home is well maintained with easy access to the secure gardens and paths.

Each small home has their own dining/lounge areas. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. Communal service areas are separate and activities can occur in the lounge's and/or the dining area. The service has in place policies and procedures for effective management of laundry and cleaning practices. The service has implemented policies and procedures for civil defence and other emergencies. There is staff on duty with a current first aid certificate. Fire drills are conducted six monthly and the fire service has approved the evacuation scheme. General living areas and resident rooms are appropriately heated and ventilated.

**Restraint Minimisation and Safe Practice**

There is a Restraint Minimisation and Safe Practice Policy and Procedure applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint training is provided at orientation and is completed as part of the services annual training schedule. This includes restraint a self-directed learning and competency for restraint minimisation. Individual restraint interventions are evaluated monthly and documented in the care plan and on the restraint register. There are four residents on the register assessed as requiring intermittent restraint (three hand holding' and one resident with T belt). The register shows a monthly review by the restraint coordinator and the register is updated each month. There is a robust restraint approval group and process in place that meet six monthly. Restraint approval group also includes a consumer representative and the service is focused on minimising restraint.

**Infection Prevention and Control**

The infection control management systems are well documented and implemented to minimize the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality and risk management plan. There is a comprehensive orientation and education programme for all staff. Infection rates are monitored and benchmarked with other facilities within the organisation. Benchmarking also occurs through an external agency and the results are used to identify any shortfalls in care services and infection control.

Avonlea Rest Home

Avonlea Dementia Care Limited

Certification audit - Audit Report

Audit Date: 24-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Avonlea Dementia Care Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Avonlea Rest Home | 224 Lincoln Road | Addington | Christchurch |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 24-Jul-13 **End Date:** 25-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 | RCompN, Health audit cert | 13.00 | 6.00 | 24-Jul-13 to 25-Jul-13 |
| Auditor 1 | xxxxxxx | RN, Health audit cert | 13.00 | 5.00 | 24-Jul-13 to 25-Jul-13 |
| 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** | 26.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 38.00 |
| **Staff Records Reviewed** | 7 of 47 | **Client Records Reviewed** *(numeric)* | 8 of 53 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 8 |
| **Staff Interviewed** | 17 of 47 | **Management Interviewed** *(numeric)* | 4 of 4 | **Relatives Interviewed** *(numeric)* | 8 |
| **Consumers Interviewed** | 1 of 53 | **Number of Medication Records Reviewed** | 16 of 53 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

# Declaration

I, (full name of agent or employee of the company) xxxxxxxx (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 26 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Avonlea Rest Home | 64 | 53 |  | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Avonlea Dementia Care provides dedicated dementia rest home level care for up to 54 residents and hospital level care in a small 10 hospital bed unit. On the day of audit, there were 47 residents across the five dementia homes and six residents in the hospital unit (home).

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings. The service continues to maintain a continued improvement focus since previous audit. A number of education initiatives are implemented at Avonlea included specialist dementia training for staff and families.

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There is one improvement required by the service around the medication fridge temperature.

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1.1 Consumer Rights

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1.2 Organisational Management

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1.3 Continuum of Service Delivery

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The main kitchen provides food to each unit. The service also has access to a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files. Improvement is required around medication fridge temperature.

1.4 Safe and Appropriate Environment

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness displayed in the foyer. Residents were able to move freely inside and within the secure outside environments off the dementia units.

Avonlea is divided into six small homes. Their philosophy of the 'small homes' mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel. The smaller homes also have a higher staff ratio. Each home is well maintained with easy access to the secure gardens and paths.

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2 Restraint Minimisation and Safe Practice

There is a Restraint Minimisation and Safe Practice Policy and Procedure applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint training is provided at orientation and is completed as part of the services annual training schedule. This includes restraint a self-directed learning and competency for restraint minimisation. Individual restraint interventions are evaluated monthly and documented in the care plan and on the restraint register. There are four residents on the register assessed as requiring intermittent restraint (three hand holding' and one resident with T belt). The register shows a monthly review by the restraint coordinator and the register is updated each month. There is a robust restraint approval group and process in place that meet six monthly. Restraint approval group also includes a consumer representative and the service is focused on minimising restraint.

3. Infection Prevention and Control

The infection control management systems are well documented and implemented to minimize the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality and risk management plan. There is a comprehensive orientation and education programme for all staff. Infection rates are monitored and benchmarked with other facilities within the organisation. Benchmarking also occurs through an external agency and the results are used to identify any shortfalls in care services and infection control.

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 | CI | 1 | 0 | 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 | 1 | 1 | 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:1 FA: 11 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:2 FA:21 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 | CI | 1 | 1 | 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 | CI | 2 | 6 | 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 | CI | 1 | 3 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:3 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:4 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 | 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 | CI | 1 | 0 | 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 Low | 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:1 FA: 10 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:1 FA:19 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 | FA | 0 | 5 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 0 **CI:** 5 **FA:** 44 **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:** 7 **FA:** 93 **PA:** 1 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Avonlea Dementia Care Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:24-Jul-13 End Date: 25-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: xxxxxxx

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.12 | 1.3.12.1 | PA  Low | **Finding:**  The hospital medication fridge temperature is outside of the acceptable range 2 - 8 degrees Celsius. There was no evidence of corrective action, however this was established on the day.  **Action:**  Ensure the medication fridge temperature is maintained within an acceptable range. | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Avonlea Dementia Care Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:24-Jul-13 End Date: 25-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: xxxxxxx

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| **Std** | **Criteria** | **Evidence** |
| 1.1.8 | 1.1.8.1 | **Finding:**  Benchmarking with QPS also occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents, staff accidents) and clinical record audits. At service level incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including on-going review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting. There are a number of quality improvement projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities. QI's are raised as a result of feedback, complaints, surveys, and discussions at handover. Once completed the QI's are logged in the six monthly statistics for health and safety/infection control/quality. There is a quality and risk management plan for 2012 - 2013. The plan is reviewed monthly at quality meetings to measure progress towards meeting the programme objectives. The education programme includes a comprehensive orientation programme with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling, and restraint. All care staff are supported to complete first aid qualifications and the ACE programme including dementia unit standards. The annual education programme is comprehensive and includes programmes designed and implemented by the service: "best friends" is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular “Best Friends Approach to Dementia Care” (putting yourself in their shoes) training is carried out for all staff regularly and this is key to living their values and philosophy. At an organisational level there is an Diversional Therapy Coordinator to provide support to the diversional therapy team and provide Diversional Therapy Coordinator services to residents as required. There is a Principal Clinical Manager to lead and provide guidance to the clinical managers. Both Clinical Manager and Operations Manager have received Leadership training using Human Synergistic programme. Management coaching with vargo and lewis is provided. All Clinical Managers meet annually to discuss clinical issues or policy changes. There is Supervision for all RNs. Mentoring of staff by more senior members is facilitated. Non-Violent Crisis Intervention training is on-going at Avonlea and Intercultural Awareness Training has commenced. In-service education sessions include input from external specialists and clinical policies and procedures are updated to reflect good practice. Families are provided with two programmes called 'sharing the journey' and ‘orientation for families’. These provide information and support for family members in understanding dementia. Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. Avonlea is divided into six small homes. The small homes mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel. The smaller homes also have a higher staff ratio. |
| 1.1.12 | 1.1.12.1 | **Finding:**  The service, as part of its commitment to holistic care has implemented a series of education sessions for families and friends, this ensures that families are well informed and are part of, and informed about, their family member's care and condition. There an orientation for families course, this is a voluntary for new families of residents to assist them with the transition into care. The orientation informs the family about dementia care provided at Avonlea. This includes a) dementia as a journey for both the resident and the family, b) provision of information to families, c) advise on communication, and d) provide a family support network. This course is followed by the 'Sharing the Journey' course; a short course for families of people with dementia based on the service's 'Best Friends Approach to Dementia Care'. The premise of the 'best friends' approach is that the service provides care and support that one could expect of a best friend. The course aims to enable family members to understand the dementia journey, and effective ways of both communicating with and managing their family member in care. Families interviewed from the dementia unit ( three) were complimentary about the information received and the courses. |
| 1.2.1 | 1.2.1.1 | **Finding:**  Avonlea is governed by directors/proprietors who provide specialist dementia care services to residents in facilities around New Zealand. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. The vision for the organisation is: 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'. The service aims to achieve the vision by promoting the uniqueness of each person, acknowledging the immense value of each person and by promoting openness, honesty and integrity. Philosophy of care incorporates: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and involved in their loved one’s care. They are encouraged to share their knowledge of their loved one to build trust and to promote honesty and openness; c) small homely units provides residents with a stable and familiar environment; d) staff are acknowledged as people with skills and abilities who have the potential to be a positive impact on residents, families and their work teams; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. The philosophy care is to promote participation in life activities, promote physical and emotional wellness. This is well demonstrated at Avonlea. The service monitors performance in a number of ways and evidence of on-going improvements identified. The operations manager completes monthly reports that analysis internal audits completed, follow ups required, progress to meeting quality projects, corrective action status, document/review changes and general. Monthly incident trend analysis. Progress towards meeting the quality and risk management plan is monitored quarterly at organisational level and the entire plan reviewed and re-developed annually by the quality team. Meeting minutes for quality committee, health and safety committee and infection control committee are comprehensive and include review of the organisational and local objectives against performance measures. Quality meeting minutes include review of infection control, health and safety, staff, families, restraint, education, quality audit outcomes, activities and marketing. Key performance indicators are benchmarked internally and with the other homes owned by the proprietors - as well as QPS benchmarking. Friends and family satisfaction surveys are completed annually (2012). Actions are identified and followed through as required. |

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| 1.2.3 | 1.2.3.6 | **Finding:**  Quality data gathered includes comprehensive templates to identify trends, actions and identification of resolution. Internal audits include QI plan . The QI plans include identified problem, action and on-going evaluation of action undertaken. Audit results are collated and document. Results are then fed back to staff at appropriate forums, e.g. staff, H&S meeting. Meeting minutes reflect a culture of quality improvements and on-going review of practice. Quarterly QPS analysis is completed that includes outcomes. Resident and family are provided with quality feedback and initiatives through newsletters and meetings, QI initiatives are logged and include (but not limited to) Internal management meetings include a quality focus for the week. The quality meeting includes a discussion of new quality improvements, unresolved/outstanding quality improvements. The service is proactive in identifying QIs on an on-going basis and monitoring these until signed out as completed. The May 2013 clinical indicator analysis and outcomes report identified that falls were the highest across their facilities. Multiple falls by one resident resulted in the increase and a frequent falls review was completed. Education was provided at handovers around reasons why a resident falls. Hip protectors and sensor maps in place. Clutter in lounges also minimised. Falls reduced in June. QIs are also developed around managing specific resident behaviours. |
| 1.2.3 | 1.2.3.7 | **Finding:**  The service is proactive in monitoring outcomes from their quality management programme through meetings, and quality reports, also through their vision and values and the impact on family through the family focus group. Reports provided to the monthly quality meeting include clinical manager/RN monthly report, education co-ordinator monthly report, quality and systems manager monthly report, activities team monthly report, marketing monthly report, and home managers’ report. On-going quality improvements are monitored through all meetings and annual goals are evaluated. The family focus group meeting is held annually (last Oct 12) with the two directors and five participants. An action plan was completed as a result of areas family members would like to improve. Interview with a relative that was involved in that meeting spoke positively about the openness of the directors to make improvements. Team Gathering meeting with staff June 13 included input into reviewing previous business goals and developing goals for 2013- 14. Six week post admission surveys provides early feedback to the service friends and family satisfaction surveys are conducted annually. |
| 1.2.7 | 1.2.7.5 | **Finding:**  A number of education initiatives are implemented at Avonlea. The annual education plan is comprehensive and covers both compulsory and additional topics. Topics are included in the plan in response to and following feedback from audits(i.e.: fire competency re-written to include more relevant questions), complaints, incidents/accidents, infection, meeting minutes, health and safety issues and quality improvement initiatives. The organisation has developed a programme called 'best friends' which comprises four x one hour sessions for all staff. The programme is part of the annual education plan and includes promoting the approach that care staff are the residents 'best friend'. The education package includes role playing, and discussions to promote empathy, understanding dementia, communication with dementia residents and providing activities that are meaningful and resident focused. The programme is tied to the vision and values of the organisation. This year the training has further extended with the introduction of ' come into my world' training which is across three sessions. Non-violent crisis intervention training is also provided for staff annually to enable them to safely manage residents with challenging behaviours. Intercultural Awareness programme was developed in partnership with the Office of Ethnic Affairs using their in-house Intercultural Course contextualised by the service to suit the aged care sector. The course raises staff awareness of their own and other cultures and how different cultures communicate. Further training initiatives implemented at Avonlea include; programmes called ‘orientation for families’ and 'sharing the journey' which is designed for dementia resident's families to provide education, understanding and coping with dementia progression, understanding behaviours, and responding to behaviours. Eight family members interviewed (six dementia unit and two hosp) confirmed that they felt well supported and appreciated the service's provision of education for them around understanding dementia. The organisation supports new grads with competency packages. All RNs have commenced their PDRP and annual RN study days are held. Three sessions based around 'leaderships tools' have been held with RNs. |

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| 1.3.7 | 1.3.7.1 | **Finding:**  The DT plan is a key part of the overall LTCP and the service is pro-active in providing a meaningful programme. The programme is regularly reviewed with family and is extensive across the day. Interview with five activities staff from the five units noted that they are committed to working with residents and families and described how they had developed good connections with residents and have got to know them. Activities are based on the 'Best friends' approach to care. Staff have attended a "best friends “course and are now doing a refresher "come into my world". A range of activities are available for residents to choose from, with staff spending a large proportion of their time with 1 on 1 interaction with the residents. The hospital unit programme includes reminiscing, hand massages, music, chair exercises. Physical capabilities are considered in the delivery of the activities programme and there is a greater proportion of their time with 1 on 1 interaction with the residents. Everyday life activities are included in the programme for the residents within the dementia care, such as baking, folding laundry, household chores, walks in the garden and exercises. Advised that household chores are voluntarily undertaken by residents within their small homes. Each unit has an oven for home baking activities. There are visiting musical entertainers and sing-a-longs. There are as well as expressive programmes such as sing-a-longs and entertainers. Theme days, movies and Happy Hour is included into the programme as well as birthday celebrations and festive or special events. The DT contribute news and interesting/upcoming events for the facility newsletter. The design of the units ensures that a homely, family environment is in place to assist with normalising the service and provide activities in a calm environment. There are many seating nooks and quieter areas for residents who choose not to participate in group activities. Avonlea have a café club for the residents. There are weekly van outings which include farm animal visits. Resident outing risk assessments are completed by the DT's. Two staff (includes driver) go on every outing or van drive. All DT's have a first aid certificate. There are community visits such a shopping trips, picnics, feeding ducks and walks in the park. Family are encouraged to join in the activities programme. Families interviewed (six dementia care and two hospital) report that they are involved and can join in activities |

**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

There is a code of rights policy and procedures in place. The code of health and disability rights is incorporated into care. Discussions with five caregivers (four dementia unit, one hospital) identified their familiarity with the code of rights. A review of care plans, meetings (monthly - quality, home managers, registered nurses, and internal management meetings) and discussion with eight family members (six dementia, two hospital) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided on the code of rights and advocacy July 13. Code of rights is also included in the orientation training session and package for new staff.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

The service provides information to residents, families, next of kin and/or EPOA. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. On entry to the service, the clinical manager or registered nurse discusses the information pack with the resident and their family/whanau. This includes the code of rights, complaints and advocacy information. Discussions with eight family members identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

There is an orientation for families course is provided on admission, this is voluntary for new families of residents to assist them with the transition into care. The orientation informs the family about dementia care provided at Avonlea. This includes a) dementia as a journey for both the resident and the family, b) provision of information to families, c) advise on communication, d) provide a family support network and e) includes resident rights.

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

Resident/family right to access advocacy and services is identified and advocacy service leaflets are available at the entrance. The information identifies who the family can contact to access advocacy services. Information provided prior to entry provides them and their family/whānau with advocacy information. This includes details of the national and local advocacy services. There is an identified family support person and advocate who visits residents weekly. Discussions with five caregivers identified they are aware of the right for advocacy and how to access and provide advocacy information to residents if needed.

**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

The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident information and employment agreements bind staff to retaining confidentiality of client information.

Discussions with eight family members identified that personal belongings are not used as communal property.

During the visit, staff demonstrated gaining permission prior to entering resident private areas. Interviews with family members and residents identified that caregivers always respect residents' privacy.

Resident files are held in locked nurses' offices.

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

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

E4.1a Four families states that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

Avonlea's vision and values statement is 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly', The service aims to achieve the vision by promoting the uniqueness of each person, the immense value of each person and by promoting openness, honesty and integrity.' Residents' support needs are assessed using a holistic approach. Assessments are incorporated into a care plan which includes a section on expressing spirituality and culture. The service has developed and implements an intercultural awareness training programme for staff.

Initial and on-going assessment includes gaining details of people’s beliefs and values. Interventions to support these are identified and evaluated.

The service contacts family prior to resident reviews and multi-disciplinary meetings inviting them to attend and discuss any concerns.

All eight family members interviewed confirmed that the service is respectful and responsive to the resident’s needs, values and beliefs. Single rooms are provided.

There is an abuse and neglect policy that includes definitions and examples of abuse. Staff could describe definitions. Discussions with two registered nurses, clinical nurse manager, and four caregivers identify that there is a strong culture of reporting. Eight relatives interviewed said that the care provided is very good. Abuse and neglect training was last delivered in March 13 by aged concern.

**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 gathers appropriate spiritual, religious and cultural information that is relevant and sufficient to support an appropriate response to the needs of residents. There is one Maori resident that does not have any specific cultural needs or affiliation. Planning is done in conjunction with the resident/family. The service's philosophy of care results in each person's cultural needs being considered individually. External specialist advice is sought as necessary.

There are current guidelines for the provision of culturally safe care for Māori residents. Discussions with three registered nurses, clinical nurse manager, operations manager and five caregivers indicate that they have an awareness of the need to respond appropriately to the cultural values and beliefs of Māori. Individual cultural values are identified and documented through the assessment and admission processes and staff make every effort to assist residents to practice their cultural values. Special events and occasions are celebrated at Avonlea.

Family/whanau involvement is actively encouraged through all stages of service delivery. Whanau are invited to attend residents' reviews. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau.

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

D20.1i The service has established a local contact who is Māori and is available for advice as required.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service establishes links with family/whanau or other appropriate representatives as required. Family meetings occur at admission, and at multi-disciplinary team meetings. The operations manager, clinical nurse manager or registered nurse contacts family when required. Eight family members confirm they are consulted regarding individual values and beliefs.

D3.1g The service provides a culturally safe service by implementing Avonlea's vision and values of care and service which promotes the uniqueness of the individual and provides opportunities to enrich the lives of each resident. During the admission process, the registered nurse along with the family/whanau complete the documentation. The assessment process and philosophy of care enables appropriate responses to individual cultural beliefs. Initial and on-going assessment includes gaining details of people’s culture, beliefs and values. D4.1c There is a section around expressing spirituality and culture in the care plan.

Families are actively encouraged to be involved in their relative's care in whatever way they want. Two programmes developed for families called ‘Orientation for Families’ and "Sharing the Journey" involves education and practical assistance for families around caring for loved ones with dementia. Family and friends are able to visit at any time of the day and are actively encouraged to participate in the resident reviews. The service provides a Intercultural Awareness education programme for staff that was developed in partnership with the Office of Ethnic Affairs using their in-house Intercultural Course contextualised by the service to suit the aged care sector . Cultural safety is part of the orientation training and competency package

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

There is an abuse and neglect policy, residents code of rights policy, complaints policy and process , staff code of conduct which includes discrimination and professional boundaries.

Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. Qualified staff are, in addition, required to abide by a professional code of ethics. The code of conduct discusses consequences if the code of conduct is not followed.

Complaints regarding any alleged harassment, coercion, discrimination or abuse of any kind by a staff member are fully investigated and may be dealt with via both the complaint management and disciplinary processes. Discussion with the operations manager and a review of complaints identified no complaints of discrimination, coercion or exploitation of residents.

Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment. Performance appraisals are conducted and staff receive supervision. Discussions with eight family identify that privacy is ensured.

Discussions with five (four dementia, one hosp) caregivers described how professional boundaries are maintained.

**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:** CI

A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.

At service level incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including on-going review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting. There are a number of quality improvement projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities.

The annual education programme is comprehensive and includes programmes designed and implemented by the service: "best friends" is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular “Best Friends Approach to Dementia Care” (putting yourself in their shoes) training is carried out for all staff regularly and this is key to living their values and philosophy.

Avonlea is divided into six small homes. The small homes mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel. The smaller homes also have a higher staff ratio.

The service is commended for maintaining good practice.

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

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

 A2.2 Services are provided at Avonlea that adhere to the health and disability services standards. There is an implemented quality improvement programme that includes performance monitoring. There are well developed manuals for all areas of the service and include management, human resource, clinical, health and safety, kitchen, laundry and activities. Policies and procedures and associated implementation systems are in place 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.

A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.

There is an internal audit schedule. It includes (but is not limited to): clinical compliancy, complaints management, environmental safety, health and safety, infection control, kitchen/food, household services, medications, quality and risk management, residents admission, resident care, restraint minimisation, staff education, incidents and accidents, and asset and maintenance review.

Eight family members interviewed (six dementia unit, two hosp) spoke very positively about the care provided and were well informed and supported.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for all staff including caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions .

**Finding Statement**

Benchmarking with QPS also occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents, staff accidents) and clinical record audits. At service level incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including on-going review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting. There are a number of quality improvement projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities. QI's are raised as a result of feedback, complaints, surveys, and discussions at handover. Once completed the QI's are logged in the six monthly statistics for health and safety/infection control/quality. There is a quality and risk management plan for 2012 - 2013. The plan is reviewed monthly at quality meetings to measure progress towards meeting the programme objectives. The education programme includes a comprehensive orientation programme with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling, and restraint. All care staff are supported to complete first aid qualifications and the ACE programme including dementia unit standards. The annual education programme is comprehensive and includes programmes designed and implemented by the service: "best friends" is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular “Best Friends Approach to Dementia Care” (putting yourself in their shoes) training is carried out for all staff regularly and this is key to living their values and philosophy. At an organisational level there is an Diversional Therapy Coordinator to provide support to the diversional therapy team and provide Diversional Therapy Coordinator services to residents as required. There is a Principal Clinical Manager to lead and provide guidance to the clinical managers. Both Clinical Manager and Operations Manager have received Leadership training using Human Synergistic programme. Management coaching with vargo and lewis is provided. All Clinical Managers meet annually to discuss clinical issues or policy changes. There is Supervision for all RNs. Mentoring of staff by more senior members is facilitated. Non-Violent Crisis Intervention training is on-going at Avonlea and Intercultural Awareness Training has commenced. In-service education sessions include input from external specialists and clinical policies and procedures are updated to reflect good practice. Families are provided with two programmes called 'sharing the journey' and ‘orientation for families’. These provide information and support for family members in understanding dementia. Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. Avonlea is divided into six small homes. The small homes mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel. The smaller homes also have a higher staff ratio.

**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

There is an open disclosure policy, a complaints policy and an incident/accident reporting policy. Eight family members stated they and the resident were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur monthly in each dementia unit (home) and monthly in the hospital. Residents are encouraged to attend and to comment on the questions asked.

A family focus meeting is held annually and is chaired by a director. Advised by the operations manager that staff do not attend this meeting as it provides opportunities for residents/families to talk openly and freely. Outcomes of this meeting are fed back the operations manager and any issues that arise are dealt with through the quality improvement programme. The clinical nurse manager and the operations manager has an open-door policy.

Incident forms have a section to indicate if family have been informed (or not) of an incident/accident. Twenty-two incident/accident forms were reviewed for July 2013. In all 22 forms reviewed, contact with families after an incident/accident is documented on the incident forms and in the progress notes.

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 Residents/family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.

D16.4b Eight family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.

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

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.

**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

There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. Residents have a medical guidance plan that covers admission to hospital and resuscitation. There is evidence of resident/EPOA/GP and Clinical Manager participation in the medical guidance plan.

Avonlea's philosophy includes an emphasis on getting to know the resident, spending time with them and treating them as if they were your "best friend". Interviews with staff and families supported that they have input and are given choices. Care plans and 24 hours multidisciplinary care plans demonstrate resident choice as appropriate.

D13.1 there were eight admission agreements sighted and these had been signed on the day of admission

D3.1.d Discussion with eight family (six dementia care and two hospital) identified that the service actively involves them in decisions that affect their relatives lives.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

The right to access advocacy services is identified for residents/families. There is an advocacy and consumer support policy in place. Leaflets are available at the entrance . The information identifies who to contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. An independent advocate visits monthly.

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

D3.1h; Discussion with six family members confirmed that they are encouraged to be involved with the service and care of the residents.

Visiting is actively encouraged. Relatives interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e Interviews with five activity staff described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping. Entertainers are included in the hospital/dementia units activities programme. The activities coordinators described how outings in the van are tailored to meet the interests of the residents. Residents are encouraged to maintain outside interests as appropriate. Assistance with transport is provided as required

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

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

A family focus meeting is held annually and is chaired by a director. Advised by the operations manager that staff do not attend this meeting as it provides opportunities for residents/families to talk openly and freely. Outcomes of this meeting are fed back the operations manager and any issues that arise are dealt with through the quality improvement activities programme. The clinical nurse manager and the operations manager has an open-door policy.

**Finding Statement**

The service, as part of its commitment to holistic care has implemented a series of education sessions for families and friends, this ensures that families are well informed and are part of, and informed about, their family member's care and condition. There an orientation for families course, this is a voluntary for new families of residents to assist them with the transition into care. The orientation informs the family about dementia care provided at Avonlea. This includes a) dementia as a journey for both the resident and the family, b) provision of information to families, c) advise on communication, and d) provide a family support network. This course is followed by the 'Sharing the Journey' course; a short course for families of people with dementia based on the service's 'Best Friends Approach to Dementia Care'. The premise of the 'best friends' approach is that the service provides care and support that one could expect of a best friend. The course aims to enable family members to understand the dementia journey, and effective ways of both communicating with and managing their family member in care. Families interviewed from the dementia unit ( three) were complimentary about the information received and the courses.

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. Complaints information is available in each unit and information is provided to residents and relatives at entry.

There is an established and up to date complaints register that is also included on an access database format. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response. Specific QIs are raised from complaints. For 2013 (to date) there has been one written complaint. The complaint was well documented and managed.

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

E4.1biii.There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

**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:** CI

Avonlea Dementia Care provides dedicated dementia rest home level care for up to 54 residents and 10 hospital level beds. On the day of audit, there were 47 residents in the dementia homes. The facility is divided into six separate units. Awahi whanau includes eight resident beds, Hoa Pumau includes 15 resident beds, Aroha includes 11 resident beds and Mahal (hospital unit), Rudo and Ofa house have 10 resident beds in each.

Dementia Care NZ is the parent company for Avonlea Dementia Care and has a current charter and business plan and a quality and risk organisational plan that aligns with the business plan (July 13-14). The vision and values statement sets out the philosophy of the providers. Avonlea Rest Home holds regular meetings including (but not limited to); quality, infection control, staff, health and safety and resident/family meetings. The operations manager of Avonlea reports to the proprietors on a range of issues on a monthly basis. The service is managed by an operations manager who is supported by a team of experienced staff - clinical nurse manager, registered nurses, caregivers and the management team of Dementia Care NZ.

D17.4b (hospital), The operations manager is an experienced manager and has been in the role for the last three years. She has completed a management course and has worked in various management roles within the organisation during the last 10 years. The clinical manager (has been in the role for the last four months) provides clinical oversight. The organisation provides training days with the clinical managers and senior management team to ensure at least eight hours annually of professional development activities occurs including those related to managing a hospital.

The service is commended for the implementation of the organisation vision, values, goals and objectives including (but not limited to) promoting independence and valuing the lives of residents and staff.

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

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

Dementia Care NZ Ltd owns and operates Avonlea Dementia Care in Christchurch. Avonlea is governed by directors/proprietors who provide specialist dementia care services to residents in facilities around New Zealand. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. The vision for the organisation is: 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'. The service aims to achieve the vision by promoting the uniqueness of each person, acknowledging the immense value of each person and by promoting openness, honesty and integrity.

Philosophy of care incorporates: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and involved in their loved one’s care. They are encouraged to share their knowledge of their loved one to build trust and to promote honesty and openness; c) small homely units provides residents with a stable and familiar environment; d) staff are acknowledged as people with skills and abilities who have the potential to be a positive impact on residents, families and their work teams; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. The philosophy care is to promote participation in life activities, promote physical and emotional wellness.

Avonlea Dementia Care provides care for up to 54 dedicated dementia rest home level residents and 10 hospital level residents. On the day of the audit, there were 47 residents across the five dementia homes and six residents in the hospital wing. The intention of the service is to provide a home-like atmosphere for residents.

Dementia Care NZ Ltd has well established business, strategic, quality and risk organisational plans being implemented for Avonlea Dementia Care. The operations manager of Avonlea is responsible to the directors and reports on a monthly basis on a variety of issues relating to the strategic and quality plan.

The proprietors have a current charter, organisational structure, and business plan as well as a current quality and risk organisational plan for 2013/2014. The quality programme is managed by the operations manager and a quality and systems manager for the organisation. There are documented objectives for the current financial year including (but not limited to): vision and values, quality plan, health and safety, infection control, resident occupancy, benchmarking, medication management, complaints process, human resources, restraint minimisation, continuous quality improvement, communication, education and training for staff including orientation and competencies, food safety, fire and evacuation and code of residents rights.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

**Finding Statement**

Avonlea is governed by directors/proprietors who provide specialist dementia care services to residents in facilities around New Zealand. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. The vision for the organisation is: 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'. The service aims to achieve the vision by promoting the uniqueness of each person, acknowledging the immense value of each person and by promoting openness, honesty and integrity. Philosophy of care incorporates: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and involved in their loved one’s care. They are encouraged to share their knowledge of their loved one to build trust and to promote honesty and openness; c) small homely units provides residents with a stable and familiar environment; d) staff are acknowledged as people with skills and abilities who have the potential to be a positive impact on residents, families and their work teams; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. The philosophy care is to promote participation in life activities, promote physical and emotional wellness. This is well demonstrated at Avonlea. The service monitors performance in a number of ways and evidence of on-going improvements identified. The operations manager completes monthly reports that analysis internal audits completed, follow ups required, progress to meeting quality projects, corrective action status, document/review changes and general. Monthly incident trend analysis. Progress towards meeting the quality and risk management plan is monitored quarterly at organisational level and the entire plan reviewed and re-developed annually by the quality team. Meeting minutes for quality committee, health and safety committee and infection control committee are comprehensive and include review of the organisational and local objectives against performance measures. Quality meeting minutes include review of infection control, health and safety, staff, families, restraint, education, quality audit outcomes, activities and marketing. Key performance indicators are benchmarked internally and with the other homes owned by the proprietors - as well as QPS benchmarking. Friends and family satisfaction surveys are completed annually (2012). Actions are identified and followed through as required.

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

During a temporary absence of the operations manager, the clinical nurse manager assumes the role. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

There are relevant care and support policies including relevant clinical procedures for the management of hospital level residents. At Avonlea there is currently a house GP, Physiotherapist (visits two weekly currently) and a dietitian (visits monthly). There is also an organisational Diversional Therapy Coordinator. At an organisational level there is a Principal Clinical Manager that provides clinical support and leadership. Allied health professionals are accessed on an as required basis

**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:** CI

Avonlea has a strategic business plan and a quality and risk management plan that are implemented and managed at service level by a quality services manager and quality team. There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through monthly quality meetings, weekly planning meetings with home managers, monthly registered nurse meetings, monthly health and safety meetings, monthly infection control meetings and monthly reports to the directors.

The quality committee meeting includes (but is not limited to): infection control, accidents/incidents, restraint, quality goals, quality activities, policies and procedures, health and safety, staff, family issues, complaints, marketing, education and clinical issues. Minutes are maintained and easily available to staff in a folder. Minutes include actions to achieve compliance where relevant. Benchmarking is used as a means of identifying trends and potential risks or for advanced planning. This, together with comprehensive staff training, demonstrates the organisations and Avonlea's commitment to on-going quality improvement.

D5.4 The service has the following policies/ procedures to support service delivery. There is a document and data control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to a registered nurse who completes the follow up. All incident/accident forms are seen by the operations manager who completes any additional follow up and collates and analyses data to identify trends. Results are discussed with staff through the monthly meetings including: registered nurse, quality committee, health and safety, infection control and the operations manager's monthly report to the directors/proprietors. Complaints/concerns are recorded in a complaints folder. There is a spread sheet/data base register in place. There is evidence that complaints/concerns are followed up and any concerns raised through resident meetings, family focus meeting, and friends and family surveys are followed up and actioned. Infection control data is collated monthly and reported to the monthly infection control committee meeting, the quality committee meetings, and monthly staff bulletin. Actual and potential risks are identified and corrective actions initiated. This is discussed at the monthly quality meetings, monthly health and safety meetings and reported to the directors/proprietors in the operations manager's monthly report. There is a hazard identification register that includes type, potential harm, action to minimise, control measures and checks. The hazard register is reviewed annually. Safe work booklet introduced for staff. Two H&S goals identified for 2013. Restraint is reviewed at the monthly quality meetings and six monthly restraint approval committee.

Corrective actions are established as a result of internal audits, incidents, accidents, complaints and concerns. Corrective actions are discussed at staff meetings and quality meetings. Meeting minutes are documented using a corrective action format. Discussions with the clinical nurse manager, three registered nurse, five caregivers, described that corrective actions are implemented. Internal audits are completed. Corrective actions identify the actions required, the person responsible, documentation of actions completed and signed completion. The QI log identified new quality initiatives.

D19.3 There are implemented risk management and health and safety policies and procedures in place including incident/accident and hazard management. The health and safety policies include (but are not limited to): hazard identification; hazard management; staff responsibilities; employee participation in health and safety systems. There is a hazard register that is reviewed annually. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate.

The monthly health and safety meetings identify actual and potential risks and corrective actions are initiated. Monthly incident/accident data are collated and actual and potential risks are identified.

D19.2g Falls prevention strategies are in place that include: assessment of risk, medication review, bone health introducing vitamin D, vision and hearing assessments, mobility assessments with physiotherapy input, exercises/physical activities, training for staff on detection of falls risk, and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.

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

The service has a quality programme that is implemented in practice. Quality improvement data is analysed to identify trends and themes. This includes incidents, infections, hazards, audits and complaints. The service continues to maintain the quality programme and improve on areas of service delivery. Staff are knowledgeable about quality processes. Meeting minutes reviewed include: registered nurse; quality committee; infection control; health and safety; and internal management. Minutes reviewed document the discussion of all quality activities.

The service has an internal audit schedule that is implemented. Internal audits are completed and actions identified

**Finding Statement**

Quality data gathered includes comprehensive templates to identify trends, actions and identification of resolution. Internal audits include QI plan . The QI plans include identified problem, action and on-going evaluation of action undertaken. Audit results are collated and document. Results are then fed back to staff at appropriate forums, e.g. staff, H&S meeting. Meeting minutes reflect a culture of quality improvements and on-going review of practice. Quarterly QPS analysis is completed that includes outcomes. Resident and family are provided with quality feedback and initiatives through newsletters and meetings, QI initiatives are logged and include (but not limited to) Internal management meetings include a quality focus for the week. The quality meeting includes a discussion of new quality improvements, unresolved/outstanding quality improvements. The service is proactive in identifying QIs on an on-going basis and monitoring these until signed out as completed. The May 2013 clinical indicator analysis and outcomes report identified that falls were the highest across their facilities. Multiple falls by one resident resulted in the increase and a frequent falls review was completed. Education was provided at handovers around reasons why a resident falls. Hip protectors and sensor maps in place. Clutter in lounges also minimised. Falls reduced in June. QIs are also developed around managing specific resident behaviours.

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

A process is implemented to measure achievement against goals in the strategic business plan and quality and risk management plan. Formal review takes place six monthly.

Avonlea holds monthly quality meetings, weekly internal management meetings, monthly registered nurse meetings, home managers’ meetings and the operations manager reports monthly to the directors of Dementia Care NZ.

Internal audits are completed and include the identification of any issues and corrective actions where required. Corrective actions are discussed at the monthly quality meetings and monthly staff meetings and the service ensures that all corrective actions are followed through and signed off. Incidents, accidents, hazards, complaints, infections, education, activities, marketing, quality systems and restraint are monitored through the monthly quality meetings.

Monthly internal benchmarking and quarterly QPS benchmarking of the service in areas but not limited to resident accidents and infections, staff accident are used to measure the effectiveness of the objectives of the quality and risk management plan.

Resident meetings occur monthly in the dementia unit and the hospital unit and an annual family focus group is held.

**Finding Statement**

The service is proactive in monitoring outcomes from their quality management programme through meetings, and quality reports, also through their vision and values and the impact on family through the family focus group. Reports provided to the monthly quality meeting include clinical manager/RN monthly report, education co-ordinator monthly report, quality and systems manager monthly report, activities team monthly report, marketing monthly report, and home managers’ report. On-going quality improvements are monitored through all meetings and annual goals are evaluated. The family focus group meeting is held annually (last Oct 12) with the two directors and five participants. An action plan was completed as a result of areas family members would like to improve. Interview with a relative that was involved in that meeting spoke positively about the openness of the directors to make improvements. Team Gathering meeting with staff June 13 included input into reviewing previous business goals and developing goals for 2013- 14. Six week post admission surveys provides early feedback to the service friends and family satisfaction surveys are conducted annually.

**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

D19.3d the service is aware that they will inform the DHB of any serious accidents or incidents. Discussions with the operations manager, and clinical nurse manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required.

A review of 22 incident forms identified they were all fully completed and followed up appropriately by the RN including completing neuro obs for three residents, when the residents fell and hit their head.

Minutes of the monthly quality and health and safety meetings, registered nurse, management meetings and the monthly staff bulletin reflect a discussion of incidents/accidents and actions taken. QPS benchmarking includes an analysis. The service analyses the trends and a comprehensive report is completed that includes outcomes and further actions required at a facility and organisational level. A regular review is completed of frequent falls (link 1.2.3.6)

**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:** CI

Avonlea employs a total of 52 staff. Staff orientation policy and procedures includes training and support packages for operations manager, registered nurses, caregivers, activities team and cook and kitchen staff. There are job descriptions available for all positions and staff have employment contracts.

Seven staff files were reviewed ( clinical nurse manager, home manager, registered nurse, two caregivers, one activities coordinator, cook). Job descriptions were evident in all files reviewed. Performance appraisals are up to date.

The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates sighted for all registered nurses, and allied/medical staff.

There are comprehensive human resources manual which includes policies around recruitment, selection, orientation and staff training and development. Seven staff files were reviewed. Reference checks are completed before employment is offered and are evident in the seven staff files reviewed.

Orientation programme and packages for all roles. All seven files reviewed showed evidence of orientation to roles with competency packages completed. The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Twelve caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Competency packages for registered nurses include - 'best friends' approach to care, restraint minimisation and safe practice, first aid, ACE dementia series, delirium, syringe driver, medication, neurological conditions and leadership. Caregivers competency package - 'best friends' approach to care, restraint minimisation and safe practice, first aid, taking vital signs, safe medication administration, ACE programme and leadership. All staff also complete safe food handling, chemical safety, safe manual handling (hoist use), bi-cultural awareness and infection control.

The education coordinator manages a spread sheet of all staff and records all completed orientations, competencies and education attended.

There are 40 caregivers employed in Avonlea that work in the dementia unit. Thirty -three have completed the required dementia standards, and seven caregivers are in the process of completing. There is an in-service calendar completed for 2012 and currently being implemented for 2013. The annual training programme well exceeds eight hours annually. Additionally, all caregivers are supported to complete the aged care education certificate core and dementia standards.

The service is commended for the number of quality initiatives based around education of staff and relatives.

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

Education plan for 2013-2014 is an objective of the quality and risk management plan. Human resource manual includes - training and supervision, staff training, ACE programme, maintaining training records, performance management and appraisals policy and procedures.

E4.5f There are 40 caregivers employed in Avonlea that work in the dementia unit. Thirty-three have completed the required dementia standards, and seven caregivers are in the process of completing.

Discussion with the education coordinator for the organisation, the operations manager, clinical nurse manager, three registered nurses and five caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar completed for 2012 and currently being implemented for 2013. The annual training programme well exceeds eight hours annually. Additionally, all caregivers are supported to complete the aged care education certificate core and dementia standards. Five caregivers interviewed advised that they have all completed the ACE dementia training. The registered nurses attend external training days through the organisation.

The operations manager attends training provided by the organisation in leadership and management, and attends organisational wide managers’ meetings as well as professional supervision. An education coordinator is employed to oversee the organisation's education programme for all homes and is available to facilitate sessions. The education coordinator develops the annual education plan in conjunction with the operations manager. There are essential/compulsory attendance sessions. Other topics are added to the plan as required following feedback from audits, complaints, incidents/accidents, infection, health and safety issues and quality improvement initiatives.

**Finding Statement**

A number of education initiatives are implemented at Avonlea. The annual education plan is comprehensive and covers both compulsory and additional topics. Topics are included in the plan in response to and following feedback from audits(i.e.: fire competency re-written to include more relevant questions), complaints, incidents/accidents, infection, meeting minutes, health and safety issues and quality improvement initiatives. The organisation has developed a programme called 'best friends' which comprises four x one hour sessions for all staff. The programme is part of the annual education plan and includes promoting the approach that care staff are the residents 'best friend'. The education package includes role playing, and discussions to promote empathy, understanding dementia, communication with dementia residents and providing activities that are meaningful and resident focused. The programme is tied to the vision and values of the organisation. This year the training has further extended with the introduction of ' come into my world' training which is across three sessions. Non-violent crisis intervention training is also provided for staff annually to enable them to safely manage residents with challenging behaviours. Intercultural Awareness programme was developed in partnership with the Office of Ethnic Affairs using their in-house Intercultural Course contextualised by the service to suit the aged care sector. The course raises staff awareness of their own and other cultures and how different cultures communicate. Further training initiatives implemented at Avonlea include; programmes called ‘orientation for families’ and 'sharing the journey' which is designed for dementia resident's families to provide education, understanding and coping with dementia progression, understanding behaviours, and responding to behaviours. Eight family members interviewed (six dementia unit and two hosp) confirmed that they felt well supported and appreciated the service's provision of education for them around understanding dementia. The organisation supports new grads with competency packages. All RNs have commenced their PDRP and annual RN study days are held. Three sessions based around 'leaderships tools' have been held with RNs.

**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 Staffing Levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Rosters are in place and show staff coverage across the rest home and dementia unit. There is an RN based in the hospital unit 24/7 and another RN rostered five mornings a week. Operations Manager Mon - Fri and Clinical Manager (RN) - three days a week.

Interviews with eight relatives, three registered nurses and five caregivers confirmed that staffing levels are good across each area.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in offices. Resident records are kept up to date and reflect residents' current overall health and care status. Records can be accessed appropriately by staff.

D7.1 Entries are legible, dated and signed by the relevant staff member including designation.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

There are pre-entry and admission procedures in place. Residents are assessed on entry to the service and needs assessments are sighted on the eight resident files sampled. The service liaises with assessment services and service coordinators as required. The service is pro-active in the community and meets with groups such as Alzheimer’s Society/Age concern. The service has a well presented information booklet for residents/families/whanau at entry. It is comprehensive and designed so it can be read with ease (spaced and larger print). Promotional material is currently being updated and the website is under review. The service has implemented "sharing the journey" family support group to assist them with coming to terms with a resident with dementia and provides education, care and support for both the family and the resident.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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

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

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

E3.1 Six resident files were reviewed and all includes a needs assessment as requiring specialist dementia care

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

The reason for declining service entry to residents is recorded should this occur and communicated to the resident/family/whanau. Staff report that the referring coordinator would be advised when a resident is declined access to the service and it is then their responsibility to inform the resident/family/whanau of other options that may assist them to meet their needs.

**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

Avonlea Dementia care and Hospital provide a caring homely environment for its residents to assist with normalising the service. Each unit has its own open plan kitchenette, dining and lounge area. The staff are committed to valuing each resident as an individual and practice the "best friends" approach to care and activities. Establishing relationships with families is achieved with community visits and bringing together families together "sharing the journey “at family support groups. Guest speakers such as lawyers, age concern and Alzheimer’s speakers attend the meetings. The Avonlea promotional material and website is currently being updated. Relatives (six dementia care and two hospital) spoke highly of the all the staff, the care, activities programme, medical care and the environment.

D16.2, 3, 4: The eight files reviewed (two hospital and six dementia care), identified that in all eight files an assessment was completed within 24 hours and all eight files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed by a RN and amended when current health changes. All eight care plans evidenced multidisciplinary reviews completed at least six monthly.

D16.5e: Eight resident files reviewed (two hospital and six dementia care) identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly. GP practicing certificate sighted.

The home GP is currently on leave with a locum GP providing the medical services. The four RN's interviewed stated the house GP visits twice weekly for three hours each time. The GP is notified prior to the visit if there are any resident concerns and three monthly reviews are conducted. The RN's send faxes for any resident concerns and the GP responds by a phone call or visit. After hours service is provided by the Pegasus group.

The physiotherapist is contracted for two hours a week to assess new residents, attend the six monthly reviews, update transfer plans and follow-up any concerns written into the communication book. The physio states that when she leaves any instructions required for the residents these are carried out by the staff. She is also involved in the assessment/purchase of equipment. The physio has a link with Arthritis N.Z. and provides an exercise training programme for the activities persons. Physiotherapist practicing certificate sighted.

Palliative care is provided with support from Nurse Maude nurses and specialists. Avonlea are in the process of implementing the Liverpool care pathway.

The four RN's interviewed described verbal and written RN handovers. The caregivers then receive handover from the RN on duty. The RN's state the caregivers are very prompt in reporting any resident health changes or incidents. Progress notes are maintained each shift.

A range of assessment tools are completed on admission and reviewed at least six monthly as applicable and include (but not limited to); continence assessment, falls risk, St Thomas risk assessment in falling elderly residents, braden pressure area tool, wound, nutritional screening, activity initial assessment , and pain assessment tools. There are other allied health assessments completed such as dietitian assessment and physio assessment. The diversional therapist also completes a comprehensive social assessment.

Tracer Methodology: Hospital resident

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

Tracer Methodology: Dementia resident

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

The information gathered at admission is used to set care plan goals and objectives for residents. The admission health assessment form provides a comprehensive assessment on admission and is used to develop the care plan goals and objectives. There is an on-going assessment of residents policy that includes assessments that should be in place and timeframes. RN's complete initial assessments within 24 hours of admission.

A range of assessment tools are completed on admission and reviewed at least six monthly as applicable and include (but not limited to); continence assessment, falls risk, St Thomas risk assessment in falling elderly residents, braden pressure area tool, wound, nutritional screening, activity initial assessment , and pain assessment tools. There are other allied health assessments completed such as dietitian assessment and physio assessment. The diversional therapist also completes a comprehensive social assessment. Assessments are conducted at the facility in agreement with the resident/family member or EPOA. Residents have private rooms where they can be assessed

Frequent falls physiotherapy assessments are carried out as required. Falls risk and interventions are well documented in care plans that include the use of sensor mats and hip protectors. Challenging behaviour assessments are well documented with excellent follow up into care plans for the dementia care files sampled. Behaviour monitoring forms are used to record behavioural or disruptive actions and describe distraction techniques. Wandering resident and identification form is included in the resident files as needed.

E4.2; Six resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a; Challenging behaviours assessments are completed

**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

Care plans are developed and reviewed by the RN’s. The long term care plan is developed within three weeks of admission. The care plan plans are holistic, comprehensive and meets residents needs and includes diagnosis/needs, aim and action. The first page of the long term care plan includes the resident details, medical problems, any special needs and name and signature of the resident/family member who has participated in the development of the long term care plan. The long term care plan describes needs as follows: hygiene and grooming, mobility, nutrition, continence, communication, cultural, rest and sleep, skin integrity, behaviour, medical and pain needs. A 24 hour MDT (multidisciplinary) care plan is completed by the DT and RN. The MDT care plan details the residents morning and afternoon habits, behaviours, activities or diversions that work, nocte pattern, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation. The activities person or family complete a resident activity profile sheet. The activity care plan identifies the residents individual values, beliefs, spirituality and culture. Short-term care plans are being utilised and reviewed on an on-going basis. The care plans are monitored for integration of notes through the regular care plan audit last completed in March-13 (100% compliance). Service delivery plans demonstrate service integration

Resident files are integrated and include; a) admission details, b) permissions, consents, c) activities profile, d) ID- walking resident at risk profile, e) restraint (if applicable, f) property list, g) significant events. h) LTCP and 24 hour care plan, i) activities plan, j) STCP, k) progress notes, l) incident forms. m) all assessments, n) allied health input, o) GP and other medical notes, p) lab results, q) NASC, r) correspondence.

E4.3, Six resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, Short term care plans are in use for changes in health status.

D16.3f; Eight resident files reviewed identified that family were involved. Relatives interviewed confirmed they are involved in the care planning process.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussion with caregivers, registered nurses, activity/DT staff and management. The care plans are well written, in-depth and reflect the service philosophy of care and support. The service actively links with community groups such as Alzheimer’s. The staff and facilities are appropriate for providing these services and are meeting the needs of residents.

Two hospital resident files sampled.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessments are comprehensive and include type, location and body map, graph, braden score, classification, factors delaying healing and any additional information. There is a wound dressing schedule and photographs for chronic or acute wounds (excludes skin tears). There are seven wounds (ulcers, one pressure area) and four skin tears across the five units. Wound assessments and treatment schedules are current. Specialist wound management advice is available as needed and this could be described by the RN's interviewed.

Continence products are available and resident files include an admission urinary and bowel continence assessment that is reviewed at least six monthly or earlier if there are any changes in resident continence. Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained.

Specialist continence advice is available as needed and this could be described by the RN's interviewed. Staff attended continence management in-services July-13.

Abbey pain assessments are completed on admission and reviewed at least six monthly for all residents prescribed pain relief. The effectiveness of pain relief is written into the progress notes.

Monitoring forms in use included behaviour monitoring, blood sugar levels, neuro observations and vital signs. RN faxes to GPs regarding changes in resident health status, suspected infections, new admission, medication requests sighted in the resident files sampled.

The dietitian visits monthly and completes any resident reviews due and attends to any referrals received for example residents with weight loss, initiates special authority for supplements and liaises with the cook regarding any resident dietary changes/requirements. Residents are weighed monthly or more frequently as per the weight loss management policy.

**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:** CI

Avonlea have five Diversional therapists (one qualified and four almost qualified) that work a variety of hours to implement a planned seven days activities programme across the five units. monthly teleconferences with other diversional therapy staff and the Diversional Therapy Coordinator at Christchurch. Activities staff are supported by a motivational and diversional therapy specialist who provides over-sight and leadership to the recreation team. Activities are also discussed at teleconferences so that each facility can learn from each other. There are monthly teleconferences with other diversional therapy staff and the Diversional Therapy Coordinator at Christchurch. Activities are also discussed at teleconferences so that each facility can learn from each other. DT's meet monthly with the Operations manager. The DT's develop a programme for each unit and there is close liaison with each other to ensure residents can attend entertainment or activities happening in other units. Resident preferences, including spiritual and cultural preferences and capabilities are considered in the delivery of the service activities programme. Monthly Anglican church services are held on-site. Other spiritual visitors can be accessed on resident or family request.

Over the two days of audit a variety of small group and individual activities are observed happening throughout the units from the morning until late afternoon. The hospital programme commences at 10am to 4.30pm and the dementia activities commence from 1.30-5.30pm in each unit.

D16.5d Resident files reviewed identified that the 24 hour individual activity plan is reviewed when at care plan review.

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

The programme reflects resident’s interest in the environment as appropriate to dementia care and they have choice in their level of participation. The activity staff complete individual assessments on resident admission, this is documented on the activities profile sheet, which is then used to develop the 24 hour activities care plan. Families are involved in the activity plan and provide information on the residents past and current interests and social profile.

**Finding Statement**

The DT plan is a key part of the overall LTCP and the service is pro-active in providing a meaningful programme. The programme is regularly reviewed with family and is extensive across the day. Interview with five activities staff from the five units noted that they are committed to working with residents and families and described how they had developed good connections with residents and have got to know them. Activities are based on the 'Best friends' approach to care. Staff have attended a "best friends “course and are now doing a refresher "come into my world". A range of activities are available for residents to choose from, with staff spending a large proportion of their time with 1 on 1 interaction with the residents. The hospital unit programme includes reminiscing, hand massages, music, chair exercises. Physical capabilities are considered in the delivery of the activities programme and there is a greater proportion of their time with 1 on 1 interaction with the residents. Everyday life activities are included in the programme for the residents within the dementia care, such as baking, folding laundry, household chores, walks in the garden and exercises. Advised that household chores are voluntarily undertaken by residents within their small homes. Each unit has an oven for home baking activities. There are visiting musical entertainers and sing-a-longs. There are as well as expressive programmes such as sing-a-longs and entertainers. Theme days, movies and Happy Hour is included into the programme as well as birthday celebrations and festive or special events. The DT contribute news and interesting/upcoming events for the facility newsletter. The design of the units ensures that a homely, family environment is in place to assist with normalising the service and provide activities in a calm environment. There are many seating nooks and quieter areas for residents who choose not to participate in group activities. Avonlea have a café club for the residents. There are weekly van outings which include farm animal visits. Resident outing risk assessments are completed by the DT's. Two staff (includes driver) go on every outing or van drive. All DT's have a first aid certificate. There are community visits such a shopping trips, picnics, feeding ducks and walks in the park. Family are encouraged to join in the activities programme. Families interviewed (six dementia care and two hospital) report that they are involved and can join in activities

**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

Nursing care plans are reviewed regularly and care plans are evaluated at least six monthly in the dementia and hospital unit and more frequently when clinically indicated. A multidisciplinary six monthly review is also completed with input from the nursing and care staff, GP, physio, resident or family/whanau as appropriate. Short-term care plans are reviewed as required. There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes.

There is evidence of on-going review and changes to care plans.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. There is evidence of on-going review and changes to the care plans in eight of eight resident files sampled.

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

**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 service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. Discharge and Transfer Planning and Resident Transfer to Hospital (Acute) policies are available to guide staff in this process. The service has a physiotherapist that visits weekly and a dietitian that visits monthly. There is good communication with the mental health for the older person’s team and the psychogeriatric services. Residents' and/or their family/whanau are involved as appropriate when referral to another service occurs. Referrals sighted in the resident files sampled include: dietitian, Canterbury Health DHB psychiatric service for elderly community team, wound nurse specialist, plastic surgery outpatient department, psychiatric district nurse, physio, consultant psychiatrist.

D16.4c; the service provided an example of where a residents condition had changed and the resident was reassessed from dementia care to hospital level of care.

D 20.1 discussions with three registered nurses identified that the service has access to a physio, dietitian and nurse specialists from the DHB.

**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

There is a Discharge Planning and Transfer Policy and Resident Transfer to Hospital (Acute) policies to guide staff in this process. Discussions with the service confirm that resident exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of residents care through the completed transfer form, copy of relevant progress notes, copy of medication chart and doctors notes. A staff member or family member accompany dementia care residents to the hospital. Discussions with the RN's and Clinical manager confirm that resident exit from the service is co-ordinated and planned and relevant people are informed. There is a verbal handover where required to new service providers to ensure continuity of residents care.

**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 Low

The medication management system includes Medication Policy and Procedures that follows recognised standards and guidelines for safe medicine management practice including, but are not limited to: a) medication management, b) medication charting c) standing orders, d) medication storage, e) blister pack management, f) medication administration, g) specific medication devices (such as spacers, oxygen, IV therapy, sub-cut fluid administration, novo-pen, etc.) h) medication errors, i) emergency medications, j) staff training, k) storage and administration of controlled drugs, l) alternative medication and m) medication audit. The service uses robotic system for regular medication and medico blister packs for PRN medications. The RN checks these on arrival from the supplying pharmacy. Radius pharmacy are available after hours to the service for urgent requests. Pharmacist practicing certificate sighted. Medication reconciliation is implemented via the 'Medication Management on Admission and Transfer policy' .RN's and Caregivers administer medications. Orientation to medications include a self-learning package and supervised medication rounds. Annual competency and medication education has been completed May-13. The medication folder contains standing orders, medication information folder on common medications, MOH medication guidelines and nutritional supplements list.

Each unit has a medication trolley and locked medication storage area. Controlled drugs are stored in a locked safe in a locked cupboard in each unit. A CD register is maintained and checked weekly in each unit. The hospital unit has emergency medications, suction and oxygen concentrator. Nurse Maude is accessed for advice, resources and syringe drivers as required. Staff attended Liverpool care pathway education May-13. There are adequate pharmaceutical and medical supplies sighted. Eye drops are dated when opened. Medication expiry dates are checked four weekly. The hospital medication fridge is monitored daily however the temperature (0-1 degrees Celsius) recorded over the last six months is outside of the acceptable range and there is no evidence of corrective action taken. The second medication fridge in the dementia unit is not currently in use.

D16.5.e.i.2; 16 medication charts (four hospital and 12 dementia care) reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed. GP prescribing meets the legislative requirements.

All medication charts had current photo identification and allergies noted. Special medication instructions and precautionary advice is recorded on the medication charts. There are no gaps in the administration signing sheets.

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

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

The hospital medication fridge is monitored daily however the temperature (0-1 degrees Celsius) recorded over the last six months is outside of the acceptable range.

**Finding Statement**

The hospital medication fridge temperature is outside of the acceptable range 2 - 8 degrees Celsius. There was no evidence of corrective action, however this was established on the day.

**Corrective Action Required:**

Ensure the medication fridge temperature is maintained within an acceptable range.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

There is a Kitchen Service Manual located in the kitchen which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. The main kitchen provides food to all the kitchenettes in each unit. Food is transported by hot boxes. Temperature checks are undertaken daily for the fridges, freezers, sanitizer, and hot foods at each meal time. Food in the pantry is stored off the floor and stock is rotated each week when the food order is delivered. Perishable food is covered and dated in the fridges. The cooks have undertaken food safety and hygiene training. Food safety competencies are also completed. Kitchen hands assist the cook and there is an evening meal assistant. There is a four weekly menu in place. An organisational food services management consultant reviews and advises on menus 12 monthly and more often if necessary. The service also has access to a Dietician monthly for review of resident needs. A resident dietary profile is undertaken on each resident on admission and a copy provided to the cook and updated as required by the RN’s. Special diets (eg. gluten-free), meal textures, likes and dislikes are known and catered for. Changes to residents’ dietary needs are communicated to the Kitchen. Monthly weights are completed and where there is an issue this is addressed through the care planning process and communicated to the cooks. Special equipment is available as required such as lipped plates. Care plans include clear instructions for nutrition needs across the 24 hours. Nutrition and hydration is identified as a component of the care plan and these were noted in the eight resident files sampled (two hospital and six dementia).

Feedback on the food service is received through staff and resident meetings. The cooks meet with management regularly. Kitchen service audits undertaken March and July-13 have 93-100% compliance. Ecolab provide the chemicals and conduct quality control checks. Chemicals are stored safely. Common kitchen hazards are identified.

Meals viewed in units noted that food services and the staff serving made efforts to provide meals that resident would eat.

E3.3f, there is evidence that there is additional nutritious snacks available over 24 hours.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

The service has in place Management of Waste and Hazardous Materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. These include, but are not limited to: a) sharps procedure and b) cleaning/chemicals procedures and c) exposure to blood or other body fluid contamination policy. There is an incident reporting system that includes investigation of these types of incidents. Chemicals are labelled correctly and stored safely throughout the facility. There is appropriate protective equipment and clothing for staff. Staff attended chemical safety training in Jan-13 and chemical safety competencies have been completed. Ecolab supply the chemicals, provide the safety data sheets and conduct quality control checks on the effectiveness of chemicals. Waste management contractors deliver and collect the drums weekly. Infectious material is double bagged and disposed of into the general rubbish drum. Recycling occurs. Mediwaste deliver and collect the approved containers for the disposal of sharps. Staff interviewed were able to describe waste management and chemical safety procedures.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The building has a current warrant of fitness that expires 1/6/2014. The building, plant and equipment appear to meet the required regulatory standards. The service is divided into five smaller home-like dementia care units (Awhi Whanua, Hoa Pumau, Ofa, Rudo and Aroha) and a 10 bed hospital unit (Mahal). Each unit has its own kitchenette, dishwasher, microwave, fridge, oven (dementia units) open plan dining and lounge areas. The décor is calming with bright artwork and adornments. Fresh flowers on the tables added to the home-like setting. Furniture and fittings are selected with consideration to residents’ abilities and functioning.

The maintenance person checks the maintenance books in each nurse station for day to day requests. Hot water temperature is checked weekly at the nearest and furthest point from the heating source. There is a pool of contractors available for larger maintenance problems. Planned maintenance schedules are in place for internal and external building maintenance. All resident related equipment has been checked. Electrical testing of equipment is current. Contractors complete a work sheet and report that is forwarded to the operations manager. An environmental safety audit is completed six monthly. The service has a smoking policy and smoking is only permitted in designated outside areas.

Residents were able to move freely inside and within the secure outside environments. The paths are flat and the exterior including the gardens are well maintained. The residents can enter/visit the other units from any of the external walk ways. There is shaded seating areas/gazebo and raised flower gardens. The hospital and dementia units are spacious and wide corridors allow for the use of mobility equipment. Handrails are in place within the communal areas.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; The following equipment is available, shower trolley, shower chairs, walking frames, gutter frames, overbed tables, commodes

pressure relieving mattresses, shower chairs, electric beds, ultra-low beds, roho pressure relieving cushions, hoist, resident transferring aids.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; There is a safe and secure outside area that is easy to access

**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

Two hospital rooms are ensuited. There are large communal toilets in the hospital wing and shower/shower trolley room. The facilities are close enough and large enough to meet the needs of the residents. All the dementia rooms have ensuites. Some are shared between bedrooms which are designated for female or male residents.

Fixtures, fittings and floor and wall surfaces are made of accepted materials for meeting hygiene and infection control practices. Communal toilets and showers are well signed and identifiable. There are engaged/vacancy signs on the doors and privacy curtains. There are appropriately placed handrails in the bathrooms and toilets in the ensuites and communal areas.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids and hoists. The bedrooms are personalised. The bedrooms in the dementia care unit have photos identifiable to the resident on their bedrooms doors. There are electric beds or ultra-low beds , all with memory foam mattresses.

**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

Each unit has its own kitchenette and open plan dining and lounge areas. Furniture is arranged to allow residents to freely mobilise between the different areas of each home and to the outside. In all units, the lounges are accessible and accommodate the equipment required for the residents. The security doors between Ofa and Rudo are opened up during the day to allow residents to mix and join in different activities. Activities take place in the dining room or lounge area of each unit dependent on the type of activity.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

The service has in place policies and procedures for effective management of cleaning and linen practices. The laundry is located at the hospital end of the facility. The caregivers carry out the laundering of the linen and personal clothing. The laundry is able to operate throughout the night. Colour coded linen bags and laundry is sorted into these. Soiled laundry is sorted into different coloured bags or buckets to identify type of treatment required. There is a dirty/clean flow which is marked on the floor of the laundry and there is an external door to the outside. There is adequate washing and drying equipment to cope with the volume of laundry and personal clothing. The daily laundry duties include the cleaning of lint from the dryers and maintaining a clean and tidy laundry area. The chemicals and oasis system are within a locked cupboard of the laundry. The cleaners carry their equipment and chemicals with them in a basket when carrying out the cleaning duties. There are two sluice rooms within the facility, one per three units. Protective equipment available in the laundry and sluice rooms are aprons, gloves and face shields. Families interviewed are very satisfied with the cleanliness of their relative’s rooms and the care taken with personal clothing. A cleaning services audit carried out March-13 scored 100%. A laundry services audit June-13 also scored 100%.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service provides staff training to implement its policies and procedures for civil defence, equipment and other emergencies. Fire safety and evacuation training is provided to staff during their orientation phase and at appropriate intervals. The following training was provided in 2013; fire warden training, fire drills, and civil defence. There is an approved evacuation scheme (July 2003). There was no changes required to the current evacuation plan and exit doors remain the same as a result of the change to include one hospital unit (Feb 13). There is someone on duty 24/7 with a current first aid certificate.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Civil defence kit and water supply is in place and meets requirements.

Resident rooms, toilets/showers and the lounge/dining areas have call bells. These also show up in other areas of the facility on panels. Emergency bells are heard throughout.

The service policies and procedures require that contractors are appropriately identified and a Contractor’s folder is well established. Security policy is in place and a daily security check is documented.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

General living areas and resident rooms are appropriately heated and ventilated. Four lounges had gas log fires with a fire surround. Corridor heating is thermostat controlled. Air conditioning is available. Family members interviewed state the home is lovely and warm. Residents have access to natural light in their rooms and there is adequate external light in communal areas.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention and it reviews past assistance / interventions. The service reviews the entire care plan monthly if a resident has restraint and this was documented well in the one restraint file reviewed.

These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The RN / restraint coordinator is involved in the assessment process along with the family and GP. Care plans include a full description of the approved restraint intervention and monthly evaluation.

Restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence such as a lap belt in a wheelchair. There is also a policy for Enablers. There are no residents with enablers. There are four residents on the register assessed as requiring intermittent restraint. Three hand holding' and one resident with T belt (requested by family following hospitalisation for safety). Although available as required, this has not been utilised.

E4.4a the care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

**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 restraint coordinator is the clinical manager and experienced in dementia care. The restraint approval process and the conditions of restraint use are recorded on the “Restraint risk assessment consent and management form”. Consent for Restraint use is logged in the Restraint register. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP in partnership with the resident and their family/ whanau. The multi-disciplinary team is involved in the assessment process.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

 The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. Restraint risk assessment, consent and management form is completed and signed by the resident rep (family / EPOA), RN, and GP and this was documented in the restraint resident file reviewed.

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

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

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

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

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

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

(f) Maintaining culturally safe practice;

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

(h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

The Restraint policy requires that restraint is only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, be monitored closely and this is done daily using a monitoring form or for hand holding in the progress notes. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. One file was reviewed for a resident with intermittent restraint. The review identified clear instructions for use of 'hand holding', approval process, risks and monitoring requirements.

The risk assessment, consent, and management form addresses this criterion and the restraint intervention is fully described in the care plan with daily monitoring records completed by staff.

The restraint register is in place and shows monthly evaluation. An updated register is completed each month and also shows discontinued restraints.

The management team completed a thorough investigation of a restraint incident Dec 12 of a resident restrained with a T belt for safety reasons. The investigation was completed because the correct process was not followed, i.e.: no approval/consent process had been completed. As a result of the investigation, findings and outcomes were established and evaluated. The residents EPOA was kept well-informed of the two restraint incidents, the investigation, outcomes and meetings were held with them. Staff statements were also read to the residents family at these meetings. Further training and competencies were completed with staff.

**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

One file was reviewed of a resident requiring intermittent 'hand holding' as a form of a restraint. The use of hand holding episodes are evaluated in the care plan monthly and documented, if a change occurs it is documented at the time. All episodes are also reviewed by the clinical manager (restraint coordinator monthly) and by the restraint committee.

**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 restraint coordinator is the clinical manager. Restraint approval group at Avonlea includes (but not limited to) a family rep, physiotherapist, GP, Safe Transferring Advisor, DT rep, management team, education coordinator (last met 27/2/13). Organisational report is completed around restraint use/training/incidents .

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The infection programme is reviewed annually (November 2012), this was completed with ICNs across the organisations.

The IC programme plan and IC programme description are available. There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the infection control committee at service and organisational level.

There is an established and implemented infection control programme that is linked into the objectives of the quality and risk management plan for 2012-2013. The IC programme includes six objectives that include performance indicators and evaluation. There is also a three monthly goal to decrease LRTIs and an annual goal to reduce UTIs. The quality committee includes a cross section of staff from all areas of the service. The IC meeting at Avonlea meets monthly and at an organisational level six monthly. The facility has access to professional advice within the organisation, from GP's and from an IC consultant CPH.

The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Hand hygiene notices are in use around the facility There is a staff health policy and staff infection and work restriction guidelines. There has been no identified outbreaks since previous audit. The outbreak management policy was recently amended to reflect current good practice with input from an IC consultant.

**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 monthly infection control committee meeting includes IC as an agenda item. The IC committee is made up of a cross section of staff from across the service. The service also has access to IC consultant, Pubic Health, GP's and southern community laboratory infection control team.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

The Infection Control Manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff. Policy development involves the organisation IC nurses, the infection control committee and expertise from the principal clinical manager, quality and systems manager, and southern community laboratories. The manual included a list of amended policies.

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff. Infection control programme includes infection control objectives as part of the quality and risk management plan. Policies include (but not limited to); a) hand hygiene, b) standard precautions c) transmission-based precautions, d) prevention and management of infection in staff, e) antimicrobial usage, f) pandemic planning, g) cleaning, disinfection, sterilisation, h) single use items, i) IC nurse duty schedule guidelines, j) IC education and staff training, k) IC education for residents and family.

The Infection Control Manual is structured around four sections includes (but is not limited to):

Section 1: directors commitment/IC programme

Section 2: staff responsibilities for IC,

Section 3: IC policies and procedures

Section 4: Management of waste and hazardous materials,

**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

The infection control nurse is responsible for co-ordinating/providing education and training to staff and is supported by the clinical nurse manager. There are internal and external sessions available for training. The IC nurse has attended a study day with an IC consultant and attends monthly IC training sessions at the DHB.

Resident/family education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of visitor education in the form of hand hygiene signs around the facility and at entrance ways. There is policy around provision of infection control education for family members. Advised that the three monthly family newsletter and family meetings are an opportunity for them to include relevant infection prevention information.

**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 policy describes and outlines the purpose and methodology for the surveillance of infections. The IC nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and southern community laboratory infection control team who advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

Infection control data is collated monthly and reported to the monthly infection control meeting. Infections are documented on the infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The IC programme is linked with the quality and risk management plan 2012-2013. The service benchmarks with other organisation owned services on a range of issues - infection control being one of them. The infection control surveillance data is also provided to QPS benchmarking service who provides reports to the organisation.

Quarterly reports are also completed from QPS benchmarking analysis. Monthly infection surveillance includes resident name, new/existing/acquired, type, symptom code, tests conducted, organism identified, treatment and whether resolved. Infection control surveillance outcomes are reported to all meetings and are included in the monthly staff bulletin. Analysis of trends is included in infection control meetings and an action plan established around good practice.

**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:**