**The O'Conor Institute Trust Board**

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

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

The O'Conor Memorial Home provides aged care rest home and hospital services in Westport on the west coast of the South Island for up to 34 residents. Eight of the 34 beds can be used for either hospital or rest home level care, and at the time of the audit there is full occupancy with eight rooms in use for hospital residents. The O'Conor Institute Trust Board provides governance to the facility, which is managed on site by a general manager, who is a registered nurse (RN), experienced in the role, and has been in the position for four years. There is a suitably experienced RN and a quality co-ordinator, who combine to relieve the general manager during any absence. There have been no additional alterations to the facility since the previous audit; however at the time of this audit, there is building on an extension underway.

There are 13 areas requiring improvement relating to: analyses of quality data; monitoring of water temperatures; designation, dating and signing all records; implementing a maintenance programme; ensuring communal rooms are free from odour; signatures on advance directives; completion of admission agreements; long term care plans; assessments; evaluations; reviews and medication management.

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

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit05-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Organisational Management** | Day of Audit05-Aug-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit05-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit05-Aug-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit05-Aug-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit05-Aug-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Some standards applicable to this service partially attained and of low risk** |

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

**Consumer Rights**

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is clearly displayed around the facility and discussed with each resident on admission. The policies of the facility support the Code and staff are trained at induction and annually on resident rights with regard to the Code. Staff display a respectful and warm manner towards the residents and actively attempt to accommodate their individual wishes in presentation of their bedrooms, social, cultural and spiritual needs. Visitors are greeted in a friendly way and meals are provided to family from out of town. Family are encouraged to be supportive of their family member and are involved in decisions regarding their care. Care is provided in a private, dignified manner which promotes independence and respect for the individual.

The spiritual and cultural needs and wishes of the residents are catered for with an on-site chapel, visiting priest and minister, and links with the local Maori and kamatua. Social opportunities exist for visits to churches and religious and cultural activities within the town.

There is a comprehensive activities programme which includes individual, group and community activities. The home has their own van and a shopping bus calls to take residents into town and return them to the facility. The programme offers connections with other facilities on the West Coast.

Feedback from residents and family confirms a welcoming, approachable staff that provide a clean homely environment for the residents and a commitment to good care. Family expressed satisfaction with the level of communication and opportunities to be involved in the lives of their family member.

The Motto of the facility is 'Our residents do not live in our facility, we work in their home'.

Improvement is required in the consent processes related to advance directives and for all residents to have their individual admission agreements and related consent forms signed.

There is a documented and implemented complaints management system that is accessible to residents, family and staff. Complaints are few and resolved within recommended timeframes.

**Organisational Management**

The quality and risk management system at O'Conor Memorial Home is recently established and implemented by the quality manager who works collaboratively with the general manager and professional staff to ensure services are planned to meet the needs of residents. The general manager is supported by registered nurses to provide clinical leadership and oversee day to day care.

Documented policies and procedures are in line with good practice, and are observed to guide staff on service delivery.

There is a robust internal audit system and an adverse event reporting process which provides quality and risk information, with information reported at the quality and risk management committee meeting held every second month, however data is not always analysed to identify trends and patterns and this is an area requiring improvement.

Risks are identified, however not all risks are being monitored to ensure the risk is minimised and this is an area of required improvement.

Resident’s records are current, accurate, and legible and kept secure. Archived records are retained according to legislation. Not all records are signed and dated and this is an area requiring improvement.

There is an extensive human resources management process in place including for appointment, orientation and on-going training. There is sufficient staffing levels and skill mix for all shifts. O'Conor Memorial Home has implemented the Aged Care Education (ACE) programme to ensure that all staff are appropriately trained to meet the needs of the resident group. On-going professional development is available for all staff and the accessibility and uptake of training is strength of the organisation.

**Continuum of Service Delivery**

Prior to admission to the facility a needs assessment is carried out by the Needs Assessment and Service Coordination (NASC) team and an Interview and Assessment form completed by the resident and family. Adequate and accurate information is supplied to the resident and family in the form of an information pack which includes pamphlets on the Code, a booklet on long term residential care, and a resident information document.

On the day of entry the Admission Agreement is signed by the resident/family and an assessment carried out to implement an initial care plan. This initial care plan is replaced by a long-term care plan within three weeks. Several supplementary assessments are carried out to support the development of the comprehensive holistic long term care plan which identifies needs and goals of the resident. The residents' identified goals have appropriate interventions written from which an evaluation of progress or achievement of, these goals can be gained.

Staff include qualified registered nurses and caregivers who undergo on-going training both within the facility and externally. A commitment to providing a respectful environment with opportunities for residents to create their own living spaces within their bedrooms is encouraged.

The medication management is overseen by a comprehensive policy which is implemented by a qualified registered nurse and trained caregivers who complete a yearly competency assessment.

An activities programme provides for individual, group and community involvement. Residents are facilitated to take part in community living with transport provided by a regular shopping bus and the O'Connor van. Several opportunities exist for involvement in religious and cultural practices.

The residents expressed satisfaction with the food and fluids offered according to a four weekly rotating menu developed by a qualified dietician. The kitchen staff display a commitment to food safety.

Areas for improvement consist of documented evaluation of the care plan and completing the supplementary assessments at least six monthly.

**Safe and Appropriate Environment**

O'Conor Memorial Home is a large building that provides a safe and comfortable environment for the residents and visiting community. Inside movement in all areas within the facility is easily managed, including with residents who are using aids and equipment. The facility has a current building warrant of fitness and an evacuation plan. The new building in progress on the south west side does not impede on access to the building and is fenced for safety.

The environment overall is well maintained, clean and tidy, and includes large communal rooms and external spaces which are accessible by the residents. There is a large chapel within the building where Mass is held weekly and as required by the community. An area requiring improvement relates to the odour of smoke impinging on communal areas.

Essential and emergency systems are well maintained and the building's warrant of fitness is current. There is fire protection, six monthly trial evacuations and procedures, and equipment for any civil defence incidents. Staff are trained in this area and their competency checked annually.

A call bell system and security measures are in place to ensure the safety of residents and staff at all times.

The maintenance person overseas on-going maintenance in the facility, however improvements are required as there is some maintenance required to be planned and documented.

Cleaning, laundry and waste management are in accordance with the documented policies and procedures. The laundry is managed onsite with some laundry contracted off site, and there is monitoring to ensure safe processes are maintained.

**Restraint Minimisation and Safe Practice**

There are policies and procedures in place for restraint minimisation and safe practice. There are three enablers in use at the facility that meet requirements, and enable the independence of the residents. There no restraints in use at the facility. Staff training occurs at least annually.

**Infection Prevention and Control**

A recognised infection control specialist is contracted to the O'Connor Memorial Home to ensure infection control knowledge, policies and procedures are current and best practice. The nurse manager performs the role of infection control coordinator as written in a specific job description. She is supported by an infection control committee with clear terms of reference. The nurse manager reports directly to the board of trustees on infection control.

The nurse manger, quality coordinator and registered nurse are involved in dispensing the written policies and procedures to the staff and supporting their knowledge of infection control. The contracted specialist is available to the infection control coordinator and committee to respond to questions and provide information and support. The infection control manual is comprehensive and was reviewed in June 2013. The infection control programme is reviewed yearly with two yearly policy reviews.

Records of infection are recorded, however these are not analysed and evaluated with the aim of infection prevention and reduction, and this is an area that requires an improvement.

Staff receive training on infection control at induction and annually. The kitchen staff undergoes specific training in food safety. Cleaning schedules promote hygiene and adequate equipment is available to ensure hand hygiene.

The O'Conor Memorial Home

The O'Conor Institute Trust Board

Certification audit - Audit Report

Audit Date: 05-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | The O'Conor Institute Trust Board |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| The O'Conor Memorial Home | 190 Queen Street, |       | Westport |

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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:** 05-Aug-13 **End Date:** 06-Aug-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXX | NZRN. Post grad dip (Otago) Lead Auditor | 16 | 12 | 05-Aug-13 to 06-Aug-13 |
| Auditor 1 | XXXXXX | NZRN, NZQA 8086 | 16 | 8 | 05-Aug-13 to 06-Aug-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXX | RN,MBA,NZQA 8086 |       | 5 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 32 | **Total Audit Hours off site** *(system generated)* | 25 | **Total Audit Hours** | 57 |
| **Staff Records Reviewed** | 9 of 36 | **Client Records Reviewed** *(numeric)* | 6 of 34 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 6 |
| **Staff Interviewed** | 8 of 36 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 5 |
| **Consumers Interviewed** | 3 of 34 | **Number of Medication Records Reviewed** | 13 of 34 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

I confirm that The DAA Group Limited has 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| The O'Conor Memorial Home | 34 | 34 | 8 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

The O'Conor Memorial Home provides aged care rest home and hospital services in Westport on the west coast of the South Island for up to 34 residents. Eight of the 34 beds can be used for either hospital or rest home level care, and at the time of the audit there is full occupancy with eight rooms in use for hospital residents. The O'Conor Institute Trust Board provides governance to the facility, which is managed on site by a general manager, who is a registered nurse (RN), experienced in the role, and has been in the position for four years. There is a suitably experienced RN and a quality co-ordinator, who combine to relieve the general manager during any absence. There have been no additional alterations to the facility since the previous audit, however at the time of this audit, there is building on an extension underway.

There are thirteen areas requiring improvement relating to: analyses of quality data; monitoring of water temperatures; designation, dating and signing all records; implementing a maintenance programme; ensuring communal rooms are free from odour; signatures on advance directives; completion of admission agreements; long term care plans; assessments; evaluations; reviews and medication management.

1.1 Consumer Rights

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Feedback from residents and family confirms a welcoming, approachable staff who provide a clean homely environment for the residents and a commitment to good care. Family express satisfaction with the level of communication and opportunities to be involved in the lives of their family member.

The Motto of the facility is 'Our residents do not live in our facility, we work in their home'.

Improvement is required in the consent processes related to advance directives and for all residents to have their individual admission agreements and related consent forms signed.

 There is a documented and implemented complaints management system that is accessible to residents, family and staff. Complaints are few and resolved within recommended timeframes.

1.2 Organisational Management

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There is a robust internal audit system and an adverse event reporting process which provides quality and risk information, with information reported at the quality and risk management committee meeting held every second month, however data is not always analysed to identify trends and patterns and this is an area requiring improvement.

Risks are identified, however not all risks are being monitored to ensure the risk is minimised and this is an area of required improvement.

Residents records are current, accurate, legible and kept secure. Archived records are retained according to legislation. Not all records are signed and dated and this is an area requiring improvement.

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1.3 Continuum of Service Delivery

Prior to admission to the facility a needs assessment is carried out by the Needs Assessment and Service Coordination (NASC) team and an Interview and Assessment form completed by the resident and family. Adequate and accurate information is supplied to the resident and family in the form of an information pack which includes pamphlets on the Code, a booklet on long term residential care, and a resident information document.

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The medication management is overseen by a comprehensive policy which is implemented by a qualified registered nurse and trained caregivers who complete a yearly competency assessment.

An activities programme provides for individual, group and community involvement. Residents are facilitated to take part in community living with transport provided by a regular shopping bus and the O'Connor van. Several opportunities exist for involvement in religious and cultural practices.

The residents expressed satisfaction with the food and fluids offered according to a four weekly rotating menu developed by a qualified dietitian. The kitchen staff display a commitment to food safety.

Areas for improvement consist of documented evaluation of the care plan and completing the supplementary assessments at least six monthly.

1.4 Safe and Appropriate Environment

O'Conor Memorial Home is a large building, that provides a safe and comfortable environment for the residents and visiting community. Inside movement in all areas within the facility is easily managed, including with residents who are using aids and equipment. The facility has a current building warrant of fitness and an evacuation plan. The new building in progress on the south west side does not impede on access to the building and is fenced for safety.

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Essential and emergency systems are well maintained and the building’s warrant of fitness is current. There is fire protection, six monthly trial evacuations and procedures, and equipment for any civil defence incidents. Staff are trained in this area and their competency checked annually.

A call bell system and security measures are in place to ensure the safety of residents and staff at all times.

The maintenance person overseas on-going maintenance in the facility, however improvements are required as there is some maintenance required to be planned and documented.

Cleaning, laundry and waste management are in accordance with the documented policies and procedures. The laundry is managed onsite with some laundry contracted off site, and there is monitoring to ensure safe processes are maintained.

2 Restraint Minimisation and Safe Practice

There are policies and procedures in place for restraint minimisation and safe practice. There are three enablers in use at the facility that meet requirements, and enable the independence of the residents. There no restraints in use at the facility. Staff training occurs at least annually.

3. Infection Prevention and Control

A recognised infection control specialist is contracted to the O'Connor Memorial Home to ensure infection control knowledge, policies and procedures are current and best practice. The nurse manager performs the role of infection control coordinator as written in a specific job description. She is supported by an infection control committee with clear terms of reference. The nurse manager reports directly to the board of trustees on infection control.

The nurse manger, quality coordinator and registered nurse are involved in dispensing the written policies and procedures to the staff and supporting their knowledge of infection control. The contracted specialist is available to the infection control coordinator and committee to respond to questions and provide information and support. The infection control manual is comprehensive and was reviewed in June 2013. The infection control programme is reviewed yearly with two yearly policy review.

Records of infection are recorded, however these are not analysed and evaluated with the aim of infection prevention and reduction, and this is an area that requires an improvement.

Staff receive training on infection control at induction and annually. The kitchen staff undergo specific training in food safety. Cleaning schedules promote hygiene and adequate equipment is available to ensure hand hygiene.

Summary of Attainment

* 1. Consumer Rights

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

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| Consumer Rights Standards (of 12): N/A:0 CI:0 FA: 11 PA Neg: 0 PA Low: 0 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA:22 PA:1 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Low | 0 | 6 | 2 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | PA Low | 0 | 3 | 1 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 5 PA Neg: 0 PA Low: 2 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:19 PA:3 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 | PA Low | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | PA Low | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | PA Moderate | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Low | 0 | 0 | 2 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 3 PA Mod: 2 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:15 PA:6 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | FA | 0 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | PA Low | 0 | 2 | 1 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | 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 | PA Low | 0 | 1 | 1 | 0 | 0 | 3 |

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

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | FA | 0 | 1 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | PA Low | 0 | 1 | 1 | 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: 4 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:8 PA:1 UA:0 NA: 0 |

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| --- |
| **Total Standards (of 50) N/A:** 5 **CI:** 0 **FA:** 34 **PA Neg:** 0 **PA Low:** 8 **PA Mod:** 3 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 80 **PA:** 13 **UA:** 0 **N/A:** 1 |

# Corrective Action Requests (CAR) Report

Provider Name: The O'Conor Institute Trust Board

Type of Audit: Certification audit

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

DAA: The DAA Group Limited

Lead Auditor: XXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.10 | 1.1.10.4 | PAModerate | **Finding:**1) There are several forms to gain written consent including for advance directives, photographs, outings, release of health information and flu vaccination. There are instances where all forms are not signed and dated. **Action:**The service demonstrates that written consent is obtained where required. | Three months |
| 1.2.3 | 1.2.3.6 | PALow | **Finding:**There is a robust audit system that covers all areas of service delivery, reported when shortfalls occur and a corrective action is implemented to address the issue, however this information is not analysed, and evaluated, and these results communicated to service providers. An example of this is repeat audits of care plans, showing deficits in assessments, and reviews. These are not analysed and evaluated to ensure the corrective action is effective and the results provided to staff. **Action:**Quality improvement data collected is analysed, evaluated and the results communicated to staff as appropriate. | Six months |

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| 1.2.3 | 1.2.3.9 | PALow | **Finding:**The facility has identified a risk relating to the hot water temperatures in two bedrooms and the back kitchen sink, in July. This is an on-going issue, however the issue has not been included on the hazard register, or a corrective action plan put in place, for this particular issue, to monitor and minimise the risk. There have been no reported risks associated with the temperature of the taps, so the risk has been mitigated.**Action:**Hot water taps that are not within recommended temperatures are identified, and monitored to minimise the risk, according to the severity of the risk, and included on the facilities hazard register. | Six months |
| 1.2.9 | 1.2.9.9 | PALow | **Finding:**In six files reviewed the date, signature and designation of the staff member is not included on a variety of forms reviewed, for example progress notes, medication signing sheets, assessment forms and activity plans.**Action:**All records include the name and designation of the staff member included, and all clinical notes are dated, as required in ARRC D7.1. There is not a register of staff signatures and designation to verify staff initials and signatures. | Six months |
| 1.3.1 | 1.3.1.4 | PALow | **Finding:**The Admission Agreement does not include information on staffing, fire and emergency, and right to request reassessment for means testing and/or level of care as per ARC D13.**Action:**The Admission Agreement includes the required information as per ARC D13. | Six months |
| 1.3.3 | 1.3.3.3 | PALow | **Finding:**One resident admitted in March 2013 does not have her long-term care plan signed by a nominated representative until July 2013.**Action:**All residents have a long-term care plan completed, in conjunction with the resident and/or their family, within 3 weeks of entering the facility. | Six months |

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| --- | --- | --- | --- | --- |
| 1.3.4 | 1.3.4.2 | PAModerate | **Finding:**Four of the six resident files have not had the supplementary clinical assessments completed within six months and the dates do not correspond to the review of the main care plan.**Action:**All supplementary clinical assessments identified as required by the RN for each patient are reassessed at least six monthly and in conjunction with the general care plan review. | Three months |
| 1.3.8 | 1.3.8.2 | PALow | **Finding:**Six of six residents' files have no evidence of evaluation of the degree of achievement, or response to, the interventions in the long-term care plan.**Action:**Evaluations are documented and indicate the degree of achievement or response to the interventions. | Six months |
| 1.3.8 | 1.3.8.3 | PALow | **Finding:**A resident’s complaints of abdominal pain and indigestion over a three day period were not transferred into a short term care plan for planned interventions and evaluation.**Action:**Where progress is identified as different from expected in the evaluation of care plans, the service responds by initiating changes to the service delivery plan. | Six months |
| 1.3.12 | 1.3.12.1 | PAModerate | **Finding:**There are instructions in the medication folder for two residents to have their medications placed in food. One resident was observed to be given crushed medication in food. **Action:**Medication that is administered in a crushed form is to comply with legislation, protocols and guidelines. | Three months |

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| --- | --- | --- | --- | --- |
| 1.4.2 | 1.4.2.1 | PALow | **Finding:**1. The facility does not have a maintenance programme in place to ensure all buildings, surfaces, plant and equipment are maintained and replacement and refurbishment is occurring. The general manager (interviewed) confirms this has been on hold until the completion of the new extension, however there are floor coverings (resident bedrooms, hallways and kitchen and toilet vinyl floors), wall surfaces in three bedrooms, the louver window that are in need of repair. 2. There is no monitoring of the touch temperature of the fixed wall heaters, and this is recommended to be included in on-going monitoring of the temperatures.3. The maintenance person (interviewed) visually checks and repairs areas on a monthly basis (for example hand rails, exit lights). But the signing register does not include any repairs made during this inspection.4. The van hoist does not have evidence of this being checked. **Action:**A maintenance register is required to be in place to ensure all buildings, plant and equipment is maintained and minimises the risk to residents. | Six months |
| 1.4.8 | 1.4.8.1 | PALow | **Finding:**There is a designated smoking room used regularly by at least one resident (observed). The door is required to remain closed, however it is observed to be open five times during the audit and the odour of cigarette smoke is prevalent in communal areas in close proximity. **Action:**Areas used by residents are ventilated and the environment is free from cigarette odour.  | Six months |
| 3.5 | 3.5.7 | PALow | **Finding:**There is no analysis and evaluation of the identified infections with the aim of identifying causes and reducing and controlling infection.**Action:**Results of surveillance, and specified recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to personnel and management in a timely manner. | Six months |

# Continuous Improvement (CI) Report

Provider Name: The O'Conor Institute Trust Board

Type of Audit: Certification audit

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

DAA: The DAA Group Limited

Lead Auditor: XXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

A policy on the Code of Rights which complies with the Code of Health and Disability Services Consumers Rights (the Code) was sighted (2011).

Staff are educated on the Code of Rights at induction and annually and expressed their knowledge of the Code. There are large posters displayed in communal areas to remind staff of the residents' rights.

Staff were observed to carry out care and communication in a manner that provides dignity, respect and privacy for the resident. Instances of the rights being enacted included the residents being addressed by their preferred name, their choices respected with regard to attendance at social gatherings, which clothing to wear and food to eat. Bedrooms are individualised with photographs, mementos, apparel and personal belongings.

Three of three residents interviewed confirm they are consulted on decisions in their daily living.

**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

Code of Rights pamphlets produced by the Health and Disability Commissioner are available at the entrance to the facility, included in the Admission Information Pack and the Service Information sheet (Feb 2012). Information on advocacy is available in pamphlet form at the entrance to the facility and included in the Resident Information document.

Staff display their knowledge of the Code of Rights and their ability to discuss this with residents.

Large posters are displayed around the facility for residents, their families and staff to read. Three of three residents and four of four family members acknowledge receiving and discussing this information and being aware of their rights. Further opportunities for rights to be discussed are at residents' meetings and during contact with families.

**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

Policies on Privacy and Dignity (November 2011) which identifies and complies with the Privacy Act 1993 and Detection and Prevention of Abuse are sighted.

Staff are observed to speak and behave towards the residents with respect, addressing residents by their preferred names. Care observed is carried out in the resident's bedroom, bathroom or toilet with the door shut to ensure privacy. All residents are dressed and groomed in a dignified manner. Three of three residents report their wishes are respected and carried out with regard to clothing worn. One resident keeps her curtains pulled to ensure privacy from the construction work next door while another resident keeps his curtains pulled back so that he can observe the construction.

Staff encourage independence with decision-making. One rest home level resident has been progressively assisted by staff to walk independently in the grounds of the facility while ensuring she is safe. This resident was initially unsettled on admission however the staff have successfully carried out a trial walking plan to ensure she can safely walk outside and return in an expected timeframe. This walk is now part of the resident's independent daily living.

There is a chapel on site to support the spiritual practices of the residents. Local priests and ministers visit. Communion is offered to residents. One resident is linked with the local Maori community and is offered the opportunity to watch the Maori television channel. One resident's bedroom was observed to display holy pictures on the wall. This resident is visited by a student nurse who is assisting the resident with learning the Maori language. The diversional therapy programme offers a variety of social opportunities for residents to choose from.

**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 Maori health plan (Nov 2011) is sighted and includes the three principles of partnership, participation and protection to underpin the organisation's philosophy and adhere to the holistic approach to healing: Whanau - Family health / wellbeing; Tinia - physical health / wellbeing; Hinengaro - Mental health / wellbeing; Wairua - Spiritual health / wellbeing.

Where, on admission, a resident identifies as Maori and wishes to obtain their own GP, that doctor will be provided with all information relevant to meeting the resident's cultural needs. A staff member, or other person appointed by the resident, can be present for the duration of all medical appointments and examinations if the resident chooses to request this.

Each resident identifying as Maori will have access to a designated person /advocate to provide support and an advocacy role. The local Maori advocate details are listed in the Resident Information document.

All staff receive Maoritanga training at orientation and on an on-going basis.

A resident who identifies as Maori is actively linked with the local Maori group, kamatua, and attends the Maori social welfare gatherings each month in the town. This resident is also facilitated to watch the Maori television channel as she understands the Maori language. Her sister, who also maintains her Maori traditions and involvement, lives locally and is in regular contact. The resident reports her sister has taken her to local activities involving the Maori culture. Another resident receives encouragement from staff with learning the Maori language and has been taken to the local library by the diversional therapist to take a book on the Maori language out on loan.

**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

Cultural safety policy (Nov 2011) is sighted. This policy states the O'Connor Memorial Home will meet cultural safety through recognising, respecting, and nurturing the unique cultural identity of individuals, and safely meet their needs.

The policy on Individual Values and Beliefs is sighted (Nov 2011). Individual values and beliefs are identified on admission through consultation with the resident / family / whanau. An historical view is recorded including culture, spirituality, family commitments and community involvement. On admission the transitional care plan records the initial preferences for cultural and spiritual identification. The care plan allows for this to be expanded on.

Feedback is obtained through regular surveys. A satisfaction survey has recently been sent out to families.

Access to interpreters, translators and cultural representatives are available on request. Information on how to access these services is included in the Resident Information document which enables privacy of access if required.

Staff training is on-going and those that attend cultural sessions report their experience at staff meetings.

Three of three residents report their satisfaction with their individual needs and wishes being accommodated and met. One resident who is a practising Catholic stated she has weekly communion in her room and attends Mass every Thursday in the chapel. She was observed to be praying with her rosary beads and her bedroom has holy pictures and religious books displayed. She is also learning the Maori language. One resident reports attending the monthly Anglican church afternoon tea and the regular Salvation Army lunch as part of the activities programme.

Four of four family members report their satisfaction with the care carried out with regards to individual needs. One resident enjoys horse racing and has been given a television in her room to enable her to watch the races.

**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

A Policy on Detection and Prevention of Abuse and Neglect is sighted (Nov 2011). Residents are given the brochure on the Code which fully explains their right to freedom from discrimination, coercion, harassment and exploitation, on admission. These brochures are also available at the entrance to the facility.

Staff receive training annually in the Code.

There is a section on sexuality and intimacy in the Resident Information document given on admission, and in the individual care plans.

Three of three residents and four of four family members reported satisfaction with the staff approach to residents with comments such as "never hear a cross word"; "can't fault the staff approach"; and "only kindness and care". The GP stated: " always clean, always nice - unfailingly nice".

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

Policies sighted that reflect good practice include: assessing and monitoring challenging conditions; management of challenging behaviours; open

disclosure and informed consent. An advance directive form which documents the residents wishes on their resuscitative status, and who they have discussed these wishes with, is available for completion on admission. There is an option on the advance directive form for the resident to document they do not wish to make these decisions at that time. There is a section related to sexuality and intimacy in the resident information document.

Clinical procedures sighted which are relevant to the resident's care were continence assessment and management, infection prevention and control, smoke free policy, medication management, pain assessment and management, personal grooming and hygiene, personal privacy and dignity, providing culturally safe care, recognition of people’s rights, restraint minimisation and safe practice, advance directives, spirituality, skin management, transportation of residents and wound care.

The O'Connor Memorial Home mission statement, clause four, includes a statement of belief in the highest standards of care, endorsement of quality improvement projects and that each caregiver should actively seek education and training opportunities to enhance knowledge and skills.

 There is a RN on duty at all times, a planned in-house training programme, and opportunities and encouragement for caregivers to take part, and gain qualifications in the ACE training programme.

Staff are observed to carry out good practice.

The care plans include information, goals and interventions related to communication, memory, behaviour and mood, personal care, dressing and undressing, skin, mobility, oral and nail care, elimination, nutrition, sleep, safety, spirituality and sexuality and intimacy.

 Three of three residents and four of four family members reported their satisfaction with the care. Comments from residents are: "great, fantastic"; "good, excellent"; and "well looked after". Family comments include: " delighted with continuing superb care"; and "happy with care, rung when something to report".

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

An Open disclosure policy is sighted (Nov 2011). The policy advocates that disclosure to the resident should generally be made when an adverse resident event has occurred. In some incidents consideration should be given to discussing adverse events that do not result in injury (i.e. near misses). Typically disclosure should be within 24 hours of the event depending on the specific circumstances of the event.

Interpreter and translation services policy (Nov 2011) is sighted and provides contact details for services. The interpreter policy identifies interpreter availability with braille, sign language, dictation, te reo Maori and other languages. The policy states those residents with hearing and visual deficits are accorded the degree of explanation or repetition necessary to establish recognition. Staff name badges are large.

The Code of Rights pamphlet provided to residents, displayed on walls, and available at the facility entrance, confirms the residents' right to effective communication.

Active family communication sheets are sighted in three resident’s files.

Staff are observed explaining and giving information to residents. Resident meetings are held regularly to enable residents to be informed, ask questions and discuss issues.

Three of three family members confirm they are kept up to date with matters relating to their family member. All report the staff to be friendly and approachable and state they feel able to discuss freely. Family members were given the opportunity to fill in a Satisfaction Survey form two weeks prior to the audit.

**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:** PA Moderate

The informed consent policy (November 2011) sighted includes residents' rights relating to advance directives and complies with the Health and Disability Commissioner's Code of Rights. The Code of Rights pamphlet given to residents on admission provides a full explanation of informed consent. Three of three residents and four of four family members confirm receiving these pamphlets.

Signatures indicating consent are gained on the admission agreement, advance directive form, care plans, restraint, release of health information, permission to photograph and consent for outings and indemnity. Six of six files reviewed contain signatures for the various consent forms. Four of the six files are fully signed.

One rest home level care resident does not have her admission agreement signed until four months after admission to the facility. One resident was observed to have her medication placed in her food and there are written instruction, on a form inside the medication folder, for two other residents to have their medication placed in their food. There is no medical authorisation or written consent for this to occur. Six advance directive forms are sighted. Four are signed by family and two by the residents. The facility stated their belief one resident has an active enduring power of attorney, however there is no documented evidence when this was activated or if it has been reviewed. One has a signed consent for an enabler and her daughter stated she signed the care plan in consultation with her mother.

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

1) Four of six residents' advance directive forms are signed by family members or a nominated representative. 2) One resident who regularly goes on outings with the O'Connor staff has not had a consent for outings form signed. 3) one of six admission agreements is not signed and dated. 4) three residents are involved with having their medication placed in food without formal consent. in the There is written consents signed for all areas requiring consent, including advance directives, outings, photographs, flu vaccination, however four of six residents who have advance directives signed by the family or nominated representative, and not all other consents are signed or completed as required.

**Finding Statement**

1) There are several forms to gain written consent including for advance directives, photographs, outings, release of health information and flu vaccination. There are instances where all forms are not signed and dated.

**Corrective Action Required:**

The service demonstrates that written consent is obtained where required.

**Timeframe:**

Three months

**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

An Advocacy Policy is sighted with written information on how advocates can be contacted. This information includes how to contact the South Island, local and Maori advocates.

Information on advocacy services is included in the resident information document and pamphlets on advocacy are available at the front entrance. Staff are aware, through training, of the advocacy services available.

Two of three residents confirm their knowledge of advocacy availability. The third resident is diagnosed with memory impairment. Four of four family members confirm the facility's encouragement, and their ability, to provide support to their family member.

**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

The Admission Interview and Assessment form (Feb 2009) collects details of the resident's primary contact, secondary contact and other family members. The diversional therapy assessment collects information on residents' interests and hobbies and the care plan links these to community resources, such as the library, care and craft group, local churches, St Vincent de Paul and the local Maori organizations.

Staff were observed to greet family members and visitors in a friendly and welcoming manner.

There is a bus that calls to take residents shopping and the O'Connor Home has their own van.

Residents have a choice of two lounges or their bedrooms to entertain their visitors. A private phone booth, computer and printer is available to facilitate contact.

Three of three residents report they are actively assisted to maintain these links with transport and staff available to accompany them to outside activities. One has a note inside the cover of her care plan stating her wish not to receive a particular person as a visitor.

Four of four families report they can visit at any time and are always made welcome. One resident spoke of her two sons being given a midday meal as they had travelled from Christchurch to Westport.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

There are policies and procedures in place that meet Right 10 of the Code. All complaints and concerns received are written, initially on a reportable events form, and then transferred to a complaints log - sighted in one of one recent complaint. A reportable events form is available at the entry to the facility, and information is included in the resident information package. Family (five of five) and residents (three of three) know how to access the complaints process, but of those interviewed no one has needed to use the process. Staff interviewed (eight of eight) verify they have training and knowledge in the complaints process.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

The facility's quality policy is reviewed (November 2011) and includes clear purpose, scope, goals and directions of the organisation, and these are reviewed regularly (two yearly). There is an overall governance trust of three persons who are notable in the community (one of one trustee interviewed), and have input into the scope and direction of the organisation.

The day to day service is managed by a registered nurse (RN) (interviewed) who has been in her role for four years, and she is ably supported by another RN who relieves in her absence. Both have current practising certificates (sighted) and on-going professional development, and job descriptions that include the management role.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

The general manager (interviewed) is a registered nurse and has oversight on a day to day basis. During her absence another RN will provide the service management (clinical) position. There is a suitably qualified quality manager (interviewed) who provides the administrative role while the general manager is on leave. Professional development and practising certificates are sighted.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

There is a comprehensive quality plan (September 2012 - August 2013) sighted and includes objectives, action points, responsibility, timeframes and progress including how these will occur. The risk management policy (sighted) details risk factors, potential harm, risk level and likelihood, monitoring and control measures, responsibility and completion dates on a detailed 12 page plan.

Policies and procedures sighted are being reviewed at least every three years, according to the organisation's document control policy, or more regularly as required. A document control system is in place to manage the reviews of all documents. These are observed to be current on the days of the audit.

Key components of service delivery is included in the risk management plan. A reportable events form is completed for any issues relating to adverse events, and these are current and closed out within acceptable timeframes.

There is a robust and comprehensive audit system that covers all areas of service delivery, health and safety and adverse events reporting. A corrective action is implemented to address issues as they occur, with one exception relating to the water temperature monitoring

The general manager is interviewed and records sighted for the facility's four committee's involved in reporting - infection control (three times each year), restraint and enablers (three times a year) , health and safety (four to five times each year) and a team meeting (monthly). Kitchen and dining room staff (interviewed) also meeting monthly. Care staff and registered nurses (interviewed) verify they receive feedback from quality meetings.

There are two areas of required improvement relating to analyses of quality improvement data, and including specific risks on the hazard register.

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

There is a robust and comprehensive audit system that covers all areas of service delivery, health and safety and adverse events reporting. A corrective action is implemented to address the issue, however this information is not analysed, and evaluated, and these results communicated to service providers

**Finding Statement**

There is a robust audit system that covers all areas of service delivery, reported when shortfalls occur and a corrective action is implemented to address the issue, however this information is not analysed, and evaluated, and these results communicated to service providers. An example of this is repeat audits of care plans, showing deficits in assessments, and reviews. These are not analysed and evaluated to ensure the corrective action is effective and the results provided to staff.

**Corrective Action Required:**

Quality improvement data collected is analysed, evaluated and the results communicated to staff as appropriate.

**Timeframe:**

Six months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

Actual and potential risks are identified, documented and measures put in place to address the issue, however this has not been included in the hazard register.

**Finding Statement**

The facility has identified a risk relating to the hot water temperatures in two bedrooms and the back kitchen sink, in July. This is an on-going issue, however the issue has not been included on the hazard register, or a corrective action plan put in place, for this particular issue, to monitor and minimise the risk. There have been no reported risks associated with the temperature of the taps, so the risk has been mitigated.

**Corrective Action Required:**

Hot water taps that are not within recommended temperatures are identified, and monitored to minimise the risk, according to the severity of the risk, and included on the facilities hazard register.

**Timeframe:**

Six months

**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

The reportable event recording, reporting and investigation policy is sighted. All reportable events are reported and the facility's general manager (interviewed) is aware of their statutory rights in relation to essential notifications, for example infections and reporting to the coroner (records sighted).

Incidents to be reported include patient related, property and equipment related, security, staff injury, near misses, hazards, harm or serious harm and environmental events that may cause staffing issues or shortfalls, or impact the services provided. There is a monthly record of incidents, and an annual graph and summary (records sighted).

Staff interviewed verify the process in reporting adverse events that is reflective of the facility's policies and procedures (sighted0.

A recent reportable event (sighted) relating to security, identified the need for increased measures to be implemented, and monitoring to increase to improve the facility's security.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

There are position descriptions sighted for all areas: activities co-ordinator, receptionist/administrator, caregiver, cook, dining room assistant, enrolled nurse, gardener/handyman, housekeeper, registered nurse (RN), team leader, general manager, and quality manager. All job descriptions sighted contain position description, responsibilities, functional relationships, key tasks and expected outcomes for all positions.

Practising certificates of five registered nurses (including the general manager) are sighted and current. The medical practitioner, pharmacist registration is (sighted).

All staff are required to complete an induction and orientation programme relevant to their area, verified in staff interviews. The booklet when completed is signed off by the RN, team leader or general manager and placed in the employee's hard copy records. Staff records are sighted of this being as completed for RNs (four) an enrolled nurse EN (one), care staff (three) and cleaning staff (one).

There is annual on-going professional development for all RNs, and monthly training for care staff (records sighted). Cleaning, kitchen and the maintenance person (interviewed) attend training appropriate to their role and all attend fire and emergency training annually (records sighted).

 The general manager is interviewed, and the facility's roster is reviewed. There is an RN on each shift, with a current first aid certificate. The roster is covered to include staff trained appropriately to meet the needs of the residents (records sighted).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

The staff number and skills mix policy (March 2012) is sighted and includes factors considered when determining staff numbers and skill mix. The general manager (interviewed) develops the roster to ensure there is a safe staffing level and the mix includes an RN, and senior trained staff. There is a separate care staff assigned for specific dementia related diagnosed residents (contract) and observed to attend specifically these residents.

The care roster sighted for a two week period is reviewed and includes:

Morning shift- one registered nurse (RN), three full time care staff (eight hours), two part shift care staff (four hours and six hours) and one specific dementia care staff (eight hours).

Afternoon shift - one RN, one full time care staff and two part shift care staff.

Night shift - one RN and one care staff.

Family and residents interviewed (including one Maori resident) verify that staff do appear to have sufficient time and are not rushed. There is the availability of casual staff to be called on if shortfalls occur.

Rosters sighted for the past two weeks verifies the regular use of on call casual staff. Staff interviewed (nine of nine) are comfortable that there are sufficient staff on all shifts (staff from all care shifts interviewed).

There are separate cleaning, kitchen, maintenance, and garden staff (records for these areas sighted). The maintenance person, cleaner and kitchen staff are all interviewed, observed and documentation and rosters are sighted. All rosters and staff schedules are in line with the facility's policies and procedures.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

Six residents' files are reviewed and show evidence that information is entered in a timely and accurate manner in the integrated files. Staff (interviewed) are aware of the need to keep information confidential, and observation on the days of the audit that this occurs.

Archived records are secure and retained according to legislation, and observed to be easily retrievable.

 An area for improvement relates to entries on patients' files having the the name and designation of the staff member included, and all clinical notes are dated, as required in ARRC D7.1. There is not a register of staff signatures and designation to verify staff initials and signatures.

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

Six resident files are reviewed. The records are legible with the signature of the person entering the information. However the signature, designation and date are not always included. There is not a register of staff signatures and designation to verify signatures.

**Finding Statement**

In six files reviewed the date, signature and designation of the staff member is not included on a variety of forms reviewed, for example progress notes, medication signing sheets, assessment forms and activity plans.

**Corrective Action Required:**

All records include the name and designation of the staff member included, and all clinical notes are dated, as required in ARRC D7.1. There is not a register of staff signatures and designation to verify staff initials and signatures.

**Timeframe:**

Six months

**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:** PA Low

Entry criteria policy (Jan 2012) is sighted. Entry criteria includes details about the facility, type of residents needs most able to be met, business location, full time residential and hospital, prioritising of residents where adequate bed numbers are not available, criteria around referral processes, self-referrals, timeframes for referrers, out of hours contact if applicable, cost of services, review of service and feedback process and when the facility may ask a resident to leave the facility. The criteria are distributed electronically to NASC agencies, other private referral agencies, the local DHB, Aged Concern and on request from the general public.

The Admission Agreement was sighted and does not include information on staffing, the right to request a reassessment for means testing and/or level of care as per ARC D13, and fire and emergency however all this information is included in the resident information document.

Pre-entry processes to determine the risk assessment of each prospective resident is undertaken in the form of a NASC assessment and the admission interview form which is completed with the resident and their family.

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

The admission agreement does not include information on staffing, fire and emergency, and the right to request a reassessment for means testing and /or level of care as per ARC D13. This information is included in a comprehensive resident information document which is given to the resident at the time of entry.

**Finding Statement**

The Admission Agreement does not include information on staffing, fire and emergency, and right to request reassessment for means testing and/or level of care as per ARC D13.

**Corrective Action Required:**

The Admission Agreement includes the required information as per ARC D13.

**Timeframe:**

Six months

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

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

ARHSS D4.2

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

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

The declining entry to service policy (Jan 2012) is sighted. The policy includes meeting with the resident and their family and guidelines and contact details for other services. Information on declining entry to the facility and when a resident will need to leave the facility is included in the admission agreement. The Nurse Manager stated only one resident has been declined entry following review of the Needs Assessment and discussion with the NASC Agency. It was decided this potential resident required more specific support and dementia care than was available at the facility. The O'Connor Home is licensed to provide general hospital and rest home care however also has individual contracts for dementia care where the facility decides it is able to provide the appropriate standard of care to the dementia resident. The Nurse Manager reports one resident was transferred to a specific dementia care facility in Greymouth after two weeks of initial care at the O'Connor Home following discussion with the resident/family and NASC agency.

The GP discussed the care of dementia clients at O'Connor and stated the need to balance dementia care with the general residents care to ensure comfort for all residents. The GP provides his services to all residents and has referred residents to other health professionals/agencies where he has deemed appropriate.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

The overall responsibility for the care of the residents is provided by the nurse manager who is a NZ qualified RN. There is a RN on duty over the full 24 hours. The RN is supported by care staff who undergo training in the ACE programme as well as attending in-house training. New care staff are buddied by experienced caregivers until deemed competent to act alone by a RN. The roster indicates new staff and their buddy with an asterisk against each name.

Each resident has an admission interview and assessment form completed prior to, or at entry, with their family. Each subsidised resident has a full interRAI assessment carried out by the NASC team prior to entry. Initial care plans are completed within 24 hours and long-term care plans within three weeks. Long-term care plans are planned for review each six months and a record of reviews is kept by the quality coordinator who discusses up-coming reviews at the registered nurse meetings.

Rosters indicated staff work in teams and documentation encourages care staff to work together. Handover takes place between shifts.

The GP expressed great confidence in one of the full-time RNs and he reports that there is now a "better quality nursing team". He described an easy congenial relationship with the nursing staff and satisfaction in the care provided.

Tracer 1 hospital level resident:

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

Tracer 2 rest home level of care 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:** PA **Risk level for PA/UA:** Low

One of six resident files reviewed did not have the long term care plan signed until four months after date of entry. There was no indication that this resident was placed in an unsafe situation.

**Finding Statement**

One resident admitted in March 2013 does not have her long-term care plan signed by a nominated representative until July 2013.

**Corrective Action Required:**

All residents have a long-term care plan completed, in conjunction with the resident and/or their family, within 3 weeks of entering the facility.

**Timeframe:**

Six months

**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:** PA Moderate

Each subsidised resident has a NASC assessment completed prior to entry. The facility has an Admission Interview and Assessment form which is completed with each resident and their family prior to, or, on entry. On admission the RN completes an initial assessment and prepares an initial care plan within 24 hours. This initial assessment is supported by the NASC assessment and supplementary assessments carried out at a later date. Supplementary assessments include falls prevention, continence, mental ability, challenging behaviour, pain and pressure area risk. Monthly recordings are taken of weight and blood pressure.

Six of six files contain initial and supplementary assessments. Four of the six files supplementary assessments are not reviewed within six months and not reassessed at the time of the review of the long-term care plan.

The assessments support the development of the residents' goals which are written on the top of each section of the care plan. Short term care plans are written for identified problems

One resident is under the care of a psychiatrist and community mental health nurse. A letter from the psychiatrist dated July 2013 and a risk management care plan developed by the community mental health nurse are included in the file. The resident had requested a review of her medications and the letter reflects the outcome of that request. This resident expressed her satisfaction that her request for a review of her medications by the psychiatrist was acknowledged and acted upon. The resident's daughter stated she is involved in the formal six monthly assessment and is kept up to date regularly on an informal basis.

On-going assessment is evidenced in the daily progress notes and short-term care plans.

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

Four of the six resident files reviewed do not have the supplementary clinical assessments completed within six months and the dates do not correspond with the review dates of the long term care plan.

**Finding Statement**

Four of the six resident files have not had the supplementary clinical assessments completed within six months and the dates do not correspond to the review of the main care plan.

**Corrective Action Required:**

All supplementary clinical assessments identified as required by the RN for each patient are reassessed at least six monthly and in conjunction with the general care plan review.

**Timeframe:**

Three months

**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

Initial, short-term and long-term care plans are completed in conjunction with the resident and/or their family. There is a section at the base of the care plan for the resident and/or family to sign off the plan.

The care plans include physical, psychological, social, and spiritual needs. The care plans identify residents' goals and the associated interventions to meet these goals. Diversional therapy assessments and records are filed alongside the nursing care plan. The long-term care plans are reviewed every six months. The resident or family sign off the reviewed care plan. Six of six files viewed contain signatures at the base of the care plans.

Three of three residents spoken with confirm their involvement with their assessment and development of the care plan. Four of four family members confirm the care plan has been discussed with them.

**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 provision of service is carried out in a daily routine that meets the resident's needs as identified in their care plan. Staff are observed carrying out care in a competent and friendly manner. Residents have access to linen cupboards, telephone, computer, television, separate lounges and social activities. There is a supply of continence products, disposable gloves, paper towels and hand wash in each bedroom. Meals, morning and afternoon tea rounds were observed to be carried out at expected times. All three residents spoken with state great satisfaction with the care they receive and the manner in which it is given. Four of four relatives spoken with state their satisfaction with the care delivered.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

On admission a diversional therapy assessment is completed for each resident. This assessment includes past occupations, lifestyle, interests, hobbies and spiritual and cultural priorities. An individual activities plan is developed in conjunction with the resident.

A monthly activities programme is written and includes group, individual and community sessions. Community involvement is encouraged with visitors and entertainers coming into the facility and residents going out for various activities, such as lunches, craft groups, shopping and visits to the Museum. The programme includes opportunities for involvement in religious and cultural activities, such as the local Maori group entertaining the residents as reported by one resident. Residents identified as requiring dementia care are accompanied by a trained dementia carer for community outings. Three family members interviewed confirm they can visit at any time if the day. The monthly activities programme is displayed in each room and the daily programme is written on the whiteboard in the dining room.

Each activity is planned on an individual sheet which details the group size, resources required, benefits, adaptations for individuals, health and safety requirements and evaluations.

The transportation requirements for individual residents was reviewed in July 2013 and this is sighted.

Each resident's care file includes a diversional therapist assessment, an Activities Care Plan, a record of the resident's involvement over a one year period and individual progress notes. The assessment is up-dated six monthly when the Care Plan is reviewed.

The diversional therapist has undergone three levels of training for diversional therapy as well as completing the twelve ACE modules, the twelve Dementia Care ACE modules, yearly fire drills and two yearly first aid training. This staff member also attends the n-house training. She is employed for thirty five hours per week on a Monday to Friday basis. The diversional therapist states she receives peer support by attending a yearly diversional therapist conference and meeting with other diversional therapists on the West Coast three-four times a year.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

The care plans are computer generated and up-dated six monthly. The quality coordinator states once the up-dated care plan is generated the previous plan is filed in a separate place from the resident's record. There is no evidence in the resident's current file of the degree of achievement, or response to, the interventions of the long-term care plan.

Short-term care plans are reviewed every two/three days (eg, at each dressing for a skin tear), signed and dated as sighted in the care plans. The short-term care plans reflect the progress notes, however one resident’s complaints of indigestion and abdominal pain over a three day period were not transferred to a short term care plan.

Three of three residents and four of four families report they are included in the review of the resident's progress.

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

Six of six resident’s files do not contain evidence of an evaluation of the degree of achievement, or reponse to, the interventions in the long term care plan. The short term plans contain regular written notes of evaluation of progress.

**Finding Statement**

Six of six residents' files have no evidence of evaluation of the degree of achievement, or response to, the interventions in the long-term care plan.

**Corrective Action Required:**

Evaluations are documented and indicate the degree of achievement or response to the interventions.

**Timeframe:**

Six months

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

There was no other indication that short term care plans were not in place when required

**Finding Statement**

The complaints of abdominal pain and indigestion over a three day period were not transferred into a short term care plan for planned interventions and evaluation.

**Corrective Action Required:**

Where progress is identified as different from expected in the evaluation of care plans, the service responds by initiating changes to the service delivery plan.

**Timeframe:**

Six months

**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

Referral to outside agencies is coordinated by the RN, Nurse Manager or GP. One resident reports she requested a review of her medication. The resident was facilitated by the nursing staff and GP to attend a consultation. The resident's file recorded the subsequent letter received following the review and the Nurse Manager confirms there had been medication changes. A resident, who identifies as Maori, is linked with the local Maori community and attends Maori social groups monthly.

**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

Policies on Transition, Exit and Discharge and End of Life are sighted. Discharge from the facility is unusual as the facility provides life care options in the form of rest home, hospital and individual dementia care arrangements. The nurse manager reports one resident was transfered to a specialist mental health facility following a two week period with the facility. Once the facility decided they were unable to meet this resident's needs transfer was coordinated between the facilities and the NASC service. One resident reported on the respectful care of a deceased resident and the spiritual support offered. The admission interview form requests information on End of Life instructions, information on pre-paid funeral arrangements and whether the resident is to be cremated or buried.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

 The medication management policy (Jan 2013) is sighted. This Policy includes verbal orders and self -administration.

All residents have a medication profile and medication chart. The medication profile consists of a plastic covered photograph of the resident with their personal details and allergies documented. The profile sits in front of the resident's prescription sheet in the medication folder.

Medications are ordered from the pharmacy by delivering the medication order by hand or fax. The pharmacist makes up the packs and initials this as correct. The RN reports the packs are checked by a RN against the medication chart on receipt at the facility. The RN signs a notebook to confirm the blister pack matches the prescription. This notebook is sighted. Progress notes document the effectiveness of the medication.

Verbal orders are not considered best practice and where possible a direct photocopy or fax for the signed chart or prescription is preferred. After hours telephone orders are accepted, and are only current for 48 hours. There is one telephone order sighted that had not been prescribed in the medication sheet for 13 days. There is no other evidence of prescribing outside of the policy timeframes. Medication out of hours is available from the hospital and Buller Medical Services on prescription.

The medication Policy states 'alternative remedies' are obtained by the home as required. There is no evidence that this practice has occurred.

Medications are locked in a cupboard in blister pack folders and taken to residents in the medication trolley which is lockable. While not in use the medication trolley is locked and padlocked to a heater within the nurses’ station. Controlled drugs are kept in a locked safe attached to the floor of the cupboard. RNs check amounts monthly and reconcile in the Controlled Drug Register. A small amount of controlled drugs are kept for palliative residents.

There is a laminated poster on the outside of the locked medicine cupboard reminding staff of the 'five rights' of administration of medication. All staff administering medication have a competency assessment yearly.

There is a folder for the medication charts. Inside the folder is a sheet describing each resident's individual administration requirements (eg, in saucer, on teaspoon). Instructions to place the tablets in food are documented for two residents. On observing the medication round one resident's medications were sighted to be crushed and placed in food. There is no written instruction from the GP to administer any medications in food and no written instruction as to which medications could safely be crushed before administration. It is unclear whether the resident is aware they are having medication administered. The RN carrying out the medication round keeps the medication trolley within view at all times and waited beside each resident until the medication is taken.

On speaking with the GP he states he is willing to speak with the families and residents to gain consent and authorize for medications to be crushed and administered in food where it is deemed to be in the best interest of the resident.

As there is a RN on duty 24 hours a day all medication is dispensed by an RN. Six staff files were viewed and medication competency confirmed. The exception is the diversional therapist who may administer medication to residents when out in the community. The diversional therapist has undergone competency training and administers only prescribed medication from a blister.

All eye drops are dated and replaced after one month.

Thirteen medication charts are reviewed. Every resident had their allergies noted and a clear photograph. Each medication is written in a legible manner, signed and dated by the GP. Discontinued medications have lines drawn through the prescription and a date of discontinuation with GP signature. Six of the thirteen medications sheets did not have a reason written for all as required (prn) medications. The GP reviews each medication sheet three monthly. The blister pack sheet is initialled by nursing staff for each administration.

There is a policy on self-administration however this is not encouraged. The policy includes confirmation of competency by the GP three monthly, education of the resident, and a locked drawer to safely store the medication. One resident is self-administering her paracetamol tablets. The resident explained the process she carries out for self administration. She keeps her medication in a locked drawer in her room and signs a record of administration. There is no evidence this resident is not safe with her self-administration. A GP assessment of competency three monthly is sighted in her file.

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

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

One resident was observed to be given crushed medication in her food. Two residents have instructions written in the medication folder for their medication to be placed in food. It is unclear if the resident is consenting to receiving this medication. No corresponding written authority or consent was sighted for this practice to occur. The GP stated he is willing to discuss this issue with the residents/families to gain consent and authorize where it is deemed to be in the best interests of the resident.

**Finding Statement**

There are instructions in the medication folder for two residents to have their medications placed in food. One resident was observed to be given crushed medication in food.

**Corrective Action Required:**

Medication that is administered in a crushed form is to comply with legislation, protocols and guidelines.

**Timeframe:**

Three 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

The facility has recently delegated quality projects to staff and appointed a kitchen manager. The kitchen manager works in the kitchen and has taken responsibility for ensuring all processes and equipment meet the required standards. The hazard analysis and critical control point system was sighted as up to date.

The kitchen manager and cook were spoken with and explained the processes of the kitchen.

Goods are delivered to the back door. All dry goods are stored in dated sealed containers. All containers are either on shelves or stored off the ground on wheels or wooden platforms. Spare containers are available to be filled and used when the current container is emptied. The facility is in the process of purchasing new containers and chopping boards. The chopping boards are colour coded. A legend of the coding is displayed beside the storage area for the chopping boards.

A record of temperatures are kept for the fridge, freezers and dishwasher as well as hot and cold foods. Written guidelines for food temperatures are sighted. The freezer is checked each Monday and frozen food discarded after three months. Unused sandwich fillings are discarded after two days. Milk is dated and rotated on a left to right basis.

Food safety certificates are displayed on the kitchen wall for each of the three cooks. Each staff member working in the kitchen undergoes food safety training and infection control training at induction and annually. The cook is observed wearing gloves when making sandwiches and reported the policy is to wear gloves when preparing any foods not to be cooked. Utensils are used when serving food. Hats are worn by all staff working in the kitchen area and fully covered their hair.

Nutritional, safe food and fluid management policy (Jan 2012) is sighted and includes all processes for the safe storage and handling of food.

The menu is a four weekly cycle and divided into summer and winter menus. The menu is developed by a NZ registered dietitian, was reviewed May 2013 and sighted. The current menu being followed is the four week rotating winter menu. Three residents and four family members stated their satisfaction with the meals provided. One resident had purchased her own steak and mushrooms for herself and another resident. This meal was cooked at a special time for these two residents.

New kitchen cleaning schedules with tick lists have been developed as a kitchen staff project in conjunction with the Nurse Manager, Quality Coordinator. These schedules are due to commence next week. The current cleaning schedules were sighted. The oven is cleaned weekly. Cleaning chemicals are stored in a locked cupboard. There is a fire blanket, fire extinguisher and hose reel in the kitchen.

Two whiteboards in the kitchen record special diets, likes and dislikes, and special crockery/cutlery arrangements for individual residents.

Leftover food is covered, dated and stored for use within 24-hour. Unserved puree food is dated and frozen to provide an alternative for residents requiring puree meals. Food waste is placed in buckets and removed from the kitchen twice daily.

For the thirty four residents there were four care staff to assist with meals on the day of audit. Two more staff joined the dining room half way through the mealtime.

**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 health and safety officer is interviewed. Management of waste and hazardous substances at O'Conor Memorial Home is confirmed by on site audits of processes and inspection by the quality manager. The Waste management policy (2013) is sighted, and covers management and disposal of waste generated throughout the organisation. All waste is observed at the audit to be handled in such a manner that it does not cause harm / injury to personnel or the environment. The facility has a focus on recycling waste (sighted) and verified in discussion with cleaning, kitchen and maintenance staff. Soiled laundry is placed in designated coloured bags / trolleys and transferred in these covered trolleys to the laundry. Sheets and towels are placed in an external area and collected three times a week.

Food waste is placed in the compost heap in the back garden (observed) and reviewed daily by the maintenance person (sighted).

Appropriate sized sharps container are available in service areas and disposed of safely (observed). Personal protective equipment (PPE) is observed to be available throughout the facility and also observed to be used by staff.

Safety information data is available for all areas (sighted), and there is a chart for waste so staff can easily identify which receptacle to place the waste in. Soil, sharps, pharmaceutical, hazardous, boiler house, recycling, foul waste and safety data information is all detailed and easy for staff to follow.

 Personal protective equipment sighted in all service areas and strategically placed around the facility.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

A building warrant of fitness (sighted) expires on 6 April 2014. The current building has not had any alterations, however there is currently a new extension building on the south west side of the building, and there are appropriate barriers in place so residents and staff are able to move safely around the facility, and not enter into the hazardous building area (observed).

The maintenance person and the quality manager are interviewed. There is a register to ensure all equipment is tested biennially, and functionally tested annually (records sighted).

The physical environment is spacious enough to ensure that residents are able to move safely around the facility (observed). Handrails are placed in areas that require extra assistance (three stairs have rails installed on both sides of the stairs). Bedrooms have adequate space to allow for any equipment and aids that the resident may require, and this includes shared rooms (observed).

There are safe and accessible external areas into the large expansive gardens, including the covered porch areas. Residents and family interviewed confirmed they have access and use the expansive outdoor areas. There is one area of required improvement relating to a maintenance register.

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

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

A building warrant of fitness (sighted) is current, and there are repairs occurring as they occur. Visual inspections occur regularly by the maintenance person (records sighted), however there is not a maintenance programme in place.

**Finding Statement**

1. The facility does not have a maintenance programme in place to ensure all buildings, surfaces, plant and equipment are maintained and replacement and refurbishment is occurring. The general manager (interviewed) confirms this has been on hold until the completion of the new extension, however there are floor coverings (resident bedrooms, hallways and kitchen and toilet vinyl floors), wall surfaces in three bedrooms, the louver window that are in need of repair.

2. There is no monitoring of the touch temperature of the fixed wall heaters, and this is recommended to be included in on-going monitoring of the temperatures.

3. The maintenance person (interviewed) visually checks and repairs areas on a monthly basis (for example hand rails, exit lights). But the signing register does not include any repairs made during this inspection.

4. The van hoist does not have evidence of this being checked.

**Corrective Action Required:**

A maintenance register is required to be in place to ensure all buildings, plant and equipment is maintained and minimises the risk to residents.

**Timeframe:**

Six months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

The facility has a mix of shared (double) and single rooms that either have a shared full ensuite between two separate bedrooms, or a single bedroom with its own full ensuite, or a room with no ensuite facilities, however there are an adequate number of communal toilet, shower and bathing facilities to meet the needs of the resident group. It is noted that there is an easily accessed toilet area close to the communal dining and lounge rooms.

Each area is well equipped to manage mobility, shower and toilet aids that may be required. Observed during the audit that shower chairs are easily used in the full ensuite.

There are separate staff toilet, shower and change facilities and separate visitors toilet and hand washing facilities.

**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

Each bedroom has adequate room for equipment, aids and visitors. Privacy is maintained (verified in patient and family interviews) in shared rooms with curtains. Observed a patients in a wheelchair easily moving around his bed space. Hallways are sufficiently wide with handrails in areas to provide assistance if required.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

There are several spacious areas for family and residents to sit and have a conversation in private (observed). A large spacious dining area includes seating positioned so small groups can sit and talk without impinging on others private conversations (observed). There is a large entry foyer and chapel for those who wish to have quiet and private space.

Family and residents interviewed verify they utilise many spaces inside and outdoors. The outdoor area is easily accessed from three separate doors, and ramps lead to the spacious grounds. On the day of the audit the weather was very inclement so the outdoor areas are not observed to be in use.

**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 facility's laundry management and housekeeping policies are sighted and include guidelines for handling soiled linen, heavily soiled linen, disinfection and drying of linen, protective clothing to be used and laundry cleaning detailed. Observation of staff on the days of the audit confirm practice is reflective of policy.

Housekeeping guidelines details the cleaning duties and procedures for all aspects of the facility including chemical usage and safe storage (sighted), disinfectant use, cleaning and decontamination of equipment and environment, and staff interviewed demonstrate knowledge of this.

Records sighted verify staff are trained in all aspects of chemical, cleaning and emergency procedures.

The quality manager (interviewed) confirms audits undertaken by the external company Ecolab on the effectiveness of chemicals used (sighted).

**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

Policies and procedures relating to fire prevention, protection and response (October 2012) are sighted.

Earthquake and flood policy includes process for emergency response and use of emergency kit, collection of medication folder, telephone instructions, and await civil defence instructions. Emergency action guide is detailed and provides guidelines for all instances of an emergency response requirement.

There is an approved evacuation plan (sighted) for the facility. Fire and emergency training occurs every six months (records sighted), and all staff are expected to attend at least annually (training records sighted).

The facility general manager is interviewed. The call bell system is available at all bedsides and communal rooms for residents or staff to summon assistance as required (observed). Three calls alert an emergency.

The maintenance person is interviewed. The facility has an alternative energy source - a generator - held at the local district council (the mayor is one of the trustees). Gas cooking is also available as well as the facility's gas barbeque. There is a water stored if required (sighted) which contains over 20.000 litres of water.

Cleaning, kitchen and maintenance staff have training in handling of chemicals annually (records sighted). Staff interviewed are able to demonstrate knowledge in fire and emergency procedures.

The building is secured at night with overnight access by a bell at the front entrance.

There are documented security arrangements with a security firm, and within the facility, and the facility liaises with the Westport police if required. A recent security alert is evidenced (records sighted) to be managed appropriately by the facility.

An alternative energy lighting system is in place (records sighted), and a generator on hand for any emergency situation.

**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:** PA Low

There is a smoke free policy sighted (March 2012) in place and a smoking lounge is provided and is the only area within the building where smoking is permitted. Smoking is not allowed in the facilities vehicles for transporting residents. There is one area of required improvement relating to ensuring that smoke from the designated smoking room does not impede on communal areas.

There is at least one generous sized external room in all bedrooms and communal areas (observed).

There is one area requiring improvement relating to the odour fro the smoking room.

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

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

There is a designated smoking room used regularly by at least one resident (observed). The door is required to remain closed, and has signage to indicate this, however it is observed to be open five times during the audit and the odour of cigarette smoke is prevalent in communal areas in close proximity.

**Finding Statement**

There is a designated smoking room used regularly by at least one resident (observed). The door is required to remain closed, however it is observed to be open five times during the audit and the odour of cigarette smoke is prevalent in communal areas in close proximity.

**Corrective Action Required:**

Areas used by residents are ventilated and the environment is free from cigarette odour.

**Timeframe:**

Six months

**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 facility has policies and procedures in place for the safe use of enablers and restraints. There are three residents who have enablers in place and this is included on the enabler register, monitored and reviewed.

There are no residents who have restraints in place (observation and records sighted).

Staff interviewed (nine of nine) verify they attend restraint minimisation, training and enabler use on a regular basis (annual training sighted), and demonstrate knowledge in the definition of each.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The policy and procedure manual for infection prevention and control (June 2013) is sighted. Approved 22 November 2011 signed by a representative of the O'Conor Home Trust, and reviewed annually. The manual includes detailed policies and procedures that cover all areas of infection control. The policies have been reviewed in June 2013 by a qualified infection control specialist who is contracted to the facility. Changes to infection control policies and procedures are signed off by the board of trustees before handing to staff to read and sign. The quality co-ordinator, nurse manager and RN spoke of the process for review of policies and procedures and how the staff are educated following the signing off by the board.

The nurse manager is responsible for the overall effectiveness of the programme and is supported by an infection control committee and the board of trustees. A specified section of the nurse manager's report to the board is dedicated to informing the board on infection control matters. Records of infections form part of this report.

A job description for the position of infection control coordinator and terms of reference and members for the infection control committee are sighted. Infection control committee meeting minutes are displayed for all staff to read. A notice requesting visitors with infections not to enter the facility is displayed at the entrance.

**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

There is liaison between the infection control specialist, the nurse manager, quality coordinator, RNs and the infection control committee to ensure an adequate infection control programme. Both the nurse manager and quality coordinator confirmed the name of the person contracted to the facility in relation to infection prevention, control and educational knowledge and resources. Both staff members know how to contact the specialist if in need of advice. The signature of the specialist is sighted in the infection control manual. Notices and posters that promote infection control (eg handwashing technique, visitors not to enter the facility if unwell) were sighted around the facility. Regular infection control committee meetings take place.

Hand sanitizer dispensers were sighted in public areas and all residents bedrooms. Also in the bedrooms were disposable gloves and paper towels.

**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 which includes policies and procedures reviewed by a recognised infection control specialist is sighted. The manual is comprehensive and dated as reviewed by the specialist in June 2013. The RN, nurse manager and quality coordinator confirm their involvement with the distribution of information from the manual to the infection control committee and staff.

**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 board has contracted a recognised infection control specialist to ensure infection control information is up to date and policies and procedures meet current best practice guidelines. These policies and procedures guide the staff in carrying out their daily duties in a manner that minimises risk of infection. Infection control training is undertaken by staff at induction and annually by suitably qualified personnel. The nurse manager and quality coordinator report the topic for the infection control training in 2012 was standard precautions and in 2013 laundry policies and procedures. All staff took an active part in processing laundry to increase their knowledge of this subject.

Specific food safety training is undertaken outside of the facility by the cooks who have their qualifications displayed and both the kitchen manager and cook spoke of the processes they use to prevent infection in the kitchen.

Posters are displayed which encourage hygiene, cleanliness and infection prevention. Residents are supported to practise hand hygiene by knowledgeable staff and the provision of micro shield hand wash and paper towels in their bedrooms.

**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:** PA Low

Identified infections are recorded in an infection control record. The nurse manager states she is responsible for reporting the infections to the infection control committee and board of trustees. The RN reports the infections are collated three monthly however there is no analysis and evaluation of the infections to identify causes and promote prevention.

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

Infections are recorded in an infection control record and reported to the infection control committee and board of trustees through the nurse manager. There is no analysis and evaluation of the identified infections to identify causes of infection to promote prevention.

**Finding Statement**

There is no analysis and evaluation of the identified infections with the aim of identifying causes and reducing and controlling infection.

**Corrective Action Required:**

Results of surveillance, and specified recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to personnel and management in a timely manner.

**Timeframe:**

Six months