**Queen Rose Retirement Home Limited**

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

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

**General overview**

Queen Rose retirement home is situated in Dunedin, and is certified to provide rest home level care to up to 29 residents. On the day of audit there were 28 residents at Queen Rose. The service is owned and operated by a family partnership. One owner is in the manager role and he is supported by three other owners, registered nurses and care staff. There is an implemented quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified that improvements relating to: ensuring that advanced directives are appropriately signed, provision of cultural awareness training for staff, aspects of care plan documentation and implementation, medication management and competencies, and safe storage of chemicals.

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

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit24-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit24-Jul-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit24-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit24-Jul-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit24-Jul-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit24-Jul-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

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

**Consumer Rights**

Queen Rose strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. There is an improvement required around resuscitation forms. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. The education planner needs to include cultural awareness training for staff. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are actively managed and well documented.

**Organisational Management**

Queen Rose is owned and operated by a family partnership. There is an implemented quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following internal audits and meetings. Key components of the quality management system link to monthly staff meetings. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Discussions with residents and family identified that family are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. There is an improvement required around cultural awareness training. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

**Continuum of Service Delivery**

Residents at Queen Rose Retirement Home are assessed prior to entry by the Needs Assessment Team, and an initial assessment is completed on admission. Care plans are developed by the registered nurses who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Caregivers complete progress notes at the end of each shift. Family/whanau is kept informed about the resident's care. Families interviewed were supportive of the services provided and the needs of their family member being met. There are improvements required in regards to the documentation of assessments, care plans, evaluations and wound care management.

The medication management system includes medication policy and procedures and there is on-going education and training of staff in relation to medicine management. Improvements are required around medication management. Ace Food service provides meals for the facility with winter and summer menus appropriate for this type of service. Dietician input is obtained. Residents' food preferences are identified and this includes consideration of any particular dietary preferences or needs.

**Safe and Appropriate Environment**

Furniture and fittings are selected with consideration to residents' abilities and functioning. Residents can and do bring in their own furnishings for their rooms. Floor surfaces are appropriate and equipment is obtained as identified. There are adequate numbers of toilets and showers with access to a hand basin and paper towels. The service has two large lounges and dining area. Furniture is appropriate to the setting and arranged that enables residents to mobilise safely and independently. The service has in place policies and procedures for effective management of laundry and cleaning practices, however this audit identified improvements are required in regards to safe storage of chemicals. The service has policies and procedures for civil defence and other emergencies. There is staff on duty with a current first aid certificate. Call bells are in use. Security procedures are established. General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas

**Restraint Minimisation and Safe Practice**

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There were no residents requiring restraint or enabler use at the facility on audit day.

**Infection Prevention and Control**

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Queen Rose Retirement Home

Queen Rose Retirement Home Limited

Certification audit - Audit Report

Audit Date: 24-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Queen Rose Retirement Home Limited |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Queen Rose Retirement Home  | 63 Queens Drive | St Kilda | Dunedin |

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

# Audit Team

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| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | RCpN, Health auditor, AdDipBusMan, CertQA | 8.00 | 5.00 | 24-Jul-13 |
| Auditor 1 | XXXXXXXX | RN, Health auditor | 8.00 | 4.00 | 24-Jul-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXXX |       |       | 2.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 11.00 | **Total Audit Hours** | 27.00 |
| **Staff Records Reviewed** | 5 of 18 | **Client Records Reviewed** *(numeric)* | 6 of 28 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 6 |
| **Staff Interviewed** | 8 of 18 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 1 |
| **Consumers Interviewed** | 7 of 28 | **Number of Medication Records Reviewed** | 12 of 28 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 26 day of August 2013

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

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

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

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

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

# Services and Capacity

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|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Queen Rose Retirement Home  | 29 | 28 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Queen Rose retirement home is situated in Dunedin, and is certified to provide rest home level care to up to 29 residents. On the day of audit there were 28 residents at Queen Rose. The service is owned and operated by a family partnership. One owner is in the manager role and he is supported by three other owners, registered nurses and care staff. There is an implemented quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified that improvements relating to: ensuring that advanced directives are appropriately signed, provision of cultural awareness training for staff, aspects of care plan documentation and implementation, medication management and competencies, and safe storage of chemicals.

1.1 Consumer Rights

Queen Rose strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents’ rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. There is an improvement required around resuscitation forms. Annual staff training reinforces a sound understanding of residents’ rights and their ability to make choices. The education planner needs to include cultural awareness training for staff. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are actively managed and well documented.

1.2 Organisational Management

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1.3 Continuum of Service Delivery

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1.4 Safe and Appropriate Environment

Furniture and fittings are selected with consideration to residents’ abilities and functioning. Residents can and do bring in their own furnishings for their rooms. Floor surfaces are appropriate and equipment is obtained as identified. There are adequate numbers of toilets and showers with access to a hand basin and paper towels. The service has two large lounges and dining area. Furniture is appropriate to the setting and arranged that enables residents to mobilise safely and independently. The service has in place policies and procedures for effective management of laundry and cleaning practices, however this audit identified improvements are required in regards to safe storage of chemicals. The service has policies and procedures for civil defence and other emergencies. There is staff on duty with a current first aid certificate. Call bells are in use. Security procedures are established. General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas

2 Restraint Minimisation and Safe Practice

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There were no residents requiring restraint or enabler use at the facility on audit day.

3. Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of Attainment

* 1. Consumer Rights

|  |  |  |  |  |  |  |  |  |
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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 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: 12 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA: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 | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 6 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:21 PA:1 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | 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 | PA Moderate | 0 | 1 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Moderate | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Low | 0 | 1 | 1 | 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 | 2 | 2 | 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: 6 PA Neg: 0 PA Low: 2 PA Mod: 4 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:14 PA:7 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 | PA Low | 0 | 1 | 1 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 5 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:16 PA:1 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 1 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 1 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 3 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 2 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 1 | 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: 8 |

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 5 **CI:** 0 **FA:** 37 **PA Neg:** 0 **PA Low:** 4 **PA Mod:** 4 **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:** 83 **PA:** 10 **UA:** 0 **N/A:** 8 |

# Corrective Action Requests (CAR) Report

Provider Name: Queen Rose Retirement Home Limited

Type of Audit: Certification audit

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

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.10 | 1.1.10.7 | PALow | **Finding:**Two of the six resident files reviewed identified that resuscitation status was documented as family wishes and signed by someone other than resident.**Action:**Ensure that resuscitation wishes and/or advanced directives are only signed by resident or those with authority to do so. | 3 months |
| 1.2.7 | 1.2.7.5 | PALow | **Finding:**On review of the training provided in the past two years, it was noted that cultural safety and Treaty of Waitangi training has not been conducted.**Action:**Provide cultural safety training for staff | 3 months |
| 1.3.3 | 1.3.3.3 | PALow | **Finding:**One of the six resident files reviewed did not evidence that an initial assessment or initial care plan had been completed within 24 hours of admission.**Action:**Ensure that initial assessments and initial care plans are completed within 24 hours of admission. | 6 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.4 | 1.3.4.2 | PAModerate | **Finding:**(i) One of the six resident's reviewed has chronic pain and is on Controlled Drugs but has not had pain assessments completed and has a history of falls yet has no falls assessment completed; and (ii) one of the six resident's reviewed has challenging behaviour with no triggers or de-escalation interventions documented. **Action:**Ensure all assessments and risk assessments are conducted for all residents with identified issues, to provide the basis of documentation for care planning and interventions | 3 months |
| 1.3.5 | 1.3.5.2 | PAModerate | **Finding:**The areas of deficit are transferred to the long term care plan, however care plan lacks adequate information to provide level of intervention required in areas of non-deficit e.g. cultural and spirituality. One resident reviewed has safety concerns identified (falls risk and nutrition and hydration) on initial resident information, however there are no interventions related to the risks identified in care plan; two residents with challenging behaviour assessed have very limited documentation in regards to triggers of behaviour and interventions required to deescalate any undesirable behaviour.**Action:**Ensure needs other than areas of deficit are included in the long term care plan. | 3 months |
| 1.3.6 | 1.3.6.1 | PAModerate | **Finding:**a) Initial assessment and information documents that resident weight is to be monitored monthly. In all six files reviewed there were gaps in weight records over the past six months. b) There are currently six wounds being managed at Queen Rose Retirement Home, however there was no wound assessment and wound management plans are in place. **Action:**a) Monitor and document all interventions as identified. b) Document wound assessment and wound management plans for all wounds. | 1 month |
| 1.3.8 | 1.3.8.2 | PALow | **Finding:**Evaluations of care plans do not indicate the degree of achievement of documented goals in all six files reviewed. **Action:**Ensure that individual care plan goals are evaluated and document the degree to which goals are achieved.  | 3 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.12 | 1.3.12.1 | PALow | **Finding:**Weekly stock take of controlled medication has not occurred.**Action:**Conduct weekly checks of controlled medication | 3 months |
| 1.3.12 | 1.3.12.3 | PAModerate | **Finding:**The newly employed registered nurse has not completed a medication competency, at interview confirmed that she does administer medications **Action:**Ensure that all staff with responsibilities for medication administration are deemed competent to do so - including the registered nurse. | 1 month |
| 1.4.1 | 1.4.1.1 | PALow | **Finding:**There is a locked cupboard in the laundry for chemicals required for cleaning, however on the day of the audit, chemicals were left insecure in laundry. **Action:**Ensure that all chemicals are stored securely when not use. | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Queen Rose Retirement Home Limited

Type of Audit: Certification audit

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

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

The code of health and disability rights is incorporated into care. Discussions with four caregivers identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with seven residents and one family member confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in May 2013 in the form of a competency questionnaire.

**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 leaflets are available at the entrance to the facility. Code of rights posters are on the walls in the hallway of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. If necessary, staff will read and explain information to residents. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement as evidenced in six of six files reviewed.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people’s beliefs and values. Interventions to support these are identified and evaluated. Queen Rose's mission statements is: "To ensure a quality of life for all residents in our care with compassion, honesty and integrity. We will respect the rights of each resident, the right to privacy, and the right to be independent. We will give encouragement and assistance where needed to maximize potential for independence. We will open opportunities for involvement with friends within the home and the community. We will support and be aware of cultural and religious beliefs. We will recognize the importance of involvement of families/whanau in the provision of care to ensure residents needs are met in a caring, comfortable, safe and secure environment."

There is a policy that covers abuse and neglect and staff have completed training in September 2011.

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

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

D4.1a Six of six resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. Seven residents interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times.

**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

There are current policies and procedures for the provision of culturally safe care for Māori residents. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. Cultural awareness and Tangihanga training has not occurred in the last two years. Improvements are required in this area - link #1.2.7.

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

D20.1i The service has developed links with local iwi. There are currently no Maori residents at Queen Rose.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The Queen Rose retirement home's mission statement is implemented in practice and flows through into each person’s care plan and could be described by four care givers interviewed. During the admission process, the registered nurse, along with the resident and family/whanau, complete the documentation. Regular reviews are evident and the involvement of family/whanau is recorded in the resident care plan. One family member interviewed stated that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. Chaplaincy services are provided to residents as well as weekly church services.

D3.1g The service provides a culturally appropriate service by implementing the Queen Rose retirement home mission statement.

D4.1c Six of six care plans reviewed included the residents social, spiritual, cultural and recreational needs. Seven of seven residents interviewed confirmed that the care provided meets their needs

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct. Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment.

Performance appraisals are conducted and staff receive supervision. Discussions with seven residents identify that privacy is ensured.

Discussions with four care givers described how professional boundaries are maintained. Discussions with the manager and a review of complaints identified no complaints of this nature. Discrimination training for staff was provided in January 2013.

**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

A2.2 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are provided by an external consultant, who provides regular updates for the service to maintain best practice. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through residents meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.

There is an internal audit schedule. It includes (but is not limited to): care plan audit, laundry, recreation programme, care giver ADL audit, six week post admission procedures, care and hygiene of residents, complaints procedure, food service, infection control, medication management, restraint, lifting, admission procedures, and incident reporting.

Seven residents and one family member interviewed spoke very positively about the care provided.

D1.3 All approved service standards are adhered to.

D17.7c. There are implemented competencies for care givers and registered nurses (link finding #1.3.12). There are clear ethical and professional standards and boundaries within job descriptions .

**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

There is an open disclosure policy, a complaints policy, an accident/incident policy and adverse events policy.

Seven residents and one family member stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur three monthly and the manager and registered nurses have an open-door policy.

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

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

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

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

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

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

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

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

There is an Informed Consent policy that includes (but not limited to); a) policy, b) definitions, c) responsibility, and d) procedure – pre entry, following admission, e)outing and indemnity and f)advance directive. Two of the six resident files reviewed identified that resuscitation status was documented as family wishes and signed by someone other than resident. Improvements are required in this area.

There is an Informed consent for specific treatment policy. Related forms include; a) informed consent form, b) informed consent for specific treatment, and c) refusal/withdrawal of treatment form. Staff interviewed (three care givers, two registered nurses) are familiar with informed consent and what information to provide relatives/residents.

Informed consent training was last provided in June 2013.

D13.1 there were six admission agreements sighted and all six had been signed appropriately.

D3.1.d Information on informed consent is included in the information pack and discussed with residents and families and admission, confirmed by interview with seven residents and one family member.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

There is an Informed Consent policy that includes (but not limited to); a) policy, b) definitions, c) responsibility, and d) procedure – pre entry, following admission, e) outing and indemnity and f) advance directive. Two of the six resident files reviewed identified that resuscitation status was documented as family wishes and signed by someone other than resident.

**Finding Statement**

Two of the six resident files reviewed identified that resuscitation status was documented as family wishes and signed by someone other than resident.

**Corrective Action Required:**

Ensure that resuscitation wishes and/or advanced directives are only signed by resident or those with authority to do so.

**Timeframe:**

3 months

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

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

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy training was provided as part of Code of resident’s rights questionnaire and competency completed in May 2013.

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

D4.1e: Six of six resident files reviewed include information on resident’s family/whanau and chosen social networks

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

D3.1h Discussion with two registered nurses, four caregivers, seven residents and one family member identified that residents are supported and

encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relative interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e Interviews with the activity coordinator described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Residents are assisted to meet responsibilities and obligations as citizens. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping, bus trips, outings. Entertainers are included in the rest home activities programme. The activities coordinator and manager described how outings in the facility owned van are tailored to meet the interests of the residents.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation. The manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. Nine complaints were received for 2012 and one for 2013. A sample reviewed evidenced that the manager has managed the process appropriately. Documentation includes letter or email of response and corrective actions taken to address issues identified. Staff are informed of complaints at staff meetings and what steps are required to assist in the management of complaints received. There is a complaints register which is utilised for documenting complaints or concerns. Seven residents and one family member advised that they are aware of the complaints procedure and how to access forms.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

Queen Rose retirement home is a family owned and operated aged care facility. The manager is one of the owners. Organisational governance is provided by the owners. The manager is also supported by the other owners - one who is the hairdresser, one is the activities coordinator and one is a care giver and maintenance person. Two other owners are silent partners in the business. The rest home is certified to provide rest home level care for 29 residents with 28 residents on the day of audit. The service has a current business plan, and a quality and risk management plan for 2013. The quality and risk management programme is managed by the owner/manager, with assistance from the senior registered nurse. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The quality committee incorporates all staff and is part of the general staff meeting held monthly. Quality and risk management is assessed, monitored and evaluated at these monthly staff meetings. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The mission statement and philosophy of care sets out the vision and values of the service which is ultimately to make "Queen Rose a home away from home" .

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

During a temporary absence of the manager, the facility is managed by the senior registered nurse. The manager has been in the role for the past 11 years and is worked in the aged care industry for 37 years. The senior registered nurse has been in the role for six years and is retiring at the end of 2013. She is experienced in aged care, quality and management. A new registered nurse has commenced work at Queen Rose to orientate to the role of RN. The service has well developed policies and procedures at a service level and a business and quality and risk management plan that are structured to provide appropriate safe quality care to people who use the service including residents that require rest home level care.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

Queen Rose retirement home has business plan and a quality and risk management plan. The mission statement, philosophy and nursing objectives are outlined in the plans. The owner/manager and the long-standing RN are responsible for the implementation of the quality programme along with the other partners/owners. Goals for 2013 include a) a consumer focus which includes resident/relative survey, complaints management, residents rights are met; b) provision of effective programmes - which includes staff training, audits, incident/accident reporting, and competencies; c) certification and contractual requirements which includes preparation for audits, mandatory training; d) risk management which includes contingency plans, food safety, infection control, health and safety, audits, risk assessments for residents, emergency management; and e) continuous improvement which includes quality programme, audits, corrective actions, education for staff around the quality programme. Progress with the quality and risk management plan is monitored through monthly staff meetings.

The staff meeting agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Minutes are maintained and easily available to staff (sighted for 11-June-2013). Minutes include actions to achieve compliance where relevant. Discussions with the manager, registered nurses and four care givers confirm their involvement in the quality programme. Resident/relative meetings take place three monthly with laundry, activities and food/meals as regular agenda items. Minutes sighted for 25-June-2013.

Audits are conducted and include (but is not limited to): care plan audit, laundry, recreation programme, caregiver ADL audit, six week post admission procedures, care and hygiene of residents, complaints procedure, food service, infection control, medication management, restraint, lifting, admission procedures, and incident reporting. An internal audit corrective action report and summary is developed by either the manager or registered nurses with follow through completed and resolution documented.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Hazard registers are maintained for the kitchen, laundry, resident care and external areas.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures (link finding #1.2.7). Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

D5.4 The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. Policies are provided by an external provider who provides the service with regular updates. The manager and registered nurses are responsible for policy review.

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

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

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

D19.2g Falls prevention strategies such as falls risk assessment, medication review, physiotherapy assessment, use of appropriate footwear, correct seating, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an accident/incident policy. Accident/incident forms are commenced by care givers and given to the registered nurse who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the registered nurse/s and the manager - who completes any additional follow up. The registered nurse/s and manager collates and analyses data to identify trends. Results are discussed with staff through the monthly staff meetings. Audits for 2012 and 2013 have been completed and there is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. A resident survey was conducted in September 2013 that evidences that residents are over all very satisfied with the service. A survey evaluation has been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via resident/relative meetings.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

There is an accident/incident policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and seven residents and one family member interviewed stated family are informed of changes in health status and incidents/accidents. A sample of incident reports for June 2013 involving two residents and two medication errors were reviewed. One resident had three reports relating to challenging behaviours and one resident with a fall and a bruise. Reports were completed by caregivers with follow up with registered nurse and manager and family notified as appropriate. Monthly incident/accident analysis occurs with subsequent annual summary and analysis. Two medication errors were reported for June and involved missed doses of medications. A monthly summary of accidents and incidents is compiled by the registered nurse with subsequent analysis and investigations. Incidents and medication errors are discussed at monthly staff meetings.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

The good employer policy includes recruitment and staff selection process which requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurses and general practitioners is kept. Five staff files were reviewed (one registered nurse, three care givers and one care giver/cleaner). Advised that reference checks are completed before employment is offered and orientation checklists are completed as evidenced in three staff files - recruited within the past 18 months. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Four care givers were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Discussion with the manager, two registered nurses and four caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Four care givers interviewed have either completed the national certificate in care of the elderly or have completed the aged care education programme (as evidenced in four caregiver files reviewed). The manager and senior registered nurse have attended external training including conferences, seminars and sessions provided by the local DHB. Training for staff includes face to face, self-directed learning tools, questionnaires and competencies.

Education provided so far in 2013 includes: fire training, continence, communication and complaints, palliative care, first aid, skin care, informed consent, risk management, pain management, restraint, infection control and discrimination. In 2012 the education programme included safe food handling, first aid, ageing and sexuality, medication management, diabetes, restraint, nutrition and hydration, challenging behaviours, and observations. On review of the training provided in the past two years, it was noted that cultural safety and Treaty of Waitangi training has not been conducted. Improvements are required in this area.

Fire evacuation drill last conducted 16-May-2013. On review of five staff files, performance appraisals for three of five staff have been conducted (two staff files reviewed has been employed within the past 12 months).

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

Education provided so far in 2013 includes: fire training, continence, communication and complaints, palliative care, first aid, skin care, informed consent, risk management, pain management, restraint, infection control and discrimination. In 2012 the education programme included safe food handling, first aid, ageing and sexuality, medication management, diabetes, restraint, nutrition and hydration, challenging behaviours, and observations. On review of the training provided in the past two years, it was noted that cultural safety and Treaty of Waitangi training has not been conducted. Training for staff includes face to face, self-directed learning tools, questionnaires and competencies.

**Finding Statement**

On review of the training provided in the past two years, it was noted that cultural safety and Treaty of Waitangi training has not been conducted.

**Corrective Action Required:**

Provide cultural safety training for staff

**Timeframe:**

3 months

**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 good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home residents. At least one staff is rostered on at any one time with one staff on-call. Registered nurse or owner/manager provide first on call. Advised that extra staff can be called on for increased resident requirements.

Roster includes: manager 40 hours per week, senior registered nurse 25 hours per week, and newly recruited RN five shifts per week with weekend cover. There are four caregivers during the am shift, two caregivers in pm shift and one care giver on overnight. Three other owners provide services including activities coordinator, maintenance and hairdressing. Care staff provide laundry services and cleaners are employed. Interviews with four caregivers, seven residents and one family member identify that staffing is adequate to meet the needs of residents.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

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

D7.1 entries are legible, dates and signed by the relevant health care assistants or RN including designation

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

Queen Rose Information booklet includes mission statement, philosophy, type of care provided, entry criteria, medical care provided, general information, advocacy, safety, financial, activities, code of rights, incident/accident forms and complaints procedure and form. Resident information pack, and philosophy of service is displayed on foyer wall. Admission information is made available at entry to the resident and family/whānau.

The registered nurse confirmed that family/whanau are involved at admission and at care plan review - this was confirmed by the seven residents interviewed and by one family interviewed.

The service is open 24 hours a day, seven days per week for Rest Home level care. Doors are secured during hours of darkness. Evening staff conduct security checks to ensure doors are locked.

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. A record is kept of residents who have been declined and the reasons for this decision.

**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 service employs two registered nurses. The senior registered nurse, who has been employed by the service for six years, has extensive aged care experience and works 28 hours per week. On call is shared between senior registered nurse and owner. The second registered nurse has recently been employed and works 32 hours per week, covering the weekends. The senior RN is responsible for Infection Control and Restraint. The registered nurses are responsible for maintaining and reviewing care plans at least six monthly. Caregivers and registered nurses complete progress notes, which are integrated with care plans. An initial assessment and the beginning of the development of the residents care plan is expected to occur during admission. There is an appropriate hand-over briefing between shifts that staff are able to fully describe. Family/whānau are kept informed about the resident's care.

D16.2, 3, 4: The six files reviewed; Five of the six files identified an assessment was completed within 24 hours. One file reviewed did not evidence that an initial assessment or initial care plan had been completed. Improvements are required in this area. All six files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. All six care plans evidenced evaluations completed at least six monthly.

D16.5e: Six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. The GP interviewed stated that communication between service and GP is timely, instructions are followed through and that residents are well cared for.

A range of assessment tools were completed in resident files on admission and reviewed at least six monthly including (but not limited to); mobility, falls *risk,* pressure area risk, safety concerns, nutrition, pain and challenging behaviours.

Tracer Methodology:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

D16.2, 3, 4: The six files reviewed, identified that in five out of the six files an assessment was completed within 24 hours, however, one file did not evidence an initial assessment or initial care plan. All six files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan was reviewed by a RN and amended when current health changes. All six care plans evidenced evaluations completed at least six monthly.

**Finding Statement**

One of the six resident files reviewed did not evidence that an initial assessment or initial care plan had been completed within 24 hours of admission.

**Corrective Action Required:**

Ensure that initial assessments and initial care plans are completed within 24 hours of admission.

**Timeframe:**

6 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

Needs assessments are completed prior to admission and the RN develops an initial short term care plan. The initial care plan is completed within 24 hours as evidenced in five of six files reviewed and includes; cognitive, speech, eyes, ears, teeth, mobility, dietary needs, pain, elimination, hygiene, personal grooming, sleep - (with exception of one resident file reviewed link #1.3.3). All equipment required is assessed on the initial assessment and as required thereafter. A range of assessment tools were completed in resident files on admission and reviewed at least six monthly including (but not limited to); mobility, falls risk, pressure area risk, safety concerns, nutrition, pain and challenging behaviours, however, one of the six resident's reviewed has chronic pain and is on Controlled Drugs but has not had pain assessments completed and has a history of falls yet has no falls assessment completed; and one of the six resident's reviewed has challenging behaviours identified however, there are no triggers or de-escalation interventions documented. Improvements are required in this area.

The service uses the interRAI assessment tool, which identifies the deficits and areas for potential improvement in the resident needs. The areas of deficit are transferred to the long term care plan, however, the care plan for lacks adequate information to provide level of intervention required in areas of non-deficit (link to 1.3.5.2)

**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

A range of assessment tools were completed in resident files on admission and reviewed at least six monthly including (but not limited to); mobility, falls risk, pressure area risk, safety concerns, nutrition, pain and challenging behaviours, however, one of the six resident's reviewed has chronic pain and is on Controlled Drugs but has not had pain assessments completed and has a history of falls yet has no falls assessment completed; and one of the six resident's reviewed has challenging behaviour with no triggers or de-escalation interventions documented.(link to 1.3.5.2)

**Finding Statement**

(i) One of the six resident's reviewed has chronic pain and is on Controlled Drugs but has not had pain assessments completed and has a history of falls yet has no falls assessment completed; and (ii) one of the six resident's reviewed has challenging behaviour with no triggers or de-escalation interventions documented.

**Corrective Action Required:**

Ensure all assessments and risk assessments are conducted for all residents with identified issues, to provide the basis of documentation for care planning and interventions

**Timeframe:**

3 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:** PA Moderate

Residents have individual files and include (but are not limited to): Personal information and photograph and including next of kin; admission information/assessment; resident care plan; progress notes; medical information; assessments; observation charts for BSL, weight, BP; lab results; informed consent and resuscitation. All staff involved in resident care have access to files and document in them as required e.g. Podiatry, GP, caregivers, and registered nurse.

The care plans are developed and reviewed by the Registered Nurses. The care plans include goals and nursing interventions for the following activities of living: hygiene, mobility, sleep, nutrition, continence, orientation, pain. The service uses the interRAI assessment tool, which identifies the deficits and areas for potential improvement in the resident needs. The areas of deficit are transferred to the long term care plan, however care plan lacks adequate information to provide level of intervention required in areas of non-deficit e.g. cultural and spirituality is not identified as a need therefore care plan doesn't cover this. Improvements are required in this area.

Care Planning audit conducted in May 2013.

D16.3k, Short term care plans are utilised for wound management, infections and short term clinical and nursing issues.

D16.3f; Six resident files reviewed identified that family were involved.

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

The care plans are developed and reviewed by the registered nurses. The care plans include goals and nursing interventions for the following activities of living: hygiene, mobility, sleep, nutrition, continence, and orientation.

The service uses the interRAI assessment tool, which identifies the deficits and areas for potential improvement in the resident needs. The areas of deficit are transferred to the long term care plan.

**Finding Statement**

The areas of deficit are transferred to the long term care plan, however care plan lacks adequate information to provide level of intervention required in areas of non-deficit e.g. cultural and spirituality. One resident reviewed has safety concerns identified (falls risk and nutrition and hydration) on initial resident information, however there are no interventions related to the risks identified in care plan; two residents with challenging behaviour assessed have very limited documentation in regards to triggers of behaviour and interventions required to deescalate any undesirable behaviour.

**Corrective Action Required:**

Ensure needs other than areas of deficit are included in the long term care plan.

**Timeframe:**

3 months

**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:** PA Moderate

The care being provided is consistent with the needs of residents, this is confirmed on interviews with seven residents, one relative, four caregivers, two registered nurses, one owner/manager and general practitioner. Care plans are developed within three weeks of admission and include goals/objectives, interventions and evaluation that addresses all areas identified as deficit.(link to 1.3.5.2) The GP interviewed (one) advised that the registered nurse is prompt at informing him of changes to the health status of his patients and actions any instructions in a timely fashion. Care plans include goals and interventions relating to deficits in: hygiene needs, mobility, sleep patterns, nutrition, elimination, identity -family involvement, social history expressing spirituality, communication, cultural, and, behaviour. Initial assessment and information documents that resident weight is to be monitored monthly. In all six files reviewed there were gaps in weight records over the past six months.

Short term care plans are utilised for wound management, infections and short term clinical and nursing issues.

Three care givers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, lifting hoists, pressure relieving mattresses, continence supplies, dressing supplies.

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

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

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

There are currently six wounds being managed at Queen Rose Retirement Home, however there was no wound assessment and wound management plans are in place. Improvements are required in this area. There are no pressure related wounds noted.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

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

The care being provided is consistent with the needs of residents, this is evidenced by interviews with seven residents, one relative, three care givers, two registered nurse, manager and general practitioner. The GP interviewed (one) advised that the registered nurse is prompt at informing him of changes to the health status of his patients and actions any instructions in a timely fashion. Care plans include goals and interventions relating to deficits in: hygiene needs, mobility, sleep patterns, nutrition, elimination, identity -family involvement, social history expressing spirituality, communication, cultural, and, behaviour.

Initial assessment and information documents that resident weight is to be monitored monthly. In all six files reviewed there were gaps in weight records over the past six months. There are currently six wounds being managed at Queen Rose Retirement Home, however there was no wound assessment and wound management plans are in place. (There are no pressure related wounds).

**Finding Statement**

a) Initial assessment and information documents that resident weight is to be monitored monthly. In all six files reviewed there were gaps in weight records over the past six months. b) There are currently six wounds being managed at Queen Rose Retirement Home, however there was no wound assessment and wound management plans are in place.

**Corrective Action Required:**

a) Monitor and document all interventions as identified. b) Document wound assessment and wound management plans for all wounds.

**Timeframe:**

1 month

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The Activities Coordinator (one owner) works at least six hours per day, five days a week. The coordinator is responsible for planning and implementing activities. A social history is obtained from the resident and family which includes previous interests, cognitive ability, and general personal information, setting individual goals and plans for each resident. The activity programme is developed and reviewed at least monthly. The programme of activities involves maintaining the resident’s interests along with community involvement when possible. Residents are encouraged to participate in activities in the community. A range of activities are available. Activities include (but are not limited to): housie, hairdressing, happy hour, bus trips 2-3 times per week, walks, bowls, movies, church services monthly, music entertainment, board games, shopping, newspaper reading and chair exercises. The plan is done on a weekly basis with input from residents. The programme is monitored through regular meetings and surveys. A record of attendance is kept. Residents interviewed (seven) were complimentary of the activities programme provided.

The Activities Coordinator is involved in with other rest homes in support groups and attends in-service opportunities as available through the Dunedin DT support group.

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

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

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

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated. However, in all six files reviewed, evaluations do not indicate the level of attainment of the goals or the degree to which goals have been achieved. A resident care plan review occurred in May 2013, demonstrating the care plan has not been evaluated and updated reflecting interventions required following three falls the resident had in July. There has been no falls prevention strategies documented since falls.

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

Six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. The GP interviewed stated that communication between service and GP is timely, instructions are followed through and that residents are well cared for.

**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

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. However, in all six files reviewed, evaluations do not indicate the level of attainment of the goals or the degree to which goals have been achieved. A resident care plan review occurred in May 2013, demonstrating the care plan has not been evaluated and updated reflecting interventions required following three falls the resident had in July. There has been no falls prevention strategies documented since falls.

**Finding Statement**

Evaluations of care plans do not indicate the degree of achievement of documented goals in all six files reviewed.

**Corrective Action Required:**

Ensure that individual care plan goals are evaluated and document the degree to which goals are achieved.

**Timeframe:**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Exit/Discharge and Transfer policy and procedure. The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. In managing the referral process the service provides: a) appropriate transfer of relevant information and b) follow-up occurs where appropriate. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs.

D16.4c; the service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care.

D 20.1 discussions with the registered nurses identified that the service has access to wound, continence specialists, dietitian, speech language therapists and physiotherapist. Progress notes record when referral has been initiated.

**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

The service has transfer and discharge procedures. The procedures include a resident transfer/discharge forms and there is supporting policy and procedures, resident transfer/referral form that supports appropriate referral. All appropriate documentation is forwarded with the transfer form and copies are maintained in the residents file.

**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 service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: Medicines Care Guides for Aged Residential Care. Medicines Safety Management Protocol including storage, allergies, medication errors, antibiotic prescribing, Administration procedures, Medication for short term residents, disposal of medication. Controlled Drugs policy.

Four weekly blister pack medications are checked on arrival at the facility. There is a signed agreement with Bailey's pharmacy. All medications are kept in a locked trolley in the medicines/treatment supplies room. Medications requiring refrigeration are kept in a separate fridge. This fridge is monitored weekly, with documented evidence of these being available.

Twelve individual resident’s medication charts were sighted. Resident medication charts are identified with photographs. Every medication instruction sheet also includes an additional form to describe what each medication is used for, actions of medication and the side effects. The service has written protocols to guide staff in the event of resident experiencing chest pain and calling an ambulance in the event of an emergency.

RNs and medication competent care givers are responsible for administration of medicines. A medication competency has not occurred for the newly employed registered nurse. Improvement is required in this area.

There is a locked safe and Controlled Drug Register for the safe keeping and administration of controlled drugs. Improvements are required in regard to ensuring that weekly stock take of controlled drugs is completed.

Allergies are identified on medication instruction sheet.

There is policy and procedures in place for those residents who wish to self-medicate and are deemed competent to do so. Residents are assessed by the GP and the registered nurse as being competent to self-medicate. Advised by the registered nurse that there are currently no residents self-medicating.

D16.5.e.i.2; All twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

There is a locked safe and Controlled Drug Register for the safe keeping and administration of controlled drugs. A weekly stock take of controlled medication has not occurred.

**Finding Statement**

Weekly stock take of controlled medication has not occurred.

**Corrective Action Required:**

Conduct weekly checks of controlled medication

**Timeframe:**

3 months

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

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

RNs and competent care givers are responsible for administration of medicines. Annual competency testing occurs including a visual check with the registered nurse. The newly employed registered nurse has not completed a medication competency, at interview confirmed that she does administer medications.

**Finding Statement**

The newly employed registered nurse has not completed a medication competency, at interview confirmed that she does administer medications

**Corrective Action Required:**

Ensure that all staff with responsibilities for medication administration are deemed competent to do so - including the registered nurse.

**Timeframe:**

1 month

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

There are food policies/procedures for food services and menu planning. Food service is supplied by ACE Food company and is delivered twice a day. There is a four week cycle menu with dietician input obtained by ACE in the review of the menus. Residents' food preferences are identified and this includes consideration of any particular dietary preferences or needs. The kitchen folder includes a list of resident likes and dislikes. Residents with special dietary needs have these needs identified in their care plans. Residents were complimentary of the food provided.

Daily fridge and freezer temps are recorded weekly. Food temperatures are recorded for all dishes on receiving them at the facility and prior to serving to residents. These were sighted. Special equipment and aids are available.

The manager advises that a representative from the external catering company is available to attend residents’ meetings should there be any issues with the food service that need to be addressed.

The service has extra food for at least three days, should the delivery of the food service be disrupted for any reason. There is a pandemic plan which documents food service in disrupted times. The service has adequate supply of water for emergency. There is a BBQ available for cooking in emergency.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has a system for investigating, recording and reporting hazardous incidents including hazardous waste. There is protocol for exposure to Blood and body fluids within Infection Control policies. There is a current hazard register.

Policy for Storage of Chemicals Policy and Dealing with hazardous Substances Policy. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Chemical handling is included in the services staff orientation. The service has changed the provider of chemicals with a scheduled training session in August 2013. There is a locked cupboard in the laundry for chemicals required for cleaning, however on the day of the audit, chemicals were left unsecured in laundry. Improvements are required in this area. Safety data sheets are available in all areas where chemicals are in use.

Gloves, eye protection, aprons are available for staff use in laundry, when cleaning and in the kitchen.

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

 Policy for Storage of Chemicals Policy and Dealing with hazardous Substances Policy. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. There is a locked cupboard in the laundry for chemicals required for cleaning, however on the day of the audit, chemicals were left unsecured in laundry. Safety data sheets are available in all areas where chemicals are in use.

**Finding Statement**

There is a locked cupboard in the laundry for chemicals required for cleaning, however on the day of the audit, chemicals were left insecure in laundry.

**Corrective Action Required:**

Ensure that all chemicals are stored securely when not use.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The service displays a current building WOF which expires 4-Mar-2014. Maintenance is carried out as per the service schedule. Advised by the Owner/Manager that any maintenance requirements identified by staff are brought to the owner’s attention for action.

There is a maintenance programme (Inspection Equipment Log 2013) in place that ensures buildings, plant and equipment are maintained. Discussion with the maintenance staff confirmed this. Safety rails and ramps are appropriately located. Chair lift to access the first floor has an annual inspection certificate which was last serviced 18/7/13. Annual Calibration of medical equipment occurs.

D15.2e: There are quiet, low stimulus areas that provide privacy when required.

D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities.

D15.3e: The following equipment is available shower chairs, hoist, heel protectors, lifting aids.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

The service has 29 single rooms, 18 with toilet ensuite, four communal showers, five communal toilets, one staff toilet. Showers and toilets are well signed and have privacy locks. There are hand washing facilities in bathrooms and resident rooms as well as alcohol hand gel for staff and residents to use. Hot water temperature is monitored monthly at 40-45 degrees. The service also has a Chubb contractor to check water temperatures six monthly. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents between rooms is not necessary in the resident's bed, equipment and wheel chairs can be transferred between rooms.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

The service has two lounges and a large dining area and a conservatory and an outside courtyard for residents to enjoy. Residents are able to access areas for privacy if required. The arrangement of furniture and seating in the lounges and dining areas allows residents to mobilise safely. Corridors are wide enough to allow residents to mobilise without difficulty. Activities can occur in either the dining room or the lounge.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

The service has in place policies and procedures for effective management of laundry and cleaning practices. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. (Refer # 1.4.1) Safety Data sheets are available for all chemicals used at Queen Rose.

The laundry is of adequate and appropriate size for the size and type of service with one door leading in and one door leading to the outside. The laundry is designed to provide a clean/dirty flow around the room in a clockwise direction. Laundry audit conducted May 2013. Laundry is completed by care staff. A hand basin is available in the laundry. Cleanliness of the facility is surveyed as part of the resident survey conducted last in September 2012 with overall satisfaction reported from residents.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service has a fire and emergency manual which includes disaster management, evacuation, robbery, storm damage, earth quakes, and civil defence management. There is currently a trained person with a first aid certificate on each shift. Queen Rose retirement home has a NZFS approved fire evacuation scheme dated 20-May-2010. Fire drill last conducted 16-May-2013. Smoke detectors last checked 16-Jul-2013. A civil defence kit is stocked and checked six monthly (16-Mar-2013) . Water is stored sufficient for at least three days. Alternative gas heating and gas cooking facilities are available. Call bell system evident and in use in the resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. The building is a two storey home with external fire escapes. Six able bodied residents reside up stairs and have the use of a chair lift to transfer from ground level to first floor.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

All communal and individual areas have natural light and ventilation, heating is via radiators and heat pumps in communal areas and bedrooms. The designated smoking area is outside away from communal living areas.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

Documented systems are in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint or enabler use on audit day. Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.

Staff education programme on RMSP /Enabler provided May 2013 and challenging behaviour management training/education was provided in May 2012. Use of restraint audit was conducted in March 2013 and indicated no restraint use at that time. Restraint and management of residents with challenging behaviours is also discussed at monthly staff meetings as evidenced in meeting minutes sighted for July 2013

**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

Queen Rose retirement home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The senior registered nurse is the infection control nurse. The infection control programme is linked into the incident reporting system. There is a monthly staff meeting which incorporates infection control and health and safety and includes discussion and reporting of infection control matters and consequent review of the programme. Minutes are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The senior registered nurse at Queen Rose retirement home is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains her practice by attending infection control updates. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC expert at the DHB. The infection control team is representative of the facility. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

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

D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by an external provider and reviewed and updated annually. Last review conducted April 2013. Queen Rose's infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; personal protective equipment, medical waste and sharps and spills management.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse with expert support from external providers who provide the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. Infection control training is currently under way (July 2013) in the form of a self-directed learning tool for all staff. Infection control is discussed at monthly staff meetings. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

Infection surveillance and monitoring is an integral part of the infection control programme and is described in Queen Rose retirement home's surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. A monthly running record of individual resident infections is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager and to organisational management.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**