**Radius Residential Care Limited - Radius Maeroa Lodge**

**Current Status:** **15-Aug-13**

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

**General overview**

Radius Maeroa Lodge is a 92 bed residential care facility located in Hamilton and is part of the Radius Residential Care Ltd group. Radius Maeroa Lodge is increasing the number of beds for the provision of rest home care from 20 to 35 and reducing the number of beds for the provision of hospital level care from 72 to 57 beds.

At this audit there are 61 residents receiving care. This includes 31 residents requiring hospital level care and 30 residents requiring rest home level care. Ten of the residents are under 65 years of age. Since the last audit the Radius regional manager is working as the facility manager on an interim basis. The Waiakato operations manager is also working on site until the new facility manager commences. There have been no other changes to key personnel since the last audit. The facility renovation programme is continuing.

At this audit there is one area identified as requiring improvement. This is to ensure that call bells are readily available for all residents.

**Audit Summary AS AT** **15-Aug-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  15-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit  15-Aug-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  15-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Standards applicable to this service fully attained** |

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| **Safe and Appropriate Environment** | Day of Audit  15-Aug-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  15-Aug-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  15-Aug-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Audit Results AS AT** **15-Aug-13**

**Consumer Rights**

The residents express high levels of satisfaction with the manner in which the service upholds their rights and report that they are treated with respect and dignity and are free from discrimination. Staff demonstrate understanding of their obligations regarding residents' rights and how to incorporate that knowledge into their day-to-day practices and interactions with residents and family/whānau.

The service meets the individual resident's culture, beliefs and values, including for those residents who identify as Maori.

Evidence-based practice is observed, promoting and encouraging good practice. There is regular in-service education and staff access external education that is focused on aged care and best practice. The residents and family/whānau interviewed expressed high satisfaction with the care delivered.

The service acknowledges that all residents have a right to full and frank information as identified in the open disclosure policy. An interpreter service is accessed through the district health board as required. Written consent is gained as appropriate. Staff interviewed acknowledge the resident's right to make choices based on information presented to them and the right to withdraw consent and/or refuse treatment. Advance directives, advance care plans and end of life care planning are made available and acted upon where valid.

There is a documented complaints process which is implemented to ensure all complaints are followed up and information is used as an opportunity to improve service delivery as appropriate.

**Organisational Management**

The business plan identifies strategies used by the service to ensure that service planning is co-ordinated to meet residents' needs. The organisation's purpose, values, goals and strategic direction are developed nationally and incorporated into a Radius Maeroa Lodge strategic and quality plan. Organisation risks and hazards are documented, mitigation strategies identified and are monitored for effectiveness.

The day to day operation of the facility is undertaken by a management team who are appropriately experienced and qualified. This currently includes the Radius Waikato Operations Manager and the Radius Regional Manager. A new facility manager has been recruited and will commence in early September 2013.

Documented quality and risk management systems are implemented to assist residents, visitors and staff safety. Quality is reviewed and measured via the internal audit schedule, complaints/compliments management, and staff, resident and family/whanau annual satisfaction surveys. All quality and risk activities are monitored by the acting facility manager and corrective actions are put in place as appropriate. Incidents/accidents are being reported and managed. The reported rates are analysed and compared with three other similar sized Radius residential care facilities on a monthly basis.

The service implements safe staffing levels and skill mix to ensure contractual requirements and residents' care needs are met. Human resources management processes are implemented and comply with the organisation's policies, reflect current good practice and meets legislative requirements. Staff members are required to complete the organisation's orientation programme. Knowledge and skills are maintained through on-going education which is frequent and appropriate to staff roles. Staff performance appraisals are being completed in a timely manner.

The service have a resident information system that complies with legislative requirements. There is no information of a private and personal nature publicly displayed.

**Continuum of Service Delivery**

The residents and family/whānau express a high level of satisfaction with the quality of care and services provided at Maeroa Lodge. Services are provided by suitably qualified and trained staff to meet the needs of residents. The Radius Care organisational systems are in place to assess, plan, review and evaluate the care needs of each resident. Residents have an initial nursing assessment and care plan developed by the registered nurse (RN) on admission to the service. The service meets the contractual times frames for the development, review and evaluation of the care plan. Residents are reviewed by a GP on admission to the service and at least three monthly, or more frequently to respond to any changing needs of the resident. The provision of services is provided to meet the individual needs of the residents. A team approach to care is evident and ensures the continuity of services. Referrals to other health and disability services is planned and co-ordinated as required, based on the individual needs of the resident.

The service has a planned activities programme to meet the recreational needs of the younger and older residents at the service. Residents are encouraged to maintain links with family and the community. The residents express high satisfaction with the group and individual activities offered at the service.

A safe and timely medicine management system is observed at the time of audit. The service has documented evidence that staff responsible for medicine management are assessed as competent to do so.

Residents' nutritional requirements are met by the service. As confirmed during interviews with residents and family/whānau, likes, dislikes and special diets are well catered for. The service has a four week menu, with seasonal variations, which has been approved by a registered dietitian.

**Safe and Appropriate Environment**

Radius Maeroa Lodge has clearly documented emergency response processes which are understood and implemented by the service as required. The service has an approved fire evacuation plan and six monthly fire evacuation drills are conducted. There is at least one staff member on duty with a current first aid certificate at all times.

The building has a current building warrant of fitness and ongoing checks to maintain the building warrant of fitness are being undertaken. All clinical equipment has a current performance monitoring label and electrical safety testing of appliances is current.

The facilities are fit for purpose and provides appropriate furnishings and equipment. A facilities wide refurbishment programme is being undertaken and is ongoing. To date 33 residents' bedrooms have been repainted, 14 rooms re-floored and 20 rooms have new curtains. All residents' bedrooms are single occupancy. Thirteen residents' bedrooms have a full ensuite. Other shower and toilet facilities are centrally located. The dining, lounge and activities areas meet residents' relaxation, activity and dining needs. Calls bells are located in all occupied residents' rooms and bathroom areas. Portable call bells are used by identified residents in the lounge areas. Not all call bells are sighted to be accessible to immobile residents during the audit and the call bells in three unoccupied rooms are awaiting replacement. These are areas identified as requiring improvement.

The facility is heated by wall mounted heaters and ventilation occurs via opening the doors and windows. A number of rooms are also fitted with heat pumps which include an air-conditioning feature. There are appropriate outdoor areas (including internal courtyards) that have seating and are sheltered for residents' use.

**Restraint Minimisation and Safe Practice**

The service has nine residents assessed as requiring restraint use (bedrails, low low bed or 'fallout mattress') and 10 residents assessed as requiring enabler use (bed rails and a lap belt in wheelchair). The restraint register identifies that restraint is minimised by the service. The process for determining restraint use is clearly identified in policy and procedures and interviews with staff and review of residents' clinical files identify that the process is correctly implemented. Regular restraint education is provided for all clinical staff.

The assessment and ongoing evaluation and monitoring of restraint meets all requirements of the Health and Disability Services Standard requirements and are conducted in a safe manner. The service demonstrates the monitoring and quality review of their restraint use is undertaken monthly by the restraint committee and six monthly by the multidisciplinary team.

**Infection Prevention and Control**

Radius Maeroa Lodge has an infection prevention and control programme which was last reviewed early 2013. The quality coordinator is responsible for facilitating the infection prevention and control programme. The quality co-ordinator participates in relevant education on infection prevention and control topics. Policies and procedures are available for staff. These policies have been updated nationally by Radius Residential Care Ltd in 2013. Surveillance is occurring for resident with infections. The surveillance is appropriate to the service setting. The surveillance results are communicated to staff and managers as well as the individual resident and family/whanau in a timely manner. Education, where provided to residents on infection prevention and control activities, are detailed in residents' care plans.

Radius Maeroa Lodge

Radius Residential Care Ltd

Certification audit - Audit Report

Audit Date: 15-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Radius Residential Care Ltd |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Radius Maeroa Lodge | 135 Maeroa Rd | Maeroa | Hamilton |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
| Radius Maeroa Lodge is increasing the number of rest home level beds from 20 to 35 and reducing the number of hospital level beds from 72 to 57 beds. |

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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 15-Aug-13 **End Date:** 16-Aug-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RN, NZ 8086, Infection Preventionist | 16.00 | 8.00 | 15-Aug-13 to 16-Aug-13 |
| Auditor 1 | XXXXXXX | RN, B. Nursing, RABQSA | 16.00 | 8.00 | 15-Aug-13 to 16-Aug-13 |
| Auditor 2 | XXXXXXX | RCN, BA, Lead Auditor NZQA 8086 | 8.00 | 4.00 | 15-Aug-13 |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXX | RN,MBA,NZQA 8086 |  | 3.00 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 40.00 | **Total Audit Hours off site** *(system generated)* | 23.00 | **Total Audit Hours** | 63.00 |
| **Staff Records Reviewed** | 8 of 58 | **Client Records Reviewed** *(numeric)* | 9 of 61 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 9 |
| **Staff Interviewed** | 19 of 58 | **Management Interviewed** *(numeric)* | 3 of 4 | **Relatives Interviewed** *(numeric)* | 7 |
| **Consumers Interviewed** | 12 of 61 | **Number of Medication Records Reviewed** | 18 of 61 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

I confirm that The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 29 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Radius Maeroa Lodge | 92 | 61 | 0 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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At this audit there is one area identified as requiring improvement. This is to ensure that call bells are readily available for all residents.

1.1 Consumer Rights

The residents express high levels of satisfaction with the manner in which the service upholds their rights and report that they are treated with respect and dignity and are free from discrimination. Staff demonstrate understanding of their obligations regarding residents' rights and how to incorporate that knowledge into their day-to-day practices and interactions with residents and family/whānau.

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1.4 Safe and Appropriate Environment

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2 Restraint Minimisation and Safe Practice

The service has nine residents assessed as requiring restraint use (bedrails, low low bed or 'fallout mattress') and 10 residents assessed as requiring enabler use (bed rails and a lap belt in wheelchair). The restraint register identifies that restraint is minimised by the service. The process for determining restraint use is clearly identified in policy and procedures and interviews with staff and review of residents' clinical files identify that the process is correctly implemented. Regular restraint education is provided for all clinical staff.

The assessment and ongoing evaluation and monitoring of restraint meets all requirements of the Health and Disability Services Standard requirements and are conducted in a safe manner. The service demonstrates the monitoring and quality review of their restraint use is undertaken monthly by the restraint committee and six monthly by the multidisciplinary team.

3. Infection Prevention and Control

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Summary of Attainment

* 1. Consumer Rights

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

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

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:22 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 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: 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: 0  Criteria (of 51): CI:0 FA:21 PA:0 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | FA | 0 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | PA Moderate | 0 | 4 | 1 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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

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

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| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 49 **PA Neg:** 0 **PA Low:** 0 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 100 **PA:** 1 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Radius Residential Care Ltd

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:15-Aug-13 End Date: 16-Aug-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.4.7 | 1.4.7.5 | PA  Moderate | **Finding:**  1) Four immobile residents at audit are sighted to not have their call bells readily accessible. One rest home resident advised call bells are not always left where they can be reached.2) Three of the bedrooms in the unoccupied end of the facility are not fitted with call bells.  **Action:**  1) Ensure call bells are consistently within reach of residents.2) Ensure call bells are installed in the three unoccupied rooms prior to occupancy. | Three months |

# Continuous Improvement (CI) Report

Provider Name: Radius Residential Care Ltd

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:15-Aug-13 End Date: 16-Aug-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

The staff (two registered nurse (RNs), one enrolled nurse (EN) and three healthcare assistants (HCAs) and three activities co-ordinators) interviewed demonstrate knowledge and understanding of consumer rights, obligations and how to incorporate them as part of their everyday practice. As observed at the onsite audit staff are seen to be addressing residents with respect, knocking on doors and asking to enter rooms prior to entering, and providing the residents with choices. Education on consumer rights is last conducted in part of the two yearly in-service education programme and last conducted in May 2013.

The Aged Related Residential Care (ARRC) service agreement requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

The Code of Health and Disability Services Consumers' Rights (the Code) is displayed in both te reo Maori and English throughout the facility. The 12 of 12 residents (seven rest home and five hospital) and seven of seven family interviewed (two rest home and five hospital relatives) report they are provided with information on the Code on admission, the information is in the admission pack and information brochure and the admitting staff provide verbal information on the Code. The advice brochure is provided in the information pack and is available at the reception area.

The 12 of 12 residents and seven of seven family interviewed report they are treated with respect and dignity. The GP interviewed expressed no concerns regarding breaches of the residents' rights during service delivery and spoke highly of the care staff.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

DOCUMENT REVIEW: The submitted Abuse & Neglect policy and the Privacy & Dignity of the client policy contain information that meets the requirements of the Health and Disability Services Consumers' Rights 1996 (the Code) and the ARC contract. The policies contains clear statements about the rights of residents, and detailed descriptions of what the service expects in regards to staff respecting resident privacy (physical and auditory), protecting confidentiality, and ensuring residents are freedom from harassment, discrimination and exploitation. There is a separate policy on harassment and discrimination but this is not reviewed. The Abuse & Neglect policy contains clear definitions of abuse and detailed procedures to follow in any event of suspected abuse including lists of other services for referral or involvement.

The 12 of 12 residents and seven of seven family/whānau interviewed express high levels of satisfaction with the way they are treated by all staff and report that the residents' dignity, privacy and independence is always respected. The two RNs, one EN and three HCAs interviewed demonstrate knowledge of providing services in a manner that respects the residents' dignity, privacy and dignity. The GP expressed no concerns with abuse, neglect or culturally unsafe practice and expressed high satisfaction with the management and quality of care at the service.

All residents have single rooms which affords privacy. During interview with five of five hospital residents and five of five family/whanau members they confirm that all their rights are respected by staff and that the service is responsive to their identified needs, culture values and beliefs. This is clearly identified in five of five hospital level care resident care plan reviews. One resident who has English as a second language has their cultural, food, religious and communication needs clearly shown.

Information on the Nationwide Health and Disability Advocacy Services is provided in the admission information, with the poster and brochures displayed and available at the entrances in the rest home and hospital. Education on advocacy is last conducted May 2013 as part of the in-service programme and in January 2013 through self-directed learning packages.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

DOCUMENT REVIEW: The Maori Health Plan contains a list of commonly used te reo Maori, clear statements about cultural safety, identifies barriers to entry for Maori and describes culturally appropriate care for people who identify as Maori using te whare tapa wha model. The plan states 'Radius Residential Care is committed to respecting the cultural values and beliefs of our Maori residents and whanau, and evidence of this will be documented in Residents' Care Plans and evidenced in practice. The cultural values and beliefs of our Maori staff are respected and this is demonstrated in our staff management practices'.

The Maori Health Plan and related polices are verified to be implemented in practice at the onsite audit. Two residents currently identify as Māori. Three of the five family/whanau member interviews were conducted for family who identified as Maori. They stated that beliefs and values were identified for their relatives upon admission and have been discussed with staff. They all confirm that their relatives have no specific Maori beliefs but that as family/whanau members who do identify as Maori the service accommodates family/whanau hui and is very understanding of family/whanau needs. The three of three HCAs demonstrate good knowledge on respecting Maori beliefs, values and the importance of whānau. The interview with one Maori resident report that their individual beliefs and values are respected.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

DOCUMENT REVIEW: The Culturally Safe Care policy meet the requirements of this standard. It contain clear guidelines for providing culturally safe care and describe approaches for ensuring resident's individual culture, values and beliefs are taken into account. There are also clear guidelines to meeting individual needs in the Spirituality-Religious Beliefs policy, the Death-tangihanga policy and the Intimacy and Sexuality policy.

The nine of nine residents' files reviewed (four rest home and five hospital), record the resident's individual values and beliefs. A resident who identifies as Muslim and their family interviewed reports their cultural beliefs are respected. All residents and family interviewed express satisfaction with the care provided which reflects their individual values and beliefs. The three of three HCAs demonstrate knowledge on recognising and respecting residents individual culture, values and beliefs. Education on cultural safety is last conducted July 2013. The GP expressed no concerns about culturally unsafe practices.

The ARRC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

The acting manager reports that harassment of any nature will not be tolerated. Any harassment that comes to their attention will be taken seriously and action will be taken. Harassment may be considered serious misconduct. The policy clearly identifies the procedures to be taken should a complaint related to any form of discrimination or harassment occur.

In-service education on elder abuse is last conducted in May 2013. The three of three HCAs interviewed demonstrate knowledge on the signs of abuse, neglect and discrimination. The staff records reviewed have position descriptions that include professional boundaries. There are no instances recorded of discrimination. As observed on the day of audit professional boundaries are maintained for the well-being of the residents that still encourages a friendly and home like environment. The 12 of 12 residents and seven of seven family/whānau have no concerns with discrimination and speak highly of how they are treated by all staff.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

Evidence-based practice is observed, promoting and encouraging good practice (evidenced in interviews with the two RNs, one EN and three HCAs). Examples include policies and procedures that are linked to evidence-based practice. The organisational policies and procedures are reviewed at by the operations management team, with specialist advice from gerontological nurse specialists and nurse practitioners. The service has regular visits by the GP (three times a week), links with the local mental health services, palliative care services and the DHB wound specialist. The wound specialist visited on the day of audit to review the wound of the hospital level of care resident and the hospice nurse reviewed the rest home resident at the time of audit. The service accesses professional development through the DHB and access support from the local hospice for palliative care.

There is regular in-service education and staff access external education that is focused on aged care and best practice. The acting manager reports that reflective practice is encouraged with the clinical staff. The 12 of 12 residents and seven of seven family/whānau interviewed expressed high satisfaction with the care delivered. The GP reports that a good level of care is provided at the service. The GP also commented that even though the service has had ongoing changes with the facility manager, each have introduced improvements, which have continued to be implemented in practice.

The resident whose file was reviewed has input from specialist services related to wound care and weight management. The nurse practitioner wound care specialist who has input into the resident's care stated that the resident's wound is better now than it has been for many years. (The wound care specialist has worked with the resident for many years in the community). Staff actions are guided by evidence based practice as identified in documentation sighted.

ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

DOCUMENT REVIEW: Open disclosure is clearly described in the accident, incident, near miss policy. Cultural safety policies reference an interpreting policy but this was not submitted.

The seven of seven family member interviews confirm they are kept informed of the resident's status, including any events adversely affecting the resident. The family/whanau report that the level of communication is something that the service 'excel' at. The resident, and where appropriate family/whānau, are invited to attend the multidisciplinary team (MDT) review. Evidence of open disclosure is documented in the family communication sheets, on the accident/incident form and in the residents' progress notes (evidenced in nine of nine residents' files). The service is providing 'Skills for Work' education for the staff, this includes methods for improving communication.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

DOCUMENT REVIEW: The Informed Consent policy is comprehensive, clearly defines the principles of consent and provided clear work instructions for obtaining consent and advance directives in ways that adhere to current NZ legislation. The policy states 'Except in the case of an emergency, doctors and other health professionals must obtain a client’s agreement (informed consent) to any course of treatment. Health professionals are required to tell the client anything that would substantially affect the client’s decision. Such information typically includes the nature and purpose of the treatment, its risks and consequences and alternative courses of treatment'. The policy lists what consent is obtained for: identification (photograph), bus outings, transport of clients to appointments, care profiles and sharing of information with other healthcare professionals; Consent for Resuscitation/Advance Directive; Consent for the Use of Restraints; Flu vaccines and Medicines. The policy also provides guidelines for obtaining consent when the resident is deemed incompetent.

The informed consent polices are verified to be implemented in practice at the onsite audit. The seven of seven family report receiving the information book and signing an admission agreement. The family and residents interviewed confirm the residents' choices are respected. Written, signed consent is sighted in the nine of nine residents' files reviewed. The two RNs, one EN and three HCAs interviewed demonstrate their ability to provide information that residents require in order for the residents to be actively involved in their care and decision-making. Staff interviews acknowledge the resident's right to make choices based on information presented to them. Staff also acknowledge the resident's right to withdraw consent and/or refuse treatment.

Advance directives and end of life planning are made available to residents and family/whānau during the admission process and MDT review. The nine of nine residents' files reviewed have end of life planning in which the residents and family are consulted on end of life care and treatment.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

The service actively encourages residents to participate fully in determining how their health and welfare is managed, as confirmed at interview with two RNs. Family/whānau are encouraged to involve themselves as advocates (evidenced in interviews with seven family/whānau). Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client information booklet and with the brochure available at reception and entrances to the service. In-service education on advocacy is last conducted in May 2013.

ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

A number of residents are observed independently and/or being accompanied by visitors going out into the community and to facilities in the rest home. There are no set visiting hours and family/whānau are encouraged to visit. The 12 of 12 residents and seven of seven family/whānau interviewed confirm unrestricted visiting hours. Residents are supported and encouraged to access community services independently, with visitors or as part of the planned activities programme. The three activities coordinators report catholic communion is available weekly with individual residents and the service runs a church service fortnightly. A number of residents access their spiritual advisors individually or with family as required.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

There is a compliments and complaints policy/procedure which is dated as reviewed in December 2013. The policy notes the right to complain without prejudice and for complaints to be resolved in fair, speedy and confidential manner to achieve a positive outcome for all parties. The process for reporting, investigating and responding to complaints is included and timeframes are congruent with timeframes required by the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is a flowchart that details the complaints process and process for assigning a risk rating for complaints. A definition of a complaint is included in the policy.

Eleven staff interviewed (three health care assistant's, three housekeeping staff, one laundry employee, one activities assistant and two RNs and one EN), are able to detail their responsibilities in relation to the reporting of complaints.

All seven family members (two rest home and five hospital) and all twelve residents interviewed (seven rest home and five hospital) are aware of the complaints process. A compliments and complaints form is sighted to be accessible to residents and family members at the front entrance near a drop box.

A review of the complaints register identifies there have been 26 complaints received in the period 10 January 2013 to 23 July 2013. The majority of complaints are dated prior to 28 April 2013. Only five complaints have been received since 1 May 2013. The acting facility manager (AFM) advises there have been no new complaints received from the Health and Disability Commissioner (H&DC), the Ministry of Health (MOH), Accident Compensation Corporation (ACC) or the District health Board (DHB). Four complaints are on the complaints register from the H&DC. One has been closed in 2013 and the complaint not substantiated. The remaining three remain open.

A review of four complaints including two about damage to eye glasses (22 April and 6 May 2013); a complaint about service delivery (20 May 2013); and the H&DC complaint the MOH requested to audit team to follow up during audit verifies complaints are acknowledged, investigated, and corrective actions undertaken and follow-up communications is occurring either in person or writing as appropriate for the event.

A number of compliments are also now being received and records sighted. ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

The values, vision and purpose of Radius Residential Care Ltd (RRCL) is developed by the operations manager, regional managers, general manager and the managing director and detailed in the April 2012 to March 2015 strategic plan. This is reported by the Radius regional manager (who is currently the acting facility manager (AFM) to be reviewed on an annual basis during business planning. This is verified by the RRCL general operations manager who is also on site the first day of audit.

The Business plan for Maeroa Lodge is sighted for the same period. This details the background history to Radius Healthcare. The vision is described as 'being accountable for guiding and continuously improving the quality of our service; to be the leaders in care’. The purpose is noted as being 'to create value for everyone involved in the business on a long term and sustainable basis’. There are four key objectives specified which includes 'clinical leadership and management'. The values are detailed as being: respect for self and others, customer focused, strive for excellence, trust, integrity, honesty and transparency and having fun.

The Maeroa Lodge business plan includes a strengths, weakness, opportunity and threat (SWOT) analysis for Radius Maeroa Lodge and nearby competitors in the industry and this documented is sighted. There are seven clinical indicators (CIs) which are detailed, and the identified target has been established by the current management team. The AFM advises the targets for the CI have been reviewed and are more realistic, but still promotes an improvement focus. Monitoring of the organisation's performance is undertaken via analysis of the CI monthly data (refer to 1.2.3.6) and via the AFM fortnightly reports.

The regional manager is currently acting facility manager (AFM) and will be referred to as the AFM for the remainder of the audit report. The AFM has worked in the aged care sector for over 25 years including eight years for RRCL as a facility manager, senior facility manager and since July 2012 as a regional manager. The AFM is a registered nurse who has a current APC, current medication competency and has attended more than eight of hours of education in the past year relevant to managing and aged care facility.

The AFM's fortnightly reports for the last six weeks are sighted (21 June 2013 to 2 August 2013). These reports include commentary on the H&DC complaints, results from the DHB initiated 'spot audits', human resource management issues, new appointments including the new facility manager (who starts in September 2013), key meetings with external organisations and supports being provided to the organisation. An incident which resulted in essential notification to the DHB, ACC and Department of Business and Innovation is noted. The ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

The operations manager (OM) for the Waikato region (three facilities) was appointed to her role in January 2013. The operations manager was also acting as the Maeroa Lodge AFM earlier in the year until a period of unplanned leave was required. Currently the Waikato OM is assisting the AFM and the clinical manager. The Waikato OM is an experienced RN who has worked in aged care services including in management roles; she has a current annual practising certificate (APC) and this is sighted. She has completed a 'National certificate in business' in 2010 via the Tai Poutini Polytechnic. She has also completed a 'National diploma in business (level 5) and a 'Diploma in aged care management'. The Waikato OM attends relevant ongoing education and records sighted.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

Radius Maeroa Lodge has a quality and risk programme which includes (but is not limited to):

- business planning process (refer to 1.2.1)

- policy procedure development/review

- compliments and complaints

- incident/accident reporting

- internal audits

- external monitoring by product supplies e.g. Ecolab.

- monitoring clinical indicators (CIs)

- monitoring the use of restraint and enablers

- surveillance for residents who develop infections

- staff training/education

- resident feedback and resident meetings

- staff satisfaction survey (past done late 2012 and noted in the April 2013 audit report)

- resident satisfaction surveys (14 responses received to the 2013 survey)

- hazard identification and management

- risk review and management.

Quality and risk information is discussed at a variety of forums including staff meetings, residents' meetings, quality improvement meeting and at the RN/EN meetings and verified in minutes of these meetings as sighted. In July 2013, the functions of the infection control committee meeting and the health and safety committee meeting were amalgamated into a combined meeting. The minutes of the July and August 2013 meetings reflect discussions on education, changes in policies and procedures, incidents, compliments, complaints, residents with infections, results of internal audits and monitoring of contracted suppliers performance.

Eleven staff interviewed (three health care assistants, three housekeeping staff, one laundry employee, one activities assistant and two RNs and one EN), are able to detail their responsibilities in relation to the reporting of complaints and incidents. The clinical staff are able to identify their responsibilities for reporting of patients who are suspected of having an infection. The staff confirm being provided with appropriate feedback on incidents, complaints, infection including via the monthly staff meeting. Staff when asked identified a number of quality improvement activities have occurred since the last audit. This include: organising the content of residents' files; refurbishment of the environment; new equipment has been purchased, including in the kitchen; and night lights are being used to improve lighting in the hallways overnight. The ARM advises a review of the effectiveness of these will be undertaken at the upcoming residents' meeting.

The AFM advises policies and procedures are developed nationally and reviewed at least two yearly by the Radius operations management team, circulated for feedback and then finalised by the Radius Operations Management Team (OMT). Finalised policies are distributed to the Radius facilities. Input into policy changes is also being provided by a gerontology nurse specialist who currently works at the Auckland University School of Nursing. The AFM advises this has strengthened the clinical focus of the policy documents. The AFM advises the clinical manual, quality manual and health and safety manual has been recently updated and issued. The infection prevention and control and medical management have also been recently reviewed and updated. All policies and procedures are kept electronically and are available to those with access on the 'P drive' and this is sighted. There is a good search function to enable location of policies even if staff are unsure of the policy name and the search process sighted during audit. The quality coordinator advises she is responsible for updating the one set of hard copy manuals available on site with the assistance of the administrator. These manuals are kept accessible for all staff in the nurses’ station and these manuals are sighted. Changes to policies and procedures are discussed at the quality/health and safety meeting and are documented in the July and August 2013 minutes sighted. Information on changes is also communicated to all staff via a 'summary' of changes document which is issued from National Office. This document is kept in the staff room for staff to review. On occasions the QC advises the entire revised policy is placed for staff to read as well as the summary of changes. The document control system is detailed in a policy/procedure dated March 2013 (sighted). All policies sighted during audit have a footer denoting the policy name, manual it is located in, publication and next review date. The details of the author and who approved the document is noted. All documents sighted have age numbers and version numbers detailed. The office manager and the regional manager identified there are no Maeroa Lodge individual policies and procedures.

There is an internal audit calendar which details what audits are to be undertaken and when. Templates audit tools are used for each audit. All audits scheduled for the period April 2013 to date of audit have been completed. A summary of the results are recorded for each audit on the audit register summary calendar page (sighted). A review of audits completed between April and August 2013 selected at random for review) include: housekeeping audit; complaints procedure audit; infection control environment audit; medication management audit and hand hygiene audit shows a high level of compliance with the organisation's policies. Where the audit identifies an area for improvement corrective action plans are being developed for the identified issues, implemented and monitored for effectiveness. Audit results are discussed at the quality/health and safety meeting.

Corrective action plans are also sighted for issues/required improvement that require either a number of steps or anticipated to require some time to implement. Corrective action plans sighted in relation to decluttering the corridors, medication management, ensuring residents who self-administer medications are being assessed and streamlining the way reportable events are registered. The duplication of the summary register (which has previously resulted in some errors in data transfer) is no longer occurring. The sighted corrective action plans demonstrate regular monitoring of the improvements until the desired outcome has been achieved. Two health and safety (H&S) representatives interviewed advised staff are taking responsibility for decluttering the corridors. If equipment is sighted in the hallways the H&S representatives advises staff are proactive about getting the items removed. A delivery of gloves has occurred during audit. One H&S representative sighted to be promptly removing the items from the delivery box and placing the gloves on the shelves and keeping the corridor clear.

Information reported via the incident reporting system is used during clinical indicator monitoring. The QC maintains a register of incidents which is used to calculate the clinical indicators. Clinical indicators are reported monthly per 1000 occupied bed days and the resulted trended with three similar sized Radius facilities. Results of the CI data sighted for the period January to June 2013 inclusive shows Maeroa Lodge now with:

- improved rate of falls with no injury

- some improved periods (March and April 2013)

- well performing in relation to falls for residents on psychotropic medications

- showing some improvement in the number of skin tears in March and April 2013. Slight increase in May and June 2013

-an improved performance in relation to the number of residents with grade one pressure areas.

There is a risk register dated 2013 which details Radius Maeroa Lodge potential risks. The AFM advises some risks are combined with the business plan as a combined business and risk document. Additional high risks for Maeroa Lodge site are noted in a separate risk plans which the AFM is monitoring on a regular basis. Evaluations of process in addressing risks are being noted. The current risk register documents a variety of risks including (but not limited to): staffing; breach of client rights; medication events; clinical/care risks; staff training/development; infection; use of restraint; error/omission; and business risks. The risk plan includes the risk and associated rating, identified actions to minimise the various risks and identification of who is responsible.

There is a hazard register which is dated as last reviewed in July 2013. This includes a list of potential or actual hazards within the facility and grounds. The hazards register notes the hazards, whether it can be eliminated, isolated or minimised, and the hazard prevention measures that can be undertaken to mitigate risks. The frequency of monitoring risks is included. The maintenance man (who is one of the staff health and safety representatives) reports new hazards are promptly reported by staff and actions taken to address promptly. The Maintenance man advises work is ongoing with the Hamilton City Council (HCC) in relation to the need for a pedestrian crossing near the facility. A resident regularly goes across the road in a wheelchair to a nearby café. This is a risk due to the busy road and no designated area for the resident to safely cross. Staff are accompanying the resident in the interim. Communications with the HCC sighted.

ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

DOCUMENT REVIEW: The submitted Accidents, Incidents - Near Miss policy defines and describe the reporting, documenting, investigation and overall management of adverse events. The policy discusses notifications and provides clear guidelines on how to comply with the principles of open disclosure.

Eleven staff interviewed (three health care assistants, three housekeeping staff, one laundry employee, one activities assistant, two RNs and one EN), are able to detail their responsibilities in relation to incident reporting. The staff say they will report 'everything'.

Incident reports are completed by staff and given to the RN/EN on duty who is responsible for starting the initial investigation. As of 1 July 2013, an incident summary page is now being kept in each resident's file as a quick point of reference to identify the details of all resident's individual events. A review of five residents' files verifies reported events are noted in the progress notes and on incident forms. In all occasions the nine reported events have been investigated and a short term care plan developed for each reported event. This includes for a resident who has had six falls (and several skin tears) between April and July 2013, a resident who developed a pressure area, one medication error, and a resident who is injured manoeuvring her wheelchair.

The monthly incident summary reports are sighted for May 2013, June 2013 and July 2013. The data included number of occupied bed days per month, available bed days, number of written complaints, number of written compliments, number of admissions and discharges and number and method of resident discharges. The number of urinary tract infections (UTIs), respiratory infections, skin infections, influenza type illnesses, conjunctivitis, clostridium difficile and the various multi drug resistant organisms (MDROs). The number of falls with/without injury, number of medication errors or reactions, unintended weight loss, use of restraint, residents with new pressure areas (per grading), acute transfers to the DHB and serious/sentinel events. The rates are differentiated for the rest home and the hospital residents. (Refer to 1.2.3)

The AFM advises there has been two essential notifications since April 2013. This included notification to HealthCERT of the change in facility manager and a serious harm event. A resident is injured inadvertently while self-manoeuvring in a wheelchair. The Department of Business Innovation and Development, ACC and the DHB were advised of the events and the resident's injury. Communications in relation to the essential notification are sighted in the resident's file by another auditor during audit. The AFM is able to detail the other types of events that would be reported and state there have been none. ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

DOCUMENT REVIEW: The Human Resource planning policy states 'Radius Residential Care Ltd ensures adequate trained and skilled staff are available to provide a safe environment for clients and working environment for employees'

A register is maintained of when the EN and RN annual practising certificates are due for review. Copies of current APCs are sighted in all applicable staff files reviewed at audit (two RNs, one EN and the clinical manager at audit). The dates of the APC expiry in the staff file is congruent with details on the organisation's register which notes all seven RNs and three ENs have a current APC. Current APCs also sighted for two general practitioners, a dietitian, two physiotherapists, seven pharmacists, and four podiatrists.

Eight staff files reviewed at audit including seven staff employed since September 2012. The administrator has undertaken a full review of all staff files and noted any documents which are not present which would be expected to be present as per the organisation's policy. All eight staff files reviewed contains an application form, curriculum vitae, individual employment contract (IEC) or reference to the collective contract. All eight staff files contain a signed code of conduct, confidentiality agreement and staff handbook. Evidence is present in all eight staff files verifying a police check has been undertaken and the results are noted. The administrator advises following the staff file audit any staff member who did not have a current police check were asked for consent for this to be done. No staff are reported to have declined. In total five of the eight staff files contain all required information. Three staff (employed prior to the last audit) who do not have evidence of reference checks, or interviews present have this noted at the front of their file as this information is unable to be obtained retrospectively. The three staff (whose records reviewed) employed since April 2013 have reference checks and records from the interviews present in the files.

The staff files reviewed evidence that six of eight staff (who have been employed since 17 September 2012) have evidence of completing the requirements of the organisation's orientation programme. One staff member is still undertaking the orientation programme. One staff members whose orientation records are incomplete was employed in 2005. The orientation includes (but is not limited to) orientation to the facility, organisation values, emergency procedures, care, documentation and policies/procedures. The eleven staff interviewed confirm that staff are more confident now and contribute this to a more robust orientation programme.

There is a training calendar which includes all training requirements to meet the ARRC contract. Most in-service sessions are being repeated to facilitate staff attendance. The staff confirm they are well supported to access relevant education/training within and external to the facility. Records of attendance are sighted for in-services held between May and August 2013 for the following topics: abuse/neglect/harassment /coercion (38 staff attended); accident/incident reporting and open disclosure (18 staff attended); advocacy/code of rights/complaint management (38 staff attended): cultural safety/Treaty of Waitangi (19 staff attended); infection control/hand hygiene (10 staff attended); chemical safety (12 staff attended); death/tangihanga and sexuality/intimacy (24 staff attended); and care planning clinical assessment/documentation (11 staff (RN/EN and management team attended). This topic was one of the required education sessions as identified in the H&DC response to a recent complaint. In addition staff are required to complete manual handling training as a component of their orientation programme and records of attendance sighted.

Completed performance appraisals are present in seven of eight staff files. These are required annually or at completion of the orientation programme. One staff member is still orientating and is not yet due a performance appraisal. The AFM manager identified only two staff performance appraisals are outstanding, due this month.

ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

DOCUMENT REVIEW: The Human Resource planning policy states ' Radius Residential Care Ltd ensures adequate trained and skilled staff are available to provide a safe environment for clients and working environment for employees'.

The MOH requested that it be reviewed during audit how Radius Residential Care will ensure staffing requirements are met for the increased in rest home level care and reduction in hospital level care beds. There is an 'acuity and clinical staffing ratio' document which details that staff levels must be appropriate in staff client numbers and skill mix to meet the clients' needs. Acuity is defined as the process to determine staffing in relationship to residents' care needs. This includes the need to refer residents to the DHB needs assessment service if they have needs which cannot be met by staffing the facility. There is a clinical hours calculator which is used to identify staffing needs. The calculator template requires the number of rest home and hospital level residents be entered in the tool and it works out the number of RN or EN hours as well as caregivers and support staff hours required. The tool utilised the following formula:

Rest home residents = 0.25 RN hours and 1.5 caregiver hours per resident per day

Hospital level care = 1.0 RN hour per day and 2.5 hours caregivers direct care hours per resident per day.

The AFM demonstrates the process for calculating staffing needs. The number of residents requiring rest home and hospital level of care are entered into 'the clinical hours calculator' and this calculates the minimum number of staffing required to meet the resident’s needs. The required and actual staff hours are monitored via Time target and reports are able to be obtained that demonstrate the budgeted and actual staff hours used per staff category versus the required staffing hours per staff category. A review of the records for the period 14 July 2013 to 11 August 2013 demonstrates the organisation is providing above the minimum hours required for RN/ENs and HCAs.

A review of the current roster identifies the following:

-when rostered staff are absent they are replaced

-staff can identify if they are available to be called if extra staff are required or if there is a gap in the roster. The managers determine who will fill in vacant shift and this includes evaluating skill mix issues and the number of hours the staff member has already worked.

- Morning shifts:

There is one RNs on duty weekday mornings and one ENs weekday mornings. The role of the clinical coordinator is additional to these RN hours. The role of the quality coordinator (who is also the infection prevention and control nurse) is also additional hours. On the weekend there are two RNs on duty on the morning shift. A member of the management team is on call when not on site throughout the week.

There are four HCAs who work 6.45 am to 3 pm, and three HCAs who work 6.45 am to 2pm.

-Afternoon shifts:

There is at least one RN and one EN on afternoon duty weekdays. There are two RNs on duty in the afternoon on the weekend.

There are four HCAs who work 3 pm to 10 pm and three HCAs who work 3 pm to 11 pm .

-Night shifts:

There is one RN and three HCAs on duty between 11pm and 7am.

-There are additional designated rostered hours for kitchen staff, cleaning staff, maintenance, administration / office and to provide the activities programme.

During the weekend, the night RN documents the allocations for the week. Staff interviewed report this is an improvement of the previous practice of allocation being done on a shift by shift basis. The HCAs now know how they are caring for during the week. Staff are allocated into two groups and within each group six of the staff work in allocated pairs work together to provide care for any residents who require assistance. The remaining member of the team is 'the floater' who assists residents who are otherwise independent. The staff take turns working in the paired groups and being the 'floater' to provide some continuity for residents but also variety for staff. The four HCAs and the RN interviewed confirm the resident allocations are much fairer now.

The eleven staff interviewed speak very highly of the Waikato operations manager (Waikato OP), who has been the acting facility manager until recently and is now assisting with oversight of clinical care. The staff confirm there are sufficient staff on duty to meets residents care needs. The staff report the Waikato OP has an open door, communicates with staff in a timely manner and addresses issues promptly.

The quality manager monitors the time frames call bells are answered in. The majority of calls are answered in under four minutes. There are some calls which are noted as taking over 10 minutes to answer, however some of these are reported to be when staff forget to turn the bell off or the resident needs to go to the toilet so is assisted to do this before the bells are turned off. Seven family members interviewed (two rest home and five hospital level care) and eleven of twelve residents (seven rest home and five hospital level care) confirm staff provide timely care and answer the call bells promptly. One resident advises the call bell is not always accessible and this is raised as an area for improvement in 1.4.7.5. The RN advises all staff have a responsibility to answer call bells and this includes the cleaner or laundry staff if they are passing a rooms to enquire what the resident needs then to inform the staff.

ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

The information entered into the nine of nine residents' records is accurate and up to date. The is no private resident information displayed. When residents' photos are displayed (eg, for a record and promotion of the activities) the residents' sign a consent form for the use of their photo. All resident records are stored in locked rooms. The progress note entries sighted in the nine of nine residents' files reviewed are legible and record the date, time, signature and designation of the staff member. The nine of nine resident files reviewed evidence integration. Each resident has one folder that contains all their clinical information. A record is maintained of the records that are archived on site. The administration officer reports that records are destroyed after 10 years post resident death/discharge by a contracted documentation destruction service.

**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

The service has an admission/enquiry form that records the pre-admission information. There is an electronic resident information management system that records enquiries. The resident admission agreement meets the requirements of the ARRC service agreement. The nine of nine residents' files reviewed have signed admission agreements. The organisation's website, information packs and Eldernet clearly identifies that the service provides rest home and hospital level of care for the aged care and the younger person. Vacancies are updated daily through Eldernet.

The ARRC requirement are met.

**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 acting manager reports that entry has not been declined where a resident has an appropriate assessment at rest home hospital level of care and if there is a bed available. If a potential resident is declined entry to the service (eg, requires secure dementia care), the acting manager reports that the potential resident and there family/whanau would be informed of the reason for declining and given information of options for alternative services.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

General overview:

All staff have input into the assessment and care planning through multidisciplinary team assessments and handover each shift (confirmed in interview with three HCAs, one EN and two RNs). A physiotherapist is employed to conduct mobility assessments and plans for residents. Activities co-ordinators identify and assess, implement and evaluate residents' social, diversional and recreational programmes for each resident (confirmed in interview with the three activities co-ordinators, and nine of nine residents' files reviewed). Current annual practising certificates are sighted for all staff who require them.

The service uses the suite of assessment and care planning tools developed for Radius Care services. The initial care plan and assessment covers mobility, communication, breathing, eating and drinking, elimination, personal cleansing and dressing, control of body temperature, independence and interests, expressing sexuality, sleeping, skin and pressure care, pain, religious and spiritual needs. The additional assessment tools include sleep chart, personal grooming and hygiene, sleep, nutrition, elimination, mini nutritional assessment, continence, social history, behavioural assessment, geriatric depression scale, MMSE, communication, pain, diet requirements, skin, abbey pain scale, pressure risk, activities, physiotherapy, Berge balance scale, falls assessment. These assessment and care plans are completed in the nine of nine residents' files reviewed (four rest home and five hospital) and reflect the needs of the resident. Each resident's room sighted has a 'traffic light' code system for identifying the resident's level of assistance with mobility and transferring.

The service not commenced using the interRAI assessment tool and have attended initial information session on the use of the tool. The initial assessment and care plan are documented on the day of admission in the nine of nine residents' files reviewed (four rest home and five hospital). Within three weeks the long term care plan is developed to identify the needs and goals for each resident. All residents' files reviewed for the continuum of care are signed by residents and where appropriate family/whānau to evidence consultation. The nine of nine residents' files have documentation of at least monthly weights, blood pressure (BP) recordings, pulse and temperature (more frequently as clinically indicated). All files reviewed have documentation to evidence that the residents are reviewed by a GP within two days of admission and at least monthly (or three monthly if assessed as stable) after the initial medical review.

Progress notes entries are made each shift (confirmed in nine of nine residents' files). A verbal 'hand over' occurs for oncoming shifts where there is discussion in relation to any changes to the residents' condition (observed at time of audit. A written hand over sheet contains records of changes to residents' care for each shift.

Rest Home:

In the four of four rest home residents' files reviewed (this includes two younger residents) the initial assessments are conducted and care plans developed within 24 hours of admission. Three of the four care plans reviewed indicate six monthly evaluations of the care plan, the one remaining care plan is not applicable as their admission is under six months, though this file does evidence evaluation of care when there are changes in the resident's condition. The four of four rest home residents' files reviewed evidence short care acute care plans when changes in the resident's condition occurred. The GP medical reviews occur at least monthly or three monthly when the resident is assessed as stable and more frequently if the resident's condition requires it (confirmed in four rest home residents' files reviewed).

Follow-up regarding HDC investigation. The four of four rest home residents reviewed (includes two younger persons) files reviewed evidence, with two of these new admission in the last six months, evidence an initial review which includes the resident's wishes regarding personal care and assessment of skin integrity and pain levels. The four of four rest home level of care residents' files reviewed are accurate, up to date, reflect the current needs of the resident and have sufficient details to guide care. The three of three HCAs (work across all shifts) interviewed report they receive sufficient information to provide care that meets the residents' needs. Where the resident has special mobility needs, this is identified in the care plan and a quick reference mobility plan in all the residents' rooms is sighted. The observation of the handover, handover sheets and interviews with three of three HCAs, one EN and two RNs evidence any new health issues and changes in residents care are communicated.

Tracer example 1: rest home level of care.

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

Tracer example 2.

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

The ARRC requirements are met.

Hospital level care:

Five of five file reviews, identify that assessment, planning, and evaluation of care is undertaken by a RN. Initial assessments occur on the day of entry to the service with long term care planning being completed within a three week period. Appropriate assessments are reviewed and interventions are evaluated at a minimum of six monthly or sooner as required. Service delivery undertaken is documented on a per shift basis. Other health services who have input into resident care such as the dietitian and the nurse practitioner wound care specialist write in the same set of files that staff write in to ensure continuity of care. Evidence of this is sighted in the file review.

Tracer three:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

Rest home:

The four of four rest home residents' files reviewed (which includes two younger people) have appropriate assessments to meet the needs of the resident. The four of four rest home residents' files reviewed who are assessed as having a falls risks, have a comprehensive falls and balance assessment, input from a physiotherapist and analysis of the falls. Three of the residents' files reviewed have weight loss identified as an issue and have nutritional assessments, medical reviews and dietitian reviews. The two RNs, one EN and three HCAs interviewed demonstrate knowledge on the assessment process and have clear understanding of the falls assessment process and nutritional assessments. The seven of seven rest home residents interviewed (which includes two younger people) report they receive excellent care that meets their needs.

The relevant ARRC requirements are met.

Hospital level:

Five of five residents' files reviewed identify the use of appropriate assessments and congruent interventions to meet the needs of residents. All file reviews contain up to date assessments. The five file reviews have assessment information that is obtained during admission from the resident, family/whanau, other health care services and the NASC assessment.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

Rest Home:

The four of four rest home residents' care plans reviewed evidence individualised care plans that reflect the resident's individual needs. The file of the rest home resident reviewed has an appropriate care plan that identifies the resident's needs and care requirements, with specific plans for pain management and end of life preferences. The younger rest home resident reviewed have care planning that focus on the resident maintaining as much independence ads possible. The seven of seven rest home resident and two rest home family member interviewed report high satisfaction with the knowledge, skill and caring manner of the staff. One of the other rest home resident reviewed, who has a history falls, has a falls reduction care plan.

The handover observed includes updates of all residents, diabetic monitoring, any specialists visits (eg, GP, gerontological nurse specialist), specimens sent and results. The three of three HCAs report they receive adequate information to assist the continuity of care.

The ARRC requirements are met

Hospital level:

Five of five resident file reviews identify that care plans clearly describe residents' goals, current abilities, level of dependence, individual needs/likes/wants, idiosyncrasies and required care interventions to ensure all residents' needs are met. The file of the resident reviewed has an appropriate care plan that identifies the resident's needs and care requirements, with specific plans to respond to weight loss, wound care and change in mobility status which are all consistent with the assessment findings

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

DOCUMENT REVIEW: The policies on continence, assessment and monitoring of challenging behaviour, pain management, personal grooming and hygiene, falls prevention, skin care, wound care, death-tangihanga of a client meet the ARCC requirements and provide clear and practical guidance for the provision of residents day to day health care.

Rest Home:

The service has adequate dressing and continence supplies to meet the needs of the residents. The four of four rest home residents' care plans reviewed record interventions that are consistent with the residents' assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with the residents' needs. The seven of seven rest home residents (which includes two younger people) and two rest home family interviewed report that the service meets the needs of the resident. The rest home resident reviewed has interventions for pain management, end of life care and a short term care plan for wound management. The file of the younger rest home resident reviewed shows interventions are changed in response to their condition with specific interventions for falls, weight loss and infections. The seven of seven rest home residents and two rest home family have high praise for the interventions and the caring nature of the staff.

Hospital level:

Five of five resident file reviews and interviews with five of five hospital level residents and five family/whanau members identify that the provision of services and documented interventions are consistent with and contribute to meeting resident needs. Interventions are followed by staff to ensure desired outcomes can be obtained. This is confirmed in staff interview and in progress note documentation. Family/whanau and resident input and consultation is evident in the care planning process.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

Rest Home and Hospital:

The activities offered meet the residents' needs and are appropriate to the acuity of the residents, including rest home, hospital and the younger resident. The activities assessments and plans (sighted in nine of nine residents' files) include the resident’s preferences, social history, and past and present interests. Each resident has an activities assessment and diversional therapy plan with a resident centred goal. The activities plans sighted evidence they are updated or reviewed at least six monthly when the care plan is reviewed and a monthly summary of the residents’ participation recorded. The diversional therapy plans sighted in the nine of nine residents' files reviewed have evaluation of the resident's response to activities and provides areas for improvements to increase the resident's enjoyment of activities. The goals are developed with the resident and their family, where appropriate. The interview with two younger rest home resident indicate they are encouraged with their independence and accessing the community. They both enjoy the coffee club.

Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The three activities co-ordinators interviewed indicate they review the interest in different activities to plan activities and ensure the activities offered are of interest and are meaningful to the residents. The activities co-coordinators indicate that the female residents respond well to the community focused events and the younger residents find the one to one activities more meaningful. There is a specific men’s group with activities that are meaningful to the male residents. Residents are encouraged to attend as many activities as they choose. One to one time is spent with residents and this is recorded on the activities attendance sheet (confirmed during interview with the activities co-coordinator). The activities co-ordinator indicates relevance is incorporated into many of the van outings, such as visiting places in the local community where residents have lived which is used to stimulate conversation and reminiscing of the area and activities.

Families are invited to events, such as the garden party and Christmas lunch. There are some family members who volunteer with some activities. Church services are voluntarily run by the local parishes every second week, Catholic residents have weekly communion and residents are welcome and supported with their own spiritual advisors. The activities co-ordinators advise that there are a number of residents who go out with family or religious representative to services in the community.

The activities service is in the beginning stages of commencing quality project with the review and evaluation of the activities programme and different groups. The results of the initial quality project are not yet reviewed or evaluated.

The 12 of 12 residents (five hospital and seven rest home) interviewed report they enjoy the range and variety of planned activities.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Rest Home:

Resident reviews and evaluations are conducted at least six monthly as part of the multidisciplinary review. The evaluation includes input from the GP, family, nursing team, physiotherapy, occupational therapy, diversional therapy and the pharmacy review. The evaluation reviews if the goals set for the last six month have been achieved. Assessments are re-assessed as part of the six monthly evaluation as confirmed in the three rest home residents' (who have admissions over six months) files reviewed. The remaining rest home resident reviewed has an admission under six months. As sighted in a rest home resident's file who has a history of falls, there is a documentation of the post falls assessments. The post falls evaluation includes analysis of time of falls and evaluation process focus on reduction of further falls, which includes medical review, physiotherapy assessment and diagnostic tests.

The four of four rest home residents' files sampled demonstrate that the long term care plans are reviewed and updated as needs change. Short term care plans are used to document temporary changes in the resident's condition. The two RNs, one EN and three HCAs confirm processes are implemented and documented in the care plans when a resident's condition changes.

Hospital Level:

Evaluation of service delivery is undertaken at least six monthly or sooner if there is a change required in resident care. This is clearly identified in the documentation reviewed for the hospital level resident - where evaluation of weight, wound care and mobility have been reviewed and evaluated on almost a weekly basis over a two month period related to newly identified issues.

Evaluation includes input from the GP, family/whanau, the nursing team, physiotherapy and any other health care providers who have input in resident care, such as wound care nurse specialist and dietitian. Resident and outcome directed goals are measured to show if an intervention is working or not working. If an intervention is not working well it is reviewed, reassessed and new actions are documented to guide staff actions.

Short term care plans are used to document issues that are temporary changes to the resident’s condition. Short term care plans sighted include infection, weight management, and wound care requirements. Wound care also has a specific wound care chart to identify wound dressing requirements and frequency.

Staff interviews confirm that care plans are clearly written in a manner that allows them to deliver consistent, appropriate care to residents and that if they have any concerns related to a resident's condition a new assessment and review is undertaken by a RN. Changes to care are discussed at handover each shift and documented on a specific handover form as sighted.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Rest Home:

The GP and two RNs interviewed report that referral services respond promptly to referrals sent. Records of the process are maintained as confirmed in four of four rest home residents' files reviewed, which include referrals and consultations with the diabetic eye clinic, ophthalmology, urology, general medicine, surgery, orthopaedics, mental health, psychiatrist, radiology, gerontological nurse specialist, podiatry, cardiology, and dietitian. The GP interviewed reports that appropriate referrals to other health and disability services are well managed at the service. The rest home resident reviewed has referral and input from the hospice team.

The ARRC requirements are met.

Hospital level:

Referrals to appropriate health services sighted in five of five hospital level file reviews. This process is overseen by the GP and the RN as required. This is confirmed during interview with the RN, the GP and the nurse practitioner wound care specialist.

Residents have a choice of referral process and their right to decline services is respected by the service. This is clearly documented in the file review. The resident refused three times to attend appointments to the vascular clinic and specialist at the beginning of 2013 and then agreed to attend an appointment in July 2013. Other specific issues are well managed such as a smoking cessation programme which is supported by WDHB staff and resources. The resident review identifies that many support resources were offered to the resident to assist in smoking cessation but all were declined. During interview the resident stated it was their decision to stop smoking and that they did not need any outside interventions although they were offered.

**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

Rest Home:

Risks are identified prior to planned discharges (confirmed by interview with the two RNs). There is open communication between the service and family/whānau related to all aspects of care, including exit, discharge or transfer. If there are any specific requests or concerns that the family/whānau or resident want discussed, these are noted on the transfer form. The discharge form and care plan summary is provided that covers all aspects of care provision and intervention requirements, including any known risks or concerns. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives also accompany the resident if they are transferred to hospital.

The ARRC requirements are met.

Hospital Level:

The service has appropriate assessment tools and processes in place to identify and document known risks associated with resident's transfer or exit. There is open communication between the service and family/whānau related to all aspects of care, including exit, discharge or transfer. If there are any specific requests related to the transfer to hospital or concerns that the family/whanau or resident want discussed, these are noted on the transfer form. A copy of the resident's individual risk profile, medication profile form and allergies records, any EPOA, a summary of medical issues and a copy of any advance directives accompany the resident if they are transferred to hospital. The resident review identifies that there is an open flow of communication and appropriate documentation to and from the public hospital for the three admissions that have occurred in 2013. Upon re-entry to the facility the resident has been reassessed as appropriate and any follow up actions required by the hospital are well documented and interventions have been written on the current care plan

**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:** FA

DOCUMENT REVIEW: The Safe Administration of Medication policy describes practices associated with administration of medicines and states 'team members must have demonstrated competence to administer medication. This competency will be reviewed annually. Additional competencies’ will be required for specialist medication administration situations identified by role'. The policy discusses prescribing, and dispensing, verbal orders, and standing orders and includes clear work instructions and a flow chart for safe administration that meets current best practice guidelines and the '8 Rs'. It references other documents related to medicines management which are not reviewed as part of the document review.

Controlled Drug Register

Cleaning Log

Medicine Disposal Log

Medication Chart

Signing Sheet

Self-Administered Medicines Policy/Procedure

Medicine Storage Policy/Procedure

Medication Changes Policy/Procedure

New Client Medication Regimes

Incident Report

Adverse Drug Reactions

Disposal of Medications.

Rest Home and Hospital:

Medicines for residents are received from the pharmacy in the robotic sachet system. One RN is observed at the time of audit not to fully demonstrate a safe system for medicine administration at the time of audit (eg, signing the medicine chart before medicines are given and not checking the robotic sachet with the medicine chart). This staff member observed has a current competency for medicine administration. Further discussion with the manager confirms that safe administration is observed with this staff member as part of their orientation process. The RN received additional supervision and competency assessment at the time of audit. The RN observed on the second day of audit is observed to demonstrate safe medicine administration that reflects best practice guidelines. Observation of another one RN and one EN at the time of audit demonstrate safe medicine management. This does not reflect a systemic issue of unsafe medicine administration.

Medicines are stored securely at the service. The medicine fridge temperature and medication room temperature are recorded at least weekly, with sighted temperatures within guidelines. Controlled drugs are stored in the locked controlled drug safe in the locked treatment rooms. The controlled drugs are checked out by two staff at each administration with a weekly count recorded in red pen in the controlled drug register. The six monthly pharmacy review of the controlled drugs is last conducted 18 July 2013.

The 18 of 18 medicine prescription is signed individually by the GP. The GP's signature and date are recorded on the commencement and discontinuation of medicines. Resident photo, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. All 18 of 18 medicine administration records sighted are fully completed, including approved abbreviations when a medicine has not been given. As the medicine singing sheets were started on day prior, an additional 10 signing sheets for July 2013 are reviewed, with all medicines signed as given on these sheets. All 18 medicine charts reviewed are developed or reviewed within the past three months.

On review of the pain management of the hospital resident reviewed, the resident is consistently having their PRN (as required) medication at regular intervals, as suggested by the wound specialist. A discussion with the RN reports that the GP wishes for the pain relief to remain as PRN. The rest home resident reviewed has had their regular long acting pain relief adjusted to reflect the increase in frequency of their short acting PRN pain relief.

The RNs and ENs have the role of medicine management at the service. Current medicine competencies are sighted for all RNs and ENs (3 ENs and 8 RNs competencies sighted). The competency includes oral, suppository, inhaled medications and the use of oxygen. If a medicine administration error occurs, reflective practice and further competency assessment are conducted. The medication competency also include the use of subcutaneous infusions (conducted by the hospice service in June 2013).

There is one resident who self-administer their medicines at the time of audit. There are current assessment to ensure the resident is safe to do so (competency assessment sighted, last conducted July 2013).

The ARRC requirements are met.

Hospital level:

One resident review identifies that upon admission the resident was assessed as being competent to administer their own inhalers. A reassessment conducted in June 2013 found that the resident was no longer competent to self-administer their inhalers and this is now undertaken by nursing staff. During interview the resident stated that they understand why they can no longer self-administer their inhalers and that they agree that it is better performed by nursing staff.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Rest Home and Hospital:

The kitchen services are overseen by a contracted catering provider, with the food prepared and cooked onsite. The four week rotating summer/winter menu has been approved by a registered dietitian in April 2013 as suitable for aged care residents. The service has a number of younger residents and the cook reports that there are no major changes required to meet the nutritional needs of the younger people. The service does some additional programmes that focus on the aged appropriate aspects of nutrition for the younger residents such as the 'coffee club', pizza and fish and chip nights.

A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. The nutritional profile is updated as required to meet the changing needs and choices of the residents. Residents with modified of special dietary needs have these met by the service. The cook reports that one resident requires Halal products and they provide for special diets such as diabetic diets. Interviews with 13 of 13 residents (including younger residents) and seven of seven family/whānau members confirm they are happy overall with the food and fluids provided.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. The service kitchen policies that are based on the critical control points. The kitchen services are externally inspected by the council (current food safe certificate expiring in April 2014). Fridge and freezer recordings are undertaken daily and meet requirements. Staff have undertaken food safety management education appropriate to service delivery.

ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

DOCUMENT REVIEW: The Waste Management policy provides clear descriptions of all types of waste and guidelines for appropriate disposal and management of these. The policy contains information on using recognised waste management services, disposing of unwanted products safely, using suppliers systems for handling and disposing of chemicals and hazardous substances, provision of PPE, secure storage of chemicals and hazardous substances and providing staff education.

Supplies of appropriate personal protection sighted at audit included aprons, gloves, masks and eye protection. Supplies for use in an emergency/pandemic event are located in pandemic supply wheelie bins which have a tamper mechanism fitted. Eleven staff interviewed including three HCAs, three housekeeping staff, one laundry employee, one EN, one activities coordinator and two RNs confirm there are adequate supplies of PPE always available.

Waste and hazardous substances sighted being disposed of in accordance with the organisations policy. Sharps containers are available for the disposal of sharps. Waste and hazardous substances are clearly labelled.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

DOCUMENT REVIEW: The reviewed Transportation policy contains fully described and detailed information which is directly related to the safe transporting of residents. This meets the intent of the standard and the requirements of ARRC.

The building has a current building warrant of fitness (WOF) with an expiry dates if 13 July 2014. Ongoing checks to maintain the building WOF are being maintained and records of this are sighted.

Electrical test and tagging (ETT) is being undertaken by the maintenance man who has completed a competency assessment process and records verifying this sighted. A register is maintained of all equipment ETT and includes details of 672 individual pieces of equipment which have been tested in February and March 2013.

Calibration of clinical equipment is occurring and wheelchair scales, tympanic thermometer, portable suction, dynamap and sphygmomometer all have current performance monitoring labels present (expiry 22 November 2013). Records verifying other equipment which have been tested also sighted.

The eight hoists have been serviced by Able Techs in September 2012. The oxygen concentrators have been validated by Cubro on 21 March 2013. The syringe pump has had performance monitoring undertaken by REM systems Ltd on 11 July 2012.

The environment promotes the safe mobilisation of residents. There are handrails present in the hallways. Grab rails are present in all bathroom areas reviewed at random during audit. The floor surfaces are flat with no unexpected ledges or gradients. Residents sighted mobilising in the corridors independently including one resident self-propelling in a wheelchair and other residents using other mobility devices. The maintenance man showed the schedule of renovations which have been undertaken in recent months. Thirty three bed rooms have been repainted, 11 bedrooms have new vinyl on the floor and three bedrooms have been re-carpeted. New curtains have been installed in 20 rooms. There is an ongoing schedule of refurbishment in place.

The corridors are uncluttered. Mobility scooters now have a designated storage area outside and scooters are covered with a BBQ cover for protection.

There is an external deck that goes around the building. There are five internal courtyards which are accessible by residents. One resident interviewed advised she is taken outside by staff in a wheelchair on regular occasions and at times in a bed. All seven family members interviewed (five hospital level care and two rest home level care) and all twelve residents interviewed (seven in the rest home and five in the rest home) confirm the facility is maintained and there is sufficient space to mobilise around.

**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

There are sufficient showers and toilets on site for use by residents as verified during a visual walk-a-bout the facility and review of the Maeroa Lodge site plan. Thirteen resident bedrooms have full ensuites attached. In each wing there are all resident use showers and separate toilets including those near the lounge areas. Ablution areas have privacy mechanism and signage present which notes if the room is engaged and vacant. Three HCAs interviewed confirm there are enough toilets and showers available for residents' use.

**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

All 92 patient bedrooms are single occupancy. There is sufficient space in the rooms for residents to mobilise including while using mobility devices. This is verified during a visual review of the facility and during interview with staff and all seven family members interviewed (five hospital level care and two rest home level care) and all twelve residents interviewed (seven in the rest home and five in the rest home).

**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

All 92 bedrooms are single occupancy.

The AFM advise one of the unoccupied bedrooms is currently being used for some of the younger residents with disabilities for individual and small group activities and this room is sighted. There is a larger designated activity room with entrance to one of the internal courtyards.

There is a designated hospital dining room (by the kitchen) where residents who require assistance with meals go. There are four lounges/observation areas around the facility. There is an additional lounge area used by the residents who smoke. There is an air extraction unit present and the room has a ranch slider which opens out to an internal courtyard. At audit there are a number of residents sighted smoking in this lounge. There is no odour of tobacco smoke outside of the designated smoking room.

All seven family members interviewed (five hospital level care and two rest home level care) and all twelve residents interviewed (seven in the rest home and five in the rest home) confirm there is enough communal and recreation areas.

**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

DOCUMENT REVIEW: The linen management, cleaning services and chemical use policies provide clear guidelines and procedures for the provision of safe and effective laundry and cleaning services and include performance indicators for monitoring purposes. These meet the requirements of this standard and the ARCC.

Monitoring the effectiveness of the cleaning and laundry services is undertaken via the audit programme.

On a monthly basis Ecolab (who supply chemicals used in the cleaning service, laundry service and kitchen) come on site and undertake reviews of the chemical dispensing mechanisms, the quality of the linen appearance post laundering and aspects of environmental housekeeping. Records sighted for May to August 2013 demonstrates overall the quality of the end 'product' is meeting the chemicals suppliers expectations.

An internal audit has been undertaken of environmental cleanliness and the results presented at the August 2013 quality /health and safety meeting. Overall compliance with the organisations policies is high. An area for improvement is raised in relation to high dusting. The quality co-ordinator advises a company has been contracted to come and undertake high cleaning.

All chemicals sighted at audit are stored securely. Cleaning chemicals are mixed via wall mounted auto mixing units. The cleaning trolleys are locked in a designated room when not in use.

All seven family members interviewed (five hospital level care and two rest home level care) and all twelve residents interviewed (seven in the rest home and five in the rest home) confirm the facility is kept clean and tidy and their laundry is returned in a timely manner.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Training on management of fire and other emergency procedures is included in the orientation programme. Six of eight staff whose records reviewed at audit (who have been employed since 17 September 2012) have evidence of completing the requirements of the organisations orientation programme. One staff member is still undertaking the orientation programme. One staff members whose orientation records are incomplete was employed in 2005.

There are 13 HCA and activities staff who have a current first aid certificate. Six RNs/ENs and the clinical manager have a current first aid/resuscitation certificate as noted on the register in the staff room and the staff files reviewed during audit. There is always at least one staff member (the registered nurse) on duty at all times with a current first aid/resuscitation certificate as verified on the roster sighted.

Radius Maeroa Lodge has a fire evacuation plan which has been approved by the New Zealand Fire Service in a letter dated 16 November 2000. The most recent fire evacuation drill occurred on the 29 June 2013. This is attended by 16 staff and staff evacuations occurred in under three minutes as reported in the fire drill summary sighted. Thirty three staff attended fire evacuation training in February 2013. Thirty two staff attended an in-service on emergency procedures in May 2013.

Call bells are present in all occupied bedrooms and bathrooms areas. In three unoccupied rooms the call bells have been removed. It is observed during audit that four residents who are immobile do not have their call bells accessible. This included one resident with bed rails up. One rest home level resident stated call bells are not always made accessible. This is an area requiring improvement. All seven family members interviewed (five hospital level care and two rest home level care) and eleven of twelve residents interviewed (seven in the rest home and five in the rest home) advise call bells are answered in a timely manner.

There are adequate supplies of equipment and utilities for use in emergency. This is includes a BBQ and two spare bottles of gas. There are supplies of portable medical gas (oxygen), pandemic equipment, and a wheelie bin (with a tamper mechanism) that contains consumables such as torches, bleach, lighters, batteries and a radio. There is another wheelie bin that contains supplies of dried food stuffs. The quantity and expiry date of each item is noted on the outside of the container. This is also fitted with an anti-tamper device. Spare blankets and duvets are sighted in the linen cupboard. There are 24 ten litre bottles of drinking water as well as a water tank that container 55,000 litres of water.

There a security cameras monitoring the front and back doors and the kitchen. The footage from these cameras are displayed in the quality coordinators office. The maintenance man and administrator advise the footage is available for 'weeks' and has been 'useful' on occasions. There are additional camera devices in each of the main corridor areas. The maintenance man advises these are currently not operational, however staff are not aware of this.

The front doors are secured by staff at 8pm. The RN advises the RN is responsible for ensuring the security checks occur. Staff interviewed who work in the afternoons and evenings confirm there is a security check undertaken on both the afternoon and the night shift which includes ensuring all external doors and windows are secure. Two family members interviewed advise they work shift work so will come and visits their family member at around1.00 am in the mornings. They report ringing the door bell and staff come and check and then let them in.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Call bells are located in all patient rooms and ablution areas reviewed with the exception of three unoccupied rooms where the bells have been removed and used as replacements in occupied rooms. Five call bells tested during audit. All sound audibly and illuminate a light outside the room above the door. The room is also displayed on ceiling mounted display panels. A number of individual residents in the lounge have a portable bell which rings to the nurses’ station. Four immobile residents at audit are sighted to not have their call bells readily accessible. This includes a resident in bed with bed rails up, and a resident in a lazy boy chair. For two residents the call bell is hung at the wall and for the other two occasions the bell is on another piece of furniture in the room but is not accessible. One rest home resident advised call bells are not always left where they can be reached. Ensuring calls bells are accessible to residents is an area requiring improvement

**Finding Statement**

1) Four immobile residents at audit are sighted to not have their call bells readily accessible. One rest home resident advised call bells are not always left where they can be reached.2) Three of the bedrooms in the unoccupied end of the facility are not fitted with call bells.

**Corrective Action Required:**

1) Ensure call bells are consistently within reach of residents.2) Ensure call bells are installed in the three unoccupied rooms prior to occupancy.

**Timeframe:**

Three months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

All residents' bedrooms have a large window and or ranch slider into the internal courtyard. There is no unpleasant odours present. The maintenance man advised the heating automatically turns on if the external temperature is 16 degrees or less. There are wall mounted radiators inside each resident rooms and the ambient temperature can be adjusted by each resident (if applicable). Rooms on the sunny side of the facility have heat pump present. The maintenance man advises that is summer these rooms can get very hot. The heat pump allows the resident to cool their room if they want. Occasional monitoring of the internal ambient temperature is occurring. The recorded temperatures are noted to be 22 degrees Celsius.

All seven family members interviewed (five hospital level care and two rest home level care) and all twelve residents interviewed (seven in the rest home and five in the rest home) verify the facility is appropriately warm and ventilated. One resident interviewed has a fleece blanket on her bed (her choice) and reports she is 'kept nice and warm'.

Refer to 1.4.5 in relation to ventilation of the smoking room.

**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

DOCUMENT REVIEW: The Restraint Minimisation and Safe Practice manual contains definitions and information which is congruent with the requirements of this standard. It lists approved restraints as:

1. Non-access to self-propelling chair

2. Specialized seating designed to immobilize client

3. Lap belt

4. Bed rails

7. Low bed, nursing the client on their mattress on the floor

The policy contains clearly described and complete processes for assessment, approval and consent, monitoring and review, evaluation, cultural considerations, de-escalation and staff training. This meets the intent of the standard and the requirements of ARRC.

Interviews with the two RNs, one EN and three HCAs identifies that they fully understand all aspects of restraint minimisation and safe practice, including the requirements for enablers. Education on restraint minimisation and de-escalation techniques is conducted in February and July 2013.

Currently the facility has nine residents assessed as requiring restraint use and 10 residents assessed as requiring enablers. This has reduced from 13 resident assessed as requiring restraint. The restraint coordinator confirms enablers are used for resident safety and security and to maintain independence when in bed. Enablers are not used for residents who are confused or identified as at risk. A resident interviewed who has enabler use confirms that this is at their request.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

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

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

As per policy, the approval of restraint is undertaken by the approval group which consists of the GP, the restraint coordinator (RN), the nominated enduring power of attorney and the resident, where appropriate. This is confirmed in documentation sighted in two residents' files (two restraint of bed rails). The two RNs, one EN and three HCAs interviews confirm their knowledge of restraint approval process which they fully implement. Once a restraint is approved it is reported at handover, written in the care plan and monitoring charts in the room, under both restraint and mobility. The restraints and enablers are discussed at the monthly staff meeting. The number of restraints and enablers are reported back to Radius management. The Radius care have a notional governance committee for the review of restraint use, reporting trends and types of approved restraints for Radius Care facilities.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

Restraint is only put in place following appropriate assessment which includes exploring alternatives to restraint or enabler use by identification of triggers, health problems, medications, physical, social or environmental. Assessment also considers risk and benefits of restraint or enabler use, such as will it compromise wellbeing of the resident or others, cultural safety, emotional trauma, physical safety, mobility, will it reduce risk of falls or harm and is there a balance between independence and protection.

The two residents' file reviewed, where restraint is in use, identify that assessments are undertaken for each resident and policy is fully implemented. Assessment is completed by the restraint coordinator or RN. All restraint assessment is updated at least six monthly. The monthly restraint committee reviews restraint use monthly (as confirmed in the minutes sighted and interview with the restraint coordinator).

The two RNs, one EN and three HCAs understand and implement alternatives to restraint, such as low beds, whenever possible.

The ARRC requirements are met.

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

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

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

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

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

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

(f) Maintaining culturally safe practice;

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

(h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

Policy identifies that restraint is only applied after consideration is given to all possible alternatives and that it will be used with the least amount of force. Restraint is to be monitored according to risk and a restraint register is maintained. The restraint register records the resident, method of restraint, date commenced, date evaluated and care plan/consent review date (this is updated monthly).

At the time of audit there are nine residents assessed as requiring restraint use (bed rail, low/low bed and fallout mattress). Restraint planning is undertaken only if the assessment process indicates the use of restraint would be appropriate. All residents with restraint are monitored according to assessed risks, with hourly to two hour checks are undertaken and signed for by staff using a specific form which identifies if any cares are given (confirm for the two residents reviewed for restraint use). The restraint coordinator audits all documented evidence as part of regular audits and spot checks of monitoring forms, as confirmed at interview.

Restraint is documented in the two residents' files reviewed and in the restraint register sighted. All enablers and restraint are consented to by the family/whanau and the resident as appropriate. If a change is made to the type of restraint used the consent process is renewed.

The ARRC requirements are met.

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

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

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

(d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

All restraint and enablers are evaluated monthly at the restraint committee and at six monthly as part of the resident multidisciplinary review process (confirmed in minutes sighted and interview with the restraint coordinator). This includes family/whanau and resident input as appropriate. The two residents reviewed with restraint use and two residents with enabler use, record family participation in the authorisation and review of their use. Restraint reviews are reported and discussed at the restraint meetings and types of restraints in use are monitored by the committee. Documented six monthly reviews sighted in two file reviewed (of residents with restraint use) identify that assessments are updated as part of the review process to evidence the need for continued restraint or recommendations are made to cease restraint. Care planning is congruent with assessment findings in the two residents reviewed with restraint use and the two residents' reviewed with enabler use.

Interviews with two RNs, one EN and three HCAs confirm they have input into restraint evaluation processes. Family/whanau confirm they are required to sign ongoing consent at each review.

The ARRC requirements are met.

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

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

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

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

(d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

An annual monitoring and quality review is undertaken using a specific form which addresses all areas related to restraint practice. The Radius Care governance group conducted a six monthly review of the organisation's use of restraint (last conducted February 2013). The governance group identifies trends, actions put in place to reduce restraint use, staff compliance to policies and procedures, staff education and competency, and audit results. This report is shared with staff and management meetings (as confirmed in minutes sighted and interview with the restraint coordinator).

The ARRC requirements are met.

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

DOCUMENT REVIEW: The infection control policy submitted includes clear terms of reference for the infection control committee and the role of the infection control coordinator and where to access expert advice or resources. The policy lists a number of infection control policies and procedures and states the infection control programme will include the following:

- specific infection control policies and procedures.

- orientation for all new employees regarding the Infection control programme.

- regular reviews of infection control associated practices to evaluate compliance with established practices.

- reference and utilisation of appropriate legislation and published professional guidance (i.e. Resource Management Act, Health and Safety in Employment Act, Human Rights and Public Health Department)

- systems for reporting, recording, reviewing and evaluating infections among clients and employees.

-systems for the management of clients and employees with identified and suspected communicable diseases.

- consultation in the renovation/construction of facilities where relevant to infection control.

- consultation with the Infection Control Co-ordinator in the purchase of new patient care equipment/product where relevant to infection control.

- an infection control manual will be available for all employees and held in a known, central location.

- all resident related information is to be circulated anonymously.

- all employees are expected to be aware of and uphold infection control principles.

The quality coordinator is also responsible for infection prevention and control (IP&C). She has worked at Radius Maeroa Lodge for approximately 11 years and held the IC responsibilities. The IP&CN confirms reporting to the AFM any issues/concerns. The AFM confirms there is timely communication occurring with the IP&C nurse. Policies and procedures are available to guide staff practice. All staff are responsible for undertaking hand hygiene practices and working to minimise the spread of infection. Two RNs, one EN and three HCAs interviewed are able to describe their responsibilities in relation to reporting of residents with infections. The staff confirm there are supplies of personal protective equipment (PPE) readily available. There are six residents with a known multi-drug resistant organisms (MDRO).

Staff and residents are offered influenza vaccinations annually. Forty four residents and ten staff are noted as consenting to have the influenza vaccination in 2013.

The IP&CN advises if there are known outbreaks/public health concerns in the community, a whiteboard is placed at the front door alerting visitors to be aware of this and to not visit if they are unwell.

An annual review has occurred of the infection control programme by Radius Residential Care Limited (RRCL) and the summary sighted.

**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

DOCUMENT REVIEW: The infection control policy submitted includes clear terms of reference for the infection control committee and the role of the infection control co ordinator and where to access expert advice or resources.

The IP&CN advises she is supported in her role by the management team. The GP can be contacted if there are any concerns about residents who have infections. The clinical microbiologist at Pathlab is contacted for advice and examples are sighted (emails) in relation to whether there is any benefit to 'dip sticking' urine samples if a resident is suspected to have a MSU. The agreed outcome is that full urine cultures are recommended due to the number of false positives and false negatives from 'using dip sticks'. The IP&CN also advises the DHB IC team area can also be contacted if necessary.

**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

All required policies and procedures are available to meet the requirements of this standard. The policies meet legislative requirements and current accepted practice. The infection control policies and procedures have been recently reviewed by RRCL. The IP&CN advise the new policies were received in May 2013. Copies of the IC policies and procedures is available electronically as well as in a manual in the nurses’ station and these are sighted.

The staff interviewed confirm the policies are accessible.

**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 prevention and control nurse has been in the role for approximately 11 years and reports attending a number of national infection prevention and control conferences in the past. The IP&CN also attends study days organised by WDHB IC team and records sighted verifying attendance at two IC study days in the last 12 months.

Residents are provided with education on infection prevention and control topics. Where this occurs it is noted in the care plan or progress notes and sighted in relevant resident files reviewed at audit. The IP&CN advise the majority of education is on hand hygiene or prevention of urinary tract infections.

**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

Surveillance for residents who develop infections is occurring. The surveillance programme and associated processes are documented in the Surveillance programme criteria and methodology (infection control policy and procedures) sighted. The surveillance is appropriate to the service setting and includes (but is not limited to):

- influenza like illness

-urinary tract infections

- respiratory tract infections

- conjunctivitis

- gastrointestinal tract infections

- skin/soft tissue infections.

Three of three HCAs and the EN interviewed confirm they are responsible for reporting residents who are suspected of having infections to the RN on duty and the GP. Residents with infections are then reported to the quality coordinator (QC) who is responsible for oversight of the infection prevention and control programme.

Results of surveillance activities are analysed on a monthly basis and reports for May 2013 to July 2013 (inclusive) are sighted. The results are communicated to staff via staff meetings (and verified in minutes sighted) and via data on notice boards (also sighted). The three HCAs, two RNs and one EN confirm information on residents with infections and prevention strategies is well communicated.

The IC&PN has undertaken an analysis of the reported infections for the January to July 2013 period at Maeroa Lodge. Overall there have been 77 courses of antibiotics prescribed. Only 43 correlate with 'confirmed infections' and this is currently under review.

Of the identified infections14 are urinary tract infections, 18 are wound/skin infections, eight are respiratory tract infections and three residents had conjunctival infections. The causative organism and other contributing factors where known are also noted in this report.

**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:**