

Ativas Limited

CURRENT STATUS: 14-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

Cairnfield House has been under new ownership and management since October 2012 and is certified to provide rest home level care for up to 75 residents. On the day of the audit there were 55 residents at rest home level care including two who are under 65 years old. The service is undergoing a restructuring and the owner will take over management responsibilities when the current manager leaves. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke positively about the care and support provided.

This audit identified improvements required by the service in the following areas; governance, assessments, care plans, aspects of medication management and recording fridge temperatures.

AUDIT SUMMARY AS AT 14-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

Indicator	Description	Definition
	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

Consumer Rights	Day of Audit 14-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

Organisational Management	Day of Audit 14-Aug-13	Assessment
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk

Continuum of Service Delivery	Day of Audit 14-Aug-13	Assessment
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Safe and Appropriate Environment	Day of Audit 14-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.		Standards applicable to this service fully attained

Restraint Minimisation and Safe Practice	Day of Audit 14-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

Infection Prevention and Control	Day of Audit 14-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 14-AUG-13

Consumer Rights

Information on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents and families. The service functions in a manner that complies with the Code. Staff have a clear understanding of the Code. Staff uphold the Code and maintain the privacy and dignity of the residents. The residents' cultural values and beliefs are identified, documented and adhered to. Family involvement is actively encouraged. There is evidence of regular communication with the general practitioner (GP). Physiotherapy and podiatry services are provided. Informed consent processes are in place. Staff and managers clearly understand the informed consent process and its relevance in an aged care environment.

The complaints process meets the requirements set forth by the Health and Disability Commissioner. Complaints are dealt with in a prompt and effective manner.

Organisational Management

Cairnfield House is privately owned by a family trust. It was purchased by the trust in 2012. The director previously owned an aged care facility in Auckland. The service is currently undergoing a restructure and the owner will undertake management duties following the restructure. There is an improvement required around updating the business plan, organisational chart and relevant job descriptions to reflect the restructure.

Cairnfield House is committed to maintaining a quality management system. The service has policies and procedures that are reviewed two-yearly and are linked to legislative requirements and good practice. The internal auditing programme identifies opportunities for improvements. Corrective actions are implemented with evidence of positive outcomes.

Health and safety procedures are in place covering hazard identification, management of hazards, monitoring of hazards, and review of hazards.

Human resources policies include recruitment, selection, orientation and staff training and development. Police vetting is completed prior to the staff appointment. Completed induction checklists are held in the staff education records. Staff files contain up-to-date performance appraisals.

There is evidence of education and training for staff. Mandatory training and education programmes cover the essential topics required for the delivery of services in an aged care facility. Registered nursing staff and team leaders are encouraged to attend external education and training programmes.

A registered nurse is either on-site five days a week or is available on-call 24 hours a day, seven days a week.

Continuum of Service Delivery

The service has assessment process and consumer's needs are assessed prior to entry. There is a well-developed information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed or signed off by the registered nurse. Risk assessment tools and monitoring forms are available and partially implemented. Service delivery plans are individualised. Short term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. The diversional therapist is responsible for activities and there are programmes running that are meaningful and reflect ordinary patterns of life. There are also visits to and from community groups. There are improvements required around assessment and care plans.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. There are improvements required around medication administration and transcribing.

Food services policies and procedures are appropriate to the service setting. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. There is evidence of compliance with current legislation and guidelines. Residents and family members interviewed were very complimentary of the food service provided and report their individual preferences are well catered. Additional snacks are available if the kitchen is closed. There are improvements required around fridge temperatures in a lounge fridge.

Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Service providers receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Protective equipment and clothing is provided and used by staff

Staff documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. The facility is an older

purpose built building that is well maintained. Documented policies and procedures for the cleaning and laundry services are implemented. Staff have completed appropriate training in chemical safety. There is compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals.

There are emergency plans in place and emergency drills have been held annually. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

Restraint Minimisation and Safe Practice

The practice of restraint is relevant to individual resident requirements and is only used where it is clinically indicated, and de-escalation strategies are ineffective. At present, there are no restraints or enablers being used.

Infection Prevention and Control

The infection control policies and procedures are documented. Staff meetings are conducted quarterly with infection control noted as a regular agenda item. Regular infection control audits, hazard documented and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control programme is reviewed annually and the infection control coordinator takes overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations.

All surveillance activities are the responsibility of the infection control coordinator who is the registered nurse with assistance from all staff through the quarterly staff meeting. There is an infection register in which all infections are documented monthly.

Cairnfield House

Ativas Limited

Certification audit - Audit Report

Audit Date: 14-Aug-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RCompN, PGDipHSM, auditor certificate	16.00	6.00	14-Aug-13 to 15-Aug-13
Auditor 1	XXXXXXXX	MHADipPhys, RABQSA, lead auditor	16.00	6.00	14-Aug-13 to 15-Aug-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX			1.00	

Total Audit Hours on site	32.00	Total Audit Hours off site <i>(system generated)</i>	13.00	Total Audit Hours	45.00
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Staff Records Reviewed	7 of 38	Client Records Reviewed <i>(numeric)</i>	8 of 55	Number of Client Records Reviewed using Tracer Methodology	1 of 8
Staff Interviewed	12 of 38	Management Interviewed <i>(numeric)</i>	3 of 3	Relatives Interviewed <i>(numeric)</i>	3
Consumers Interviewed	8 of 55	Number of Medication Records Reviewed	16 of 55	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	1

Declaration

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

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

Dated this 11 day of September 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

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Cairnfield House	75	55		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

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This audit identified improvements required by the service in the following areas; governance, assessments, care plans, aspects of medication management and recording fridge temperatures.

1.1 Consumer Rights

Information on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents and families. The service functions in a manner that complies with the Code. Staff have a clear understanding of the Code. Staff uphold the Code and maintain the privacy and dignity of the residents. The residents' cultural values and beliefs are identified, documented and adhered to. Family involvement is actively encouraged. There is evidence of regular communication with the general practitioner (GP). Physiotherapy and podiatry services are provided. Informed consent processes are in place. Staff and managers clearly understand the informed consent process and its relevance in an aged care environment.

The complaints process meets the requirements set forth by the Health and Disability Commissioner. Complaints are dealt with in a prompt and effective manner.

1.2 Organisational Management

Cairnfield House is privately owned by a family trust. It was purchased by the trust in 2012. The director previously owned an aged care facility in Auckland. The service is currently undergoing a restructure and the owner will undertake management duties following the restructure. There is an improvement required around updating the business plan, organisational chart and relevant job descriptions to reflect the restructure.

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1.3 Continuum of Service Delivery

The service has assessment process and consumer's needs are assessed prior to entry. There is a well-developed information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed or signed off by the registered nurse. Risk assessment tools and monitoring forms are available and partially implemented. Service delivery plans are individualised. Short term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. The diversional therapist is responsible for activities and there are programmes running that are meaningful and reflect ordinary patterns of life. There are also visits to and from community groups. There are improvements required around assessment and care plans.

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1.4 Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Service providers receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Protective equipment and clothing is provided and used by staff

Staff documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. The facility is an older purpose built building that is well maintained. Documented policies and procedures for the cleaning and laundry services are implemented. Staff have completed appropriate training in chemical safety. There is compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals.

There are emergency plans in place and emergency drills have been held annually. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

2 *Restraint Minimisation and Safe Practice*

The practice of restraint is relevant to individual resident requirements and is only used where it is clinically indicated, and de-escalation strategies are ineffective. At present, there are no restraints or enablers being used.

3. *Infection Prevention and Control*

The infection control policies and procedures are documented. Staff meetings are conducted quarterly with infection control noted as a regular agenda item. Regular infection control audits, hazards documented and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control programme is reviewed annually and the infection control coordinator takes overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations.

All surveillance activities are the responsibility of the infection control coordinator who is the registered nurse with assistance from all staff through the quarterly staff meeting. There is an infection register in which all infections are documented monthly.

Summary of Attainment

1.1 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 1.1.6	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

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			

1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	PA Low	0	1	1	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 1.2.7	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

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

1.3 Continuum of Service Delivery

		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	PA Moderate	0	0	1	0	0	5
Standard 1.3.5	Planning	PA Moderate	0	1	1	0	0	5
Standard 1.3.6	Service delivery / interventions	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 1.3.12	Medicine management	PA Moderate	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	PA Low	0	2	1	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 8	PA Neg: 0	PA Low: 1	PA Mod: 3	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:17	PA:4	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

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

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

2 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	Not Applicable	0	0	0	0	1	3
Standard 2.2.2	Assessment	Not Applicable	0	0	0	0	1	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	3	6
Standard 2.2.4	Evaluation	Not Applicable	0	0	0	0	2	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	1	1

Restraint Minimisation and Safe Practice Standards (of 6):	N/A: 5	CI:0	FA: 1	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 21):	CI:0	FA:1	PA:0	UA:0	NA: 8		

3 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

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									

Total Standards (of 50)	N/A: 5	CI: 0	FA: 40	PA Neg: 0	PA Low: 2	PA Mod: 3	PA High: 0	PA Crit: 0	UA
Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0					
Total Criteria (of 219)	CI: 0	FA: 88	PA: 5	UA: 0	N/A: 8				

Corrective Action Requests (CAR) Report

Provider Name: Ativas Limited
 Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:14-Aug-13 End Date: 15-Aug-13
 DAA: Health and Disability Auditing New Zealand Limited
 Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.2.1	1.2.1.1	PA Low	<p>Finding: The organisation is currently undergoing a restructure. The nurse manager (RN) has given notice and will be leaving the end of August. The owner/director plans to reorganise the roles and responsibilities of the RN, assistant manager, and manager and will be taking on a role that includes additional day-to-day managerial responsibilities. She plans to hire a second (part-time) RN. She also plans to delegate additional responsibilities to the assistant manager. At present, this restructure has not been clearly defined.</p> <p>Action: Clarify the roles and responsibilities of the staff and owner/director, including (but not limited to) updating the business plan, organisational chart and applicable job descriptions.</p>	3 months
1.3.4	1.3.4.2	PA Moderate	<p>Finding: (i) Two of eight initial assessments and care plans have not been signed or dated. (ii) One of eight residents has no falls assessment and a further two have not been updated in the past six months. (iii) One of eight residents does not have a pressure risk assessment and a further one pressure risk assessment is not dated. (iv) One resident file sampled for a resident using controlled drugs for pain management does not have a pain assessment.</p> <p>Action: (i) Ensure all assessments are signed and dated. (ii) and (iii) Ensure all routine risk assessments are completed for every resident and reviewed at least six monthly. (iv) Ensure pain assessments are completed for residents who have pain.</p>	3 months

1.3.5	1.3.5.2	PA Moderate	<p>Finding: There are a number of needs not identified in care plans and care plans do not always reflect all client needs. Issues not addressed include shortness of breath, COPD, diabetes, seizure management, pain management and depression.</p> <p>Action: Ensure all identified needs have corresponding interventions in the care plan.</p>	3 months
1.3.12	1.3.12.1	PA Moderate	<p>Finding: (i) Eight of 16 medication charts sampled have regular medications charted that have not been documented as administered regularly. (ii) Eleven of 16 medication administration records have evidence of transcribing.</p> <p>Action: (i) Ensure medications are administered as prescribed. (ii) Cease the practice of transcribing.</p>	3 months
1.3.13	1.3.13.5	PA Low	<p>Finding: The fridge in the Manuka Wing lounge where food is stored has not had the temperature monitored.</p> <p>Action: Ensure all fridge's are maintained at a safe temperature.</p>	3 months

Continuous Improvement (CI) Report

Provider Name: Ativas Limited
Type of Audit: Certification audit
Date(s) of Audit Report: Start Date:14-Aug-13 End Date: 15-Aug-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has available information on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with staff (six of six healthcare assistants, two of two cleaners/laundry assistants and one of one registered nurse (RN), and three of three managers (RN) confirm their familiarity with the Code and how it is implemented into their everyday delivery of care.

Discussions with eight of eight residents and three of three family members confirm that the service functions in a manner that complies with the Code. Training on the Code is provided during new employee orientation and as a two-yearly mandatory education and training topic (reference 1.2.7).

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
Information on the Code is available to residents and their family in the resident admission pack. Posters displaying the Code are placed on walls and notice boards. If required, this information can be supplied as a video, in different languages and/or in larger print.	
On entry to the service, the RN or manager (RN) discusses aspects of the Code (eg, complaints process, role of advocacy services) with the resident and their family. Discussions with eight of eight residents and three of three family members verify that residents and family are familiar with the key points of the Code.	
D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission.	

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policies and procedures are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff recognise the importance of maintaining the confidentiality of resident information. Examples were provided by six of six healthcare assistants of how they maintain the privacy and dignity of the residents. Staff were observed gaining permission before entering residents' rooms and treating residents with dignity and respect. Interviews with eight residents and three family members identify that staff respect the residents' privacy and that the service is respectful and responsive to their needs, values and beliefs.

Discussions with six healthcare assistants, one RN, eight residents and three family confirm that residents are provided with choices and are able, within the constraints of the service, to exercise freedom of will. This includes giving residents choices about what time they would like to get up, if they would like a shower or not, what they would like to wear, choices about food, and activity choices.

An abuse and neglect policy is in place. Discussions with three of three managers (owner, manager (RN), assistant manager) identifies that there are no incidents of abuse or neglect and that there is a culture of reporting. Abuse and neglect training is included in the orientation training and in-service education programme. Interviews (three family and eight residents) verify that they are positive about the quality of care and support provided.

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

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

D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

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

Policies and procedures are in place for the provision of culturally safe care for Māori residents. Specialist advice is sought as necessary. Discussions with six of six healthcare assistants, one of one RN, three of three managers and two of two cleaners/laundry assistants confirm that they have an awareness of the need to respond appropriately to the cultural values and beliefs of Māori.

Cultural values and beliefs are identified and documented through admission and assessment processes (evidenced in eight of eight residents' files). Family involvement is actively encouraged through all stages of service delivery (evidenced in interviews with three family). Whanau are invited to attend resident care plan review meetings.

Six residents identify as Maori. This is identified in their care plans. One Maori resident was available for interview. She acknowledges that her rights as a Maori resident are respected. She enjoys speaking Te Reo and has close links with her whanau.

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

D20.1i The service has developed links with local Maori health care providers, who are listed in policy, including contact details.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The service implements policies that recognise the importance of residents maintaining their individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences (evidenced in interviews with six of six healthcare assistants, and one registered nurse).

Values and beliefs information is gathered on admission with family input. Family are invited to attend care planning and care review meetings. One resident who was interviewed is from Holland. She reports that staff have been very helpful in assisting her in improving her English.

D3.1g The service provides a culturally appropriate service.

D4.1c Care plans reviewed included the residents social, spiritual, cultural and recreational needs.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

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

How is achievement of this standard met or not met?

Attainment: FA

Policies and procedures are in place regarding maintaining professional boundaries. Interviews with one RN and six of six healthcare assistants and cleaning/laundry staff verify staffs' understanding of professional boundaries. Staff are bound by a code of conduct.

There are no episodes sighted either in the complaints folder or in the adverse events folder that would indicate an abuse of professional boundaries. This is confirmed in interviews with the manager (RN) and assistant manager.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

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

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

How is achievement of this standard met or not met?

Attainment: FA

Policies and procedures are linked to current legislative requirements, and best practice standards within an aged care environment.

Resident and family satisfaction surveys are conducted annually and residents' meetings are held two-monthly. There is evidence of regular communication with the general practitioner (GP), evidenced in interviews with the GP, RN and manager. The GP is on site twice per week. Physiotherapy and podiatry services are available.

The RN attends regular external professional development courses. In 2012 - 2013 (year to date) she has attended courses on syringe driver competency, leadership in dementia care, medication updates (16 hours), wound care and pain assessment conference (two days). There is additional evidence of the team leaders (senior healthcare assistants) attending external professional development courses in addition to the internal education and training programmes.

A2.2 Services are provided that adhere to the health & disability services standards. There is an implemented quality improvement programme that includes performance monitoring.

D1.3 All approved service standards are adhered to.

D17.7c There are implemented competencies for healthcare assistants, team leaders, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

An open disclosure policy is in place. Residents' files (eight of eight) demonstrate that residents and their families are kept informed of events that impact them. A recent initiative includes documenting the family's wishes regarding communication in the residents' files. The GP reports the service follows expected protocols for reporting, notifying and maintaining communications regarding events that impact the wellbeing of residents.

Eight residents and three families report they are kept informed. They also report that they were welcomed on entry and were given time and explanation about the services provided.

Interpreter services can be accessed through the Northern District Health Board (NDHB). The staff are multi-cultural with some Maori staff able to speak Te Reo.

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

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b Three relatives report that they are always informed when their family members health status changes.
D11.3 The information pack is available in large print and advised that this can be read to residents.

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

Informed consent policy and procedures are in place. Written consent is gained from the resident for outings, photographs, treatment procedures, flu vaccine, advance directives, and collecting and storing health information. Interviews with six healthcare assistants, the RN, and the manager confirm their understanding of informed consent. They can provide examples of how they implement the principles of informed consent in their everyday practice. A policy on advance directives is in place. The manager (RN) and RN understand that only residents who are deemed competent are allowed to sign a 'not for resuscitation' advance directive (evidenced in eight of eight residents' files).
D3.1.d Discussion with three family members identified that the service actively involves them in decisions that affect their relatives lives.

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11 Advocacy And Support

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

On admission to Cairnfield House residents are provided with written information on the role of an advocacy services and how to access the Health and Disability Advocacy Service. The complaints form includes documentation of the advocates contacted (where indicated). Interviews with eight residents confirm that they regard the staff as their advocates and would feel comfortable discussing issues with them. In addition, a consumer advocate is available to the residents. She volunteers at the rest home and has previously been employed with Aged Concern.

D4.1d; Discussion with three family identified that the service provides opportunities for the family/EPOA to be involved in decisions

ARC D4.1e: The resident file includes information on residents family/whanau and chosen social networks.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The service has visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs evidenced in interviews with residents and families. The manager reports residents receive spiritual visits on request.

The activities programme includes visits to the local Retired Services Association (RSA), markets and special community events. The list of external performers includes visits from dance schools, girls brigade and kindergartens and schools who visit the facility and perform concerts.

D3.1h; Discussions with three family and eight residents confirm that the residents are encouraged to be involved with the service and care.

D3.1.e Discussion with staff, residents and relatives confirm that residents are supported and encouraged to remain involved in the community and external groups.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The complaints process is documented in policy. Time frames are in line with the Health and Disability Commissioner’s (HDC) guidelines for responding to complaints. Complaints forms are available at the entrance to the facility. Also available are Health and Disability Commissioner brochures relating to the complaints process.

Interviews with residents (eight of eight) and three of three families confirm their understanding of the complaints process. Residents report they are comfortable talking with the staff or the manager if they have a concern.

A complaints register is in place. There is evidence of five lodged complaints in 2013. Three of the five complaints were randomly selected for review. Each complaint lodged includes acknowledgement of the complaint, investigations and sign-off when the complaint has been closed. There is evidence of the prompt response to complaints and evidence of performance management if the complaint relates to employee performance.

One complaint was lodged with the Northland DHB (NDHB) on 20 March 2013. There is evidence of a thorough investigation and sign-off by the NDHB (14 May 2013) that the issue has been resolved.

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.2 ORGANISATIONAL MANAGEMENT

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

STANDARD 1.2.1 Governance

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

Cairnfield House is a 75-bed rest home located in Whangarei that is privately owned by a family trust. Objectives have been defined, covering the categories of financial and non-financial objectives. Goals are defined by the service. The mission is clearly stated and includes the values of the organisation.

The organisation is currently undergoing a restructure. The nurse manager (RN) has given notice and will be leaving the end of August. The owner/director plans to reorganise role and responsibilities of the managers and clinical staff and will be taking on a role that includes additional day-to-day managerial responsibilities. She plans to hire a second (part-time) RN. She also plans to delegate additional responsibilities to the assistant manager and RN.

At present, this restructure has not been clearly defined in the business plan, organisational chart or in the applicable job descriptions to reflect changes in job responsibilities. This is an area requiring improvement.

The owner/director has owned this facility for less than one year. Previously, she owned a 20-bed dementia care rest home in Auckland, which she sold 10 years ago. She reports that she regularly attends the in-service education and training programmes at the facility, holds a current first aid certificate and plans to attend the three-day Aged Care Conference in Auckland later this month..

The current manager is a registered nurse who has managed this facility for four years.

The assistant manager has worked at Cairnfield House for 20 years. Previous to her role as the assistant manager, she was the diversional therapist for Cairnfield House.

ARC,D17.3di (rest home); The current manager and owner/director has maintained at least eight hours annually of professional development activities related to managing a rest home.

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

The organisation is currently undergoing a restructure. The manager (RN) has given notice and will be leaving the end of August. The owner/director plans to reorganise the roles and responsibilities of the RN, assistant manager, and will be taking on a role that includes additional day-to-day managerial responsibilities. She plans to hire a second (part-time) RN. She also plans to delegate additional responsibilities to the assistant manager, although these responsibilities have not been defined.

Finding Statement

The organisation is currently undergoing a restructure. The nurse manager (RN) has given notice and will be leaving the end of August. The owner/director plans to reorganise the roles and responsibilities of the RN, assistant manager, and manager and will be taking on a role that includes additional day-to-day managerial responsibilities. She plans to hire a second (part-time) RN. She also plans to delegate additional responsibilities to the assistant manager. At present, this restructure has not been clearly defined.

Corrective Action Required:

Clarify the roles and responsibilities of the staff and owner/director, including (but not limited to) updating the business plan, organisational chart and applicable job descriptions.

Timeframe:

3 months

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

In the temporary absence of the manager, the RN oversees clinical operations and the assistant manager oversees administrative and managerial responsibilities. The planned restructure will add more responsibilities to the director/owner (reference 1.2.1.1).

D19.1a; A review of the documentation, policies and procedures and interviews with staff identifies that the service's operational management strategies, and quality and risk programmes minimises the risk of unwanted events and enhances quality.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Cairnfield House is committed to maintaining a quality management system that continually seeks opportunities to improve. The quality and risk management programme includes monitoring risks to the organisation (eg, accidents, incidents, near misses, complaints, infections). An internal auditing programme is in place to monitor the day-to-day activities of the rest home.

Policies and procedures are in line with current accepted best and/or evidenced based practice and are reviewed a minimum of two-yearly.

A policy on document control is in place. The facility administrator is responsible for managing documents. All documentation relating to operations (eg, policies and procedures, job descriptions, clinical protocols) are reviewed two-yearly. The RNs (staff RN, nurse manager (RN) are responsible for reviewing

the clinical policies. The document management process includes sign-off by the appropriate person(s) (eg, RN, nurse manager, owner/director). Staff are required to sign that they have read new policies and/or revised policies.

There is evidence of the regular (monthly) monitoring of accidents, incidents, near misses, complaints, infections, and hazards. Trends are identified with improvements noted. For example, in March 2013, there was a substantial increase in the number of residents' falls. An investigation of this trend identified two residents as 'frequent fallers'. One of the residents was re-evaluated and placed at hospital-level care. The second resident was unwell and passed on.

The internal audit programme monitors other key aspects of the service (eg, security, food services and kitchen compliance, resident care / hygiene audit, resident admission procedure). The programme identifies areas for improvement, which are documented on an audit outcome form. Internal audits are delegated to the manager, RN and staff. Evidence was sighted of the internal audits completed for each month, the overall outcome score of the audit, a comparison of the overall outcome score, recommendations, action to be taken and by whom, explanation as to why the score was better or worse from the previous year, and the completion date and signature of the manager. The information gathered is shared at the monthly staff meetings (meeting minutes sighted).

For example, a 'transferring technique' audit was conducted in February 2013. This audit was rated as 'substantially compliant' in 2013 but was 'partially compliant' in 2012. It was determined in the audit results that ongoing training and education that was undertaken by staff prior to the 2013 internal audit reflected the improvement in the overall internal audit score. Improvements were also noted relating to staff attendance at education and training in services when comparing 2012 results to 2013.

Health and safety procedures are in place covering hazard identification, management of hazards, monitoring of hazards, and review of hazards. A health and safety officer has been appointed (assistant manager). She has received appropriate external health and safety training. Three staff have been delegated the responsibility of 'health and safety representatives' to assist the health and safety officer. The health and safety committee meets every three – four months (meeting minutes sighted). A recent initiative of the committee is the placement of locked secure storage units that have been placed in strategic locations throughout the facility for the storage of cleaning chemicals.

A workplace hazard inspection is included in the internal audit schedule. Topics relating to health and safety (eg hazard identification) are included in staff meetings (meeting minutes sighted). A hazard reporting form is used for the identification of new hazards. For example, in April 2013, a new hazard was identified relating to the collection of dust in the heaters.

Plans are in place to undergo an ACC Workplace Safety Management audit in the near future.

D5.4 The service has the following policies/ procedures to support service delivery; Policies and procedures align with the client care plans

- 1) Contingence Policy. Contingence assessments were evident/not evident in resident files.
- 2) Challenging behaviour policy.
- 3) Pain Management policy and procedure.
- 4) Personal grooming and hygiene policy
- 5) Skin integrity Management policy.
- 6) Wound care policy and procedures.
- 7) Transportation of subsidised residents policy and procedure includes costs, resident, and staff safety.

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

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

D19.2g Falls prevention strategies are in place.

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

Residents' incidents and accidents are documented on an accident/incident/hazard report and in the residents' progress notes (evidenced in eight of eight residents' files). A separate event form is used for staff incidents and accidents.

There is evidence of open disclosure following an event, which is the responsibility of the RN (evidenced in the review of eight of eight incidents reported). The residents' clinical record identifies if family want to be contacted (reference 1.1.9). An investigation is completed after each event. The RN signs off on all falls. The EN signs off on minor events.

Data is collated and is entered into a monthly report, which identifies trends. Staff meeting minutes and health and safety minutes reflect discussions relating to trends in the data.

The manager is knowledgeable regarding statutory and regulatory obligations for essential notification requirements to the applicable body (eg, Ministry of Health, the DHB portfolio manager and Occupational Health and Safety) in the event of a serious injury/sentinel event. There is evidence of the manager contacting the NDHB and the Medical Officer of Health to notify them of the scabies outbreak.

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Current practising certificates were sighted for two registered nurses (including the manager); four enrolled nurses, two GP's; dietitian, podiatrist, pharmacists, and one physiotherapist. A spread sheet is used to determine when the practising certificate will expire. The manager sights each practising certificate, evidenced on the spread sheet.

Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files were randomly selected for audit (one RN, one EN, two team leaders, one healthcare assistant and one cleaner). Signed employment contracts are in place. Completed induction checklists are held in the staff education records. All files contain up-to-date performance appraisals that are directly linked to the employees' job descriptions. Police vetting is completed prior to the staff appointment.

An orientation programme is in place, providing new employees with relevant information for safe work practice. The orientation programme is developed specifically to the worker type (e.g. RN, healthcare assistant). New staff are paired with senior staff until competency is demonstrated. Six of six healthcare assistants, and two of two cleaners/laundry staff interviewed report new staff (including themselves) are adequately orientated to the service. Medication competencies are in place for the RN, ENs, and team leaders (reference 1.3.12.3).

There is evidence of education and training programmes for staff. Mandatory training and education programmes cover the topics of manual handling, calming and restraint, elder abuse, fire safety, health and safety, infection control, wound care, client rights, emergency lifting. The two-yearly update includes the clinical topics of continence management, challenging behaviour, pain management, privacy and dignity, culturally safe care, wound care, death and dying, CPR and first aid. A 'staff training plan and in-service education' record is in place for all staff and reflects the frequency of their attendance at staff training.

Low staff attendance at education and training sessions provided by the service was identified in 2012 as a required improvement. There is documented evidence of attendance increases for 2013, that is confirmed in interviews with staff and managers (reference 1.2.3). RNs are encouraged to attend external education and training programmes (reference 1.1.8).

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service management policy aligns with contractual requirements and includes staff skill mixes. Workload standards are derived from industry norms for rest home-level aged care facilities.

The current roster is based on the current occupancy of 55 residents. The manager (RN) is available full-time, Monday - Friday.

Time target is a software programme that is used for building staffing rosters. The AM shift is staffed with one RN five days a week with an EN available two days a week. Four healthcare assistants are scheduled on the AM shift. Cleaning (two) and laundry (one) staff work seven days a week on the AM shift. The PM shift is staffed with one senior healthcare assistant (team leader) and four healthcare assistants (one who works a half shift). The night shift is staffed with either two or three staff, one whom is a team leader.

An RN is on-call seven days a week/24 hours a day.

A recruitment process is currently underway for a second, part-time RN (reference 1.2.1.1).

Eight residents and three families report staffing is adequate to meet the needs of the residents.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

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

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files (current and archived) are held in secure locations, protected from unauthorised.

Entries in eight of eight residents' files are legible and, where necessary, are signed and dated by the relevant healthcare assistant or registered nurse, including their designation. Individual resident files demonstrate service integration.

Staff interviews (six of six health care assistants and one of one RN) confirm that the information held in the residents' files keeps them well-informed. There is evidence of a minimum of one entry in the progress notes per day.

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

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
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The service has a comprehensive information pack that is given to all inquiring residents or their families. Entry criteria and access process are clearly defined in policy and the resident information pack. Interview with eight of eight residents and three of three family members indicate that entry criteria and access processes were made clear to them. Eight of eight resident files sampled have a current needs assessment indicating they have been assessed for rest home level care.

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

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

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.2 Declining Referral/Entry To Services

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

ARHSS D4.2

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

How is achievement of this standard met or not met?

Attainment: FA

The service has policies around declining entry and processes to be followed when an entry is declined including communicating with the referrer and the potential consumer and/or their family. The service has not declined entry to any potential consumer as reported by the nurse manager.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

D16.2, 3, 4: The eight resident files reviewed identified that an initial nursing assessment and care plan was completed within 24 hours (see CAR 1.3.4.2 regarding two initial assessments not being dated) and all files identify that the long term care plan was completed within three weeks. Seven of eight care plans evidenced evaluations completed at least six monthly - one resident is on short term respite care. Activity assessments and the activities sections in care plans have been completed by the diversional therapist. Eight of eight residents interviewed stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files included family contact records which were completed in all resident files sampled.

D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. More frequent GP review was evidenced as occurring on review of residents files with acute conditions.

Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Eight of eight files reviewed identified integration of allied health and a team approach is evident. The GP was interviewed. She reports good liaison and communication with the service and confidence in the care provided.

Tracer Methodology:

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

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		

Timeframe:

STANDARD 1.3.4 Assessment

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Moderate

Eight of eight residents files sampled have evidence of an initial assessment that includes activity level, orientation, sleep patterns, mobility, nutrition, elimination, perception, mental ability, behaviour, depression, pain, social history, independence, skin integrity, sexuality, privacy and values and beliefs. Two of these have not been signed and dated and this is an area requiring improvement. Six of eight files sampled also have a falls assessment (one resident is on respite care) and a further two of these have not been reviewed in the past six months. This is an area requiring improvement. Two of five residents who have continence issues have a continence assessment completed at admission. The one resident with on-going pain whose file was sampled does not have a pain assessment. One resident does not have a pressure area risk assessment and a further pressure risk assessment is not dated. Assessments are an area requiring improvement. Information gained from these assessments is used to inform the initial and long term care plans. Eight of eight residents and three of three family members interviewed report having input into assessment processes.

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Eight of eight residents files sampled have evidence of an initial assessment that includes activity level, orientation, sleep patterns, mobility, nutrition, elimination, perception, mental ability, behaviour, depression, pain, social history, independence, skin integrity, sexuality, privacy and values and beliefs. Six of eight files sampled also have a falls assessment (one resident is on respite care). Two of five residents who have continence issues have a continence assessment completed at admission. Information gained from these assessments is used to inform the initial and long term care plans. Eight of eight residents and three of three family members interviewed report having input into assessment processes.

Finding Statement

(i) Two of eight initial assessments and care plans have not been signed or dated. (ii) One of eight residents has no falls assessment and a further two have not been updated in the past six months. (iii) One of eight residents does not have a pressure risk assessment and a further one pressure risk assessment is not dated. (iv) One resident file sampled for a resident using controlled drugs for pain management does not have a pain assessment.

Corrective Action Required:

(i) Ensure all assessments are signed and dated. (ii) and (iii) Ensure all routine risk assessments are completed for every resident and reviewed at least six monthly. (iv) Ensure pain assessments are completed for residents who have pain.

Timeframe:

3 months

STANDARD 1.3.5 Planning

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

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

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

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

Assessments completed on admission are comprehensive (see CAR 1.3.4.2). Care plans are a template document that include support needs, problem/goal, interventions and evaluation. In two of eight residents files sampled all identified areas of need are well completed and individualised and reflect needs identified in the assessments. There are a number of needs not identified in care plans and care plans do not always reflect all client needs. These are areas for improvement. Six health care assistants interviewed report care plans are easy to follow. Eight of eight residents files sampled include input from GP's podiatrists, physiotherapists, mental health services and all staff from the facility.

D16.3k: Short term care plans are in use for changes in health status although no current residents require a short term care plan.

D16.3f: Eight of eight resident files reviewed identified that family were involved.

Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.**Audit Evidence****Attainment:** PA**Risk level for PA/UA:** Moderate

Assessments completed on admission are comprehensive (see CAR 1.3.4.2). Care plans are a template document that include support needs, problem/goal, interventions and evaluation. In two of eight residents files sampled all identified areas of need are well completed and individualised and reflect needs identified in the assessments. Six health care assistants interviewed report care plans are easy to follow. Eight of eight residents files sampled include input from GP's podiatrists, physiotherapists, mental health services and all staff from the facility.

Finding Statement

There are a number of needs not identified in care plans and care plans do not always reflect all client needs. Issues not addressed include shortness of breath, COPD, diabetes, seizure management, pain management and depression.

Corrective Action Required:

Ensure all identified needs have corresponding interventions in the care plan.

Timeframe:

3 months

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.6 Service Delivery/Interventions

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Eight of eight residents interviewed and three of three family members interviewed reported that they were warmly welcomed to the service, shown around and introduced to staff and residents.

Residents care plans are completed by the registered nurse. Care delivery is recorded and evaluated by health care assistants at least daily (evidenced in all eight residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. GP documentation is kept in the resident's file. Interviews with six health care assistants and the registered nurse indicate that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Sighted on the day of the audit were thermometers, a sphygmomanometer, a stethoscope, scales and blood glucose testing equipment. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Eight of eight residents interviewed and three of three family members interviewed were complimentary of care received at the facility.

The care witnessed to be provided appears to meet the needs of consumers and at all times was seen to be respectful.

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

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

Specialist continence advice is available as needed and this could be described.

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

Wound assessment and wound management plans are in place for 12 residents. Eleven of the 12 wounds do not document when the wound is next to be reviewed/dressed. The wound management form was updated during the audit to include a review date. All 12 wounds have evidence of regular review. The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

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

Audit Evidence	Attainment: 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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>There is a diversional therapist who spends 37 hours per week providing activities. Residents, other staff and volunteers also take part in providing the activities programme. There is a programme planned for that includes (but is not limited to) movies, reading, entertainers, , nails and beauty, board games and newspaper reading and visits from a school and kindergarten class and a Girls Brigade group. Residents are also able to fold washing or set tables if they wish. At least twice a week there is more than one activity happening concurrently to give residents extra choice.</p> <p>The facility has a van with a wheelchair hoist and regular outing occur. Weekly visits are made to the RSA and residents enjoy concerts at a local dance school there is an association with on a regular basis.</p> <p>Eight of eight residents report having enough to do and being able to make requests of the activities included in the programme. All spoke very highly of the diversional therapist and the activities programme.</p>	

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

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

There is at least a three monthly review by the medical practitioner.

D16.4a Care plans are reviewed and evaluated by the registered nurse six monthly or when changes to care occur as sighted in seven of eight care plans sampled (one resident is on short term respite care). There are short term care plans (mini care plans) to focus on acute and short-term issues available and there are two currently in use in the resident files relating to scabies management. Staff are informed of any changes to resident need at handover between shifts. Health care assistants interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.

ARC D16.3c: All initial nursing assessment/care plans were evaluated by a registered nurse within three weeks of admission.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There is a policy around referral to other health and disability services. Eight of eight residents interviewed and three of three family members interviewed are aware of their options to access other health and disability services and are provided with information and supported through this process. All confirm advice has been provided by the facility. The registered nurse interviewed report that possible options to which a consumer might be referred include (but are not limited to): NASC; hospital geriatricians and rehabilitation services; speech language therapists; dieticians, Medlab; radiological services; hospital specialists; cultural organisations or social workers. Advocacy information is available in the facility. When a resident requires a referral to another service, the GP takes responsibility for this task. An explanation is given to the resident and their family/whanau are informed as appropriate. Documentation relating to referrals

and completed referral forms were sighted in seven of eight residents files sampled (the other resident is on respite care). Progress notes demonstrates staff contact family when referrals for specialist review or transfer is necessary. Residents and family members interviewed were satisfied that they were kept well informed in regard to referrals and/or transfer to hospital where this had occurred. The registered nurse interviewed described the referral and or transfer processes and demonstrated an understanding of residents right to be informed. Where residents have family locally they are contacted and wherever possible encouraged to accompany the consumer to outside appointments. When this is not possible the facility endeavours to provide a staff member to accompany the resident. (ARC D 20.4).

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

D 20.1 Discussions with the clinical nurse manager identified that the service has access to NASC; hospital geriatricians and rehabilitation services; speech language therapists; dieticians, Medlab; radiological services; hospital specialists; cultural organisations or social workers.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
Three of three family members interviewed stated they were well informed of the transfer process. The service has policies for transfer or exit of the service which describes guidelines for death, discharge, transfer, documentation and follow up. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities with a transfer letter from the facility photocopied with accompanying relevant documentation including medication charts (ARC D 21.1). When a resident wishes to leave the facility the NASC service is notified as reported by the registered nurse (ARCD21.3). All relevant information is documented and communicated to the receiving health provider or service, notes are photocopied. A referral form and any other relevant documentation accompanies residents to receiving facilities. These were evident in three of eight resident files (other residents had not been transferred to another provider). Eight of eight residents	

interviewed and three of three family members interviewed were satisfied that they were kept well informed in regard to referrals and/or transfer to hospital where this had occurred. Staff could describe the referral and or transfer processes and demonstrated an understanding of residents right to be informed.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Moderate

Medication policies align with accepted guidelines. Medications are stored in the locked nurses office. Controlled drugs are stored in a locked safe in the locked storage cupboard and two medication competent persons must sign controlled drugs out. Weekly stocktakes of controlled drugs have occurred weekly. The service uses four weekly robotic sachets packed medication management system. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival by the enrolled or registered nurses and any pharmacy errors recorded and fed back to the supplying pharmacy.

Staff sign for the administration of medications on medication signing sheet. Eight of 16 medication charts sampled have regular medications charted that have not been documented as administered regularly. This is an area requiring improvement. The medication folder includes a list of specimen signatures. Competency tests are completed annually and also if there is a medication administration error.

There are currently no residents self-administering medications.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Signing sheets correspond to instructions on the medication chart. The controlled drug register is well kept and aligns with legislative requirements. Eleven of 16 medication administration records have evidence of transcribing and this is an area requiring improvement.

Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name.

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

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Staff sign for the administration of medications on medication signing sheet. The medication folder includes a list of specimen signatures. Competency tests are completed annually and also if there is a medication administration error.

There are currently no residents self-administering medications.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Signing sheets correspond to instructions on the medication chart. The controlled drug register is well kept and aligns with legislative requirements.

Finding Statement

(i) Eight of 16 medication charts sampled have regular medications charted that have not been documented as administered regularly. (ii) Eleven of 16 medication administration records have evidence of transcribing.

Corrective Action Required:

(i) Ensure medications are administered as prescribed. (ii) Cease the practice of transcribing.

Timeframe:

3 months

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

Food services policies and procedures are appropriate to the service setting. The menu has been approved by a dietitian on 9 June 2013. There are documented protocols for management of residents with unexplained weight loss or gain, including referral to a dietician and speech language therapist as required. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Copies of dietary profiles reviewed in the kitchens

and in resident files and likes and dislikes are catered for. Special equipment is available as needed. Additional snacks are available for residents when the kitchen is closed e.g. fruit, sandwiches, biscuits, bread and fillings. Residents are offered fluids throughout the day.

Residents' files sampled demonstrate regular monthly monitoring of individual resident's weight and nutritional needs, and nutritional needs and interventions are identified and documented.

Residents and family members interviewed were very complimentary of the food service provided and report their individual preferences are well catered. Residents interviewed confirmed that adequate food and fluids are provided.

The two cooks and three kitchen assistants have completed food safety education and evidence of this was reviewed on their files. Monitoring records available include food temperatures, and fridge / freezer temperature recordings for the kitchens. The fridge in the Manuka Wing lounge where food is stored has not had the temperature monitored. This is an area requiring improvement.

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expired. Fridge/freezer temperatures are checked monthly. Food in the fridge and chiller were covered and dated.

The kitchen is clean and all food is stored well above ground level. Chemicals are locked away.

D19.2 Two cooks and three kitchen assistants are employed and all have completed food safety training.

Finding Statement

The fridge in the Manuka Wing lounge where food is stored has not had the temperature monitored.

Corrective Action Required:

Ensure all fridge's are maintained at a safe temperature.

Timeframe:

3 months

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facilities and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

There is protective clothing and equipment available that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by service providers. Hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.

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

Service providers' documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Planned and reactive maintenance systems are in place and were reviewed. Medical equipment was calibrated in October 2012. Hot water temperatures are checked monthly and records show that they are maintained in a safe range. Service provider's documentation evidences current Building Warrant of Fitness that expires on 1 June 2014.

There is safe storage of medical equipment. Corridors are wide enough in all areas to allow residents to pass each other safely; safety rails are secure and appropriately located; minimal changes in floor surface and levels occur; equipment does not clutter passageways etc.; transitions between surfaces or coverings are without abrupt change in level or gradient; and floor surface changes are identifiable by the consumer. The external areas are safely maintained and are appropriate to the resident group and setting and include seating and shade.

Six health care assistants and the registered nurse interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

ARC D15.3: The following equipment is available: shower chairs, one hoist and lifting aids.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

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

ARC E3.3d ARHSS D15.3c

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

How is achievement of this standard met or not met?

Attainment: FA

There are toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly.

The requirements of the New Zealand Building Code are met. All bedrooms are single. There are adequate number of toilets and showers to cater to all residents. The toilets have appropriate access for residents based on their needs and abilities and facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two staff. Communal toilet facilities have a system that indicates if it is engaged or vacant. There is also a safe locking system that provides for privacy but allows service providers access in the case of emergency. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

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
There is adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents.	

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

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

ARC E3.4b ARHSS D15.3d

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

How is achievement of this standard met or not met?

Attainment: FA

There is adequate access is provided to lounge, dining and other communal areas and that residents are able to move freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

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

Cleaning policy and procedures, and laundry policy and procedures are available. Product user Charts, chemical safety data sheets for all chemicals used in the facilities, and cleaning & laundry task sheets reviewed. There are policies and procedures for the safe storage and use of chemicals / poisons.

The effectiveness of the cleaning and laundry services has been audited via the internal audit programme in 2013. Safe and secure storage areas are available and service providers have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste - i.e. sluice room/facilities; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Staff files reviewed indicate attendance at chemical safety education. This finding was confirmed during staff interviews where they confirm education on chemical safety and management of waste and hazardous substances has occurred.

Residents and family interviewed state their satisfaction with the cleaning and laundry services.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Security and safety policies and procedures are in place to ensure a safe environment is provided. Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety, including fire evacuation drills are held six-monthly with the most recent drill taking place on 12 June 2013. There is an approved evacuation plan for the rest home.

The service is prepared for civil emergencies. Emergency lighting and a gas BBQ are readily available in the event of a power outage. Water is stored on-site (10,000 gallons). Emergency food supplies, torches and batteries are kept in the kitchen and in a secure cupboard containing civil defence items. Extra blankets are available.

The auditory call bell system is available in all areas. During the tour of the facility residents were observed to have easy access to the call bells. interviews with residents and families confirm if they alarm a call bell, it is answered in a timely manner.

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.8 Natural Light, Ventilation, And Heating

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

ARC D15.2f ARHSS D15.2g

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

How is achievement of this standard met or not met?

Attainment: FA

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.

Residents and family interviewed confirm the facilities are maintained at an appropriate temperature.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policies and procedures on restraint minimisation and safe practice are in place and include definitions of a restraint and of an enabler. The practice of restraint is relevant to the individual resident requirements and is only used as a last resort, where is it clinical indicated, and de-escalation strategies are ineffective.

The facility is restraint-free. Education and training relating to managing challenging behaviours is included in the regular education and training programme. The RN is the designated restraint coordinator. Interviews with six of six healthcare assistants confirms their understanding of an enabler. At present, there are no enablers being used. Staff are able to give examples of ways that residents are monitored for safety during the night shift, including the use of sensor mats, and visual checks a minimum of two-hourly.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

STANDARD 3.1 Infection control management

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

The service and the environment minimise the risk of infection to residents, staff and visitors. The infection prevention and control programme is well known by staff as described by the six health care assistants and the registered nurse. There are documented processes implemented and annual review of the IC programme completed - last completed May 2013 with the programme currently being reviewed for 2012.

There are infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008..

The infection control programme includes clear lines of accountability and is appropriate for the size, complexity, and degree of risk associated with the service.

The registered nurse (infection control coordinator) could describe how the service would manage an outbreak. The service is currently experiencing a scabies outbreak. They have been in close contact with the medical officer of health and a microbiologist. All staff and residents have been treated once for scabies with a second treatment due to occur following the audit. Staff and visitors suffering from infectious diseases are advised not come to the facility. Residents suffering from infections will be isolated and there are two residents with scabies currently isolated. An outbreak management policy is documented.

Staff are aware not come to work when suffering from infections (confirmed at interviews with six health care assistants and the registered nurse). There is a staff policy around what should happen if staff are sick.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

The facility has adequate human, physical and information resources to implement the infection prevention and control programme. Administrative resources are available.

The registered nurse is able to describe access to the DHB and the GP if advice and support is needed. The nurse would predominantly work with the GP if any issues were identified and is currently working alongside a microbiologist and the medical officer of health.

Infection prevention and control policies and procedures guide the infection control personnel in implementing the infection prevention and control programme.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Infection control and prevention policies and procedures are documented and implemented. The infection prevention and control policies and procedures contained in the infection prevention and control manual are directly linked to the overarching infection prevention and control programme and the quality and risk management programme through quarterly staff meetings.

D 19.2a: Infection control policies include

Infection assessment

Infection control summary sheet

- Antimicrobial Usage
- Antimicrobial Resistance among long-term care residents (IC 1)
- Blood Related incidents
- Cleaning, Disinfection and Sterilisation
- Hand Hygiene
- Immunisation
- Infection control Co-ordinator – Job Description
- Infection Control – Outbreak
- Infection Control for Laundry (IC3)
- Linen
- Methicillin Resistant Staphylococcus Aureus (MRSA)
- Prevention and Management of staff Infection
- Resident Education and Training
- Single Use Products
- Staff training Information
- Standard Precautions
- Surveillance – data gathering and review
- Transmission Based Precautions

- Waste Management (H&S 11).
Policies and procedures relate to health and disability sector infection control standards and relevant reference material.

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
<p>All staff receive infection prevention and control education at orientation and as part of the on-going education programme. All infection control education sessions are documented with PowerPoint presentations sighted.</p> <p>Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. A sign is pre template to be displayed if there is a need to alert visitors.</p> <p>The infection control coordinator i.e. registered nurse is responsible for coordinating education and training to staff. The six health care assistants and the registered nurse interviewed said that education was included in training throughout the year.</p> <p>Infection control education was last delivered by the DHB clinical nurse specialist in March 2013 and included hand hygiene, standard precautions and other aspects of the infection control policy manual.</p>	

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

Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. Trends are analysed and discussed at quarterly staff/ including infection control meetings.

Detailed information on the type of infections, treatment, duration of treatment and its effectiveness are recorded. Resident's infection trends/patterns are identified and recorded. Any corrective actions are acted upon as sighted in the meeting minutes.

An annual review of infection control occurs and was last completed December 2012.

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: