**Oceania Care Company Limited - Palm Grove Lifestyle Care & Village**

**Current Status:** **12-Sep-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**

Palm Grove Lifestyle and Care Village provides residential care for up to 85 residents who require hospital and rest home level care. Occupancy on the day of the audit was at 75. The facility is operated by Oceania Care Company Limited. All bedrooms have wash hand basins, and four have ensuite facilities. The service is currently conducting second interviews for the business and care manager role. The service is currently managed by the regional clinical and quality manager, who previously managed the facility and the service appointed a new clinical manager. Residents and staff interviewed report the care provided is of a high standard. Staffing hours are increased if required to meet the needs of residents.

**Audit Summary AS AT** **12-Sep-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  12-Sep-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit  12-Sep-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  12-Sep-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Standards applicable to this service fully attained** |

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| **Safe and Appropriate Environment** | Day of Audit  12-Sep-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  12-Sep-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  12-Sep-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** **12-Sep-13**

**Consumer Rights**

Staff members demonstrate knowledge and understanding of The Code of Health and Disability Services Consumer's Rights 1996 (the Code) and their obligations as part of their practice.

The staff provide opportunity for explanation, discussion and clarification about the Code with residents and their family / whanau of choice where appropriate.

Residents receive services that are responsive to the needs, values and beliefs of the cultural, religious, social and ethnic groups with which the residents identify.

The Maori Health Plan includes information on how to access interpreters to aid in providing residents with information and the contact details for the Canterbury District Health Board- Maori Advisor. Residents and when applicable family / whanau of their choice are consulted on their individual values and beliefs. Staff members maintain professional boundaries and refrain from behaviours what could benefit them at the risk or expense of residents.

The service provides an environment that encourages good practice through access staff access to seminars, nursing publications, education and training opportunities, subscriptions to New Zealand Nurses Organisation's (NZNO) publications, conferences and internet access to nursing journals and articles through the Otago University Library.

Residents and family / whanau confirm they have the right to full and frank information and open disclosure. The service provide information to residents and their family / whanau regarding informed consent. Residents and their family / whanau are informed of their rights to an independent advocate and how to access the advocacy services through availability of pamphlets and information from staff members.

The facility is freely accessible from 0830 in the morning until 2000 at night and visitors can still access the building after hours by ringing the front door bell, sighted the information brochure to potential residents. The service has an easily accessed, responsive and fair complaints process, sighted the complaints policy which include and complies with Right 10 of the Code.

**Organisational Management**

The purpose, values, scope, direction and goals of the organisation are clearly defined in policy. The regional clinical and quality manager took over as the acting business and care manager. The clinical manager of the service resigned in August 2013 due to health reasons and the charge nurse is currently acting as the clinical manager. During the temporary absence of the business and care manager, the regional clinical and quality manager, who is also a registered nurse, or the clinical manager will stand in for the manager.

The service has a quality and risk management system that includes monthly internal audits, clinical indicators, education and training and meetings. The clinical indicators include incident accident reporting, health and safety reporting, staff injuries, complaints and end of life reporting. The health and safety representative completes daily health and safety rounds. The hazard register is completed as soon as a new hazard is identified. The service has a document control system where the documents are reviewed bi-annually.

The business and care manager reports to Support Office on all clinical indicators through monthly reports that are entered into the intranet system by the 5th of each month. The service conducts monthly internal audits to measure their performance against the quality improvement system.

The service documents adverse event through the incident / accident reporting. Incident / accident reports include general information regarding the event, details of the event and the injury, if applicable, corrective actions taken, treatment given, preventative and corrective actions taken, follow up actions and persons notified of the event.

The professional qualifications of staff are validated and the staff files show evidence of professional registration and scope of practice where applicable. Staff members are appointed in roles that are appropriate to safely meet the needs of residents. Staff members complete competencies for the Liverpool Care Pathway, restraint, medicines management, hand washing, and wound care. Internal education and training occurred throughout 2013.

The service has an interim staffing policy covering: staffing levels, union representation, facility manager employment responsibilities, rosters, safe staffing indicators, staff competencies and skill mix for safe service provision.

Information is entered into the services' resident information management system. The service is currently in the process of implementing the InterRAI system.

**Continuum of Service Delivery**

Palm Grove has a documented entry criteria, which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery.

A sampling of residents' clinical files validates the service delivery to the residents. Residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Residents and family interviewed confirm their participation in these evaluations. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Policies and procedures clearly detail service provider's responsibilities. Staff responsible for medicine management have attended in-service education for medication management and have current medication competencies.

There are 10 residents' who self-administer medicines, and do so according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Palm Grove has a central kitchen and on site staff that provide the food service. Kitchen staff have completed food safety training. The menu has been reviewed by a dietician. There is positive feedback from residents about the food service.

**Safe and Appropriate Environment**

The service follows documented processes for safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation.

The service use BV Medical Biomedical Equipment Services to perform biomedical equipment performance verification checks for Oceania. Fire Fighting Pacific is the contractor for monthly alarm and smoke detective checks. RAPT Electrical is responsible for electrical checks. The maintenance man is responsible for proactive maintenance programme which includes emergency lights, checking of fie doors, handrails, carpets, call bells and implementation of maintenance as required in the maintenance book.

The service provides full ensuite (84) to all but one bedroom which has a separate bathroom not directly connected to the room. The majority of the bedrooms are of studio size and four of the resident rooms are one bedroom apartments. Bedrooms are spacious with ample room for moving around the bed.

The service provides adequate, age appropriate and accessible communal areas for relaxation, activities and dining needs of residents. The service has three lounges and three alcoves for residents to meet in private with their visitors; there is an activities area and three dining areas.

Methods, frequency and material used for cleaning and laundry are monitored for effectiveness. Internal cleaning and laundry audits are conducted.

The last fire evacuation drill was conducted on 15 May 2013, sighted the records. Staff received first aid training on 16 April 2013 and again on the second day of the audit, 13 September 2013; all staff members have current first aid training. The service security systems at the facility include checks by a designated staff member every afternoon at 1800. The check includes windows and external doors as the doors are alarmed after 1800. The three security gates open at seven in the morning and close at eight at night. The service has a system to allow visitors after hours which include a security code to the gates. The fire evacuation scheme approval letter from the NZ Fire Service in Christchurch is dated 15 April 2004.

The service has air-conditioning and heat pumps throughout the facility in communal areas. Bedrooms all have under floor heating which is individually controlled to suit the needs of the residents.

**Restraint Minimisation and Safe Practice**

The service has an overarching risk and quality management system that demonstrates compliance with the Standard. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive.

The facility was using seven restraints and eight enablers on audit days.

Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed, monitoring of restraint is occurring and each episode of restraint is being evaluated. Restraint Committee meeting minutes evidence an approval review process.

**Infection Prevention and Control**

The Infection Prevention and Control (IC) Programme includes policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice.

New employees are provided with training in infection control practices and there is on-going education available for all staff.

Infection control is a standard agenda item at staff and quality meetings. Staff interviews confirm staff are familiar with infection control measures at the facility. Surveillance for residents who develop infection are collated at the end of each month and reported as a clinical indicator to the governing body and to staff through meetings.

**Palm Grove Lifestyle and Care Village**

Oceania Care Company Ltd.

Certification audit - Audit Report

Audit Date: 12-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Oceania Care Company Ltd. |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Palm Grove Lifestyle and Care Village | 108 Marshlands Road | Shirley | Christchurch |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
| none |

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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 12-Sep-13 **End Date:** 13-Sep-13 |
| **Designated Auditing Agency** | Health Audit (NZ) Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXXX | RN, LA, RABQSA | 15.50 | 8.00 | 12-Sept-13 to 13-Sept-13 |
| Auditor 1 | XXXXXXXXX | RN, Lead Auditor, BHSc | 15.50 | 4.00 | 12-Sept-13 to 13-Sept 13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXXX | RN, BN, Lead Auditor |  | 2.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 31.00 | **Total Audit Hours off site** *(system generated)* | 14.00 | **Total Audit Hours** | 45.00 |
| **Staff Records Reviewed** | 10 of 84 | **Client Records Reviewed** *(numeric)* | 9 of 75 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 9 |
| **Staff Interviewed** | 14 of 84 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 5 |
| **Consumers Interviewed** | 9 of 75 | **Number of Medication Records Reviewed** | 20 of 75 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXXXX (occupation) Company Manager of (place) Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 16 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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Palm Grove Lifestyle and Care Village | 85 | 75 | 31 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Palm Grove Lifestyle and Care Village provides residential care for up to 85 residents who require hospital and rest home level care. Occupancy on the day of the audit was at 75. The facility is operated by Oceania Care Company Limited. All bedrooms have wash hand basins, and four have ensuite facilities. The service is currently conducting second interviews for the business and care manager role. The service is currently managed by the regional clinical and quality manager, who previously managed the facility and the service appointed a new clinical manager. Residents and staff interviewed report the care provided is of a high standard. Staffing hours are increased if required to meet the needs of residents. .

1.1 Consumer Rights

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The staff provide opportunity for explanation, discussion and clarification about the Code with residents and their family / whanau of choice where appropriate.

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1.2 Organisational Management

The purpose, values, scope, direction and goals of the organisation are clearly defined in policy. The regional clinical and quality manager took over as the acting business and care manager. The clinical manager of the service resigned in August 2013 due to health reasons and the charge nurse is currently acting as the clinical manager. During the temporary absence of the business and care manager, the regional clinical and quality manager, who is also a registered nurse, or the clinical manager will stand in for the manager.

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There are 10 residents' who self-administer medicines, and do so according to policy.

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1.4 Safe and Appropriate Environment

The service follow documented processes for safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation.

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The last fire evacuation drill was conducted on 15 May 2013, sighted the records. Staff received first aid training on 16 April 2013 and again on the second day of the audit, 13 September 2013, all staff members have current first aid training. The service security systems at the facility include checks by a designated staff member every afternoon at 1800. The check includes windows and external doors as the doors are alarmed after 1800. The three security gates open at seven in the morning and close at eight at night. The service has a system to allow visitors after hours which include a security code to the gates. The fire evacuation scheme approval letter from the NZ Fire Service in Christchurch is dated 15 April 2004.

The service has air-conditioning and heat pumps throughout the facility in communal areas. Bedrooms all have under floor heating which is individually controlled to suit the needs of the residents.

2 Restraint Minimisation and Safe Practice

The service has an overarching risk and quality management system, that demonstrates compliance with the Standard. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive.

The facility was using seven restraints and eight enablers on audit days.

Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed, monitoring of restraint is occurring and each episode of restraint is being evaluated. Restraint Committee meeting minutes evidence an approval review process.

3. Infection Prevention and Control

The Infection Prevention and Control (IC) Programme includes policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice.

New employees are provided with training in infection control practices and there is on-going education available for all staff.

Infection control is a standard agenda item at staff and quality meetings. Staff interviews confirm staff are familiar with infection control measures at the facility. Surveillance for residents who develop infection are collated at the end of each month and reported as a clinical indicator to the governing body and to staff through meetings.

Summary of Attainment

* 1. Consumer Rights

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

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

* 1. Organisational Management

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

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

* 1. Continuum of Service Delivery

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 12 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:21 PA:0 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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

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

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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

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

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| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 50 **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  **Total Criteria (of 219) CI:** 0 **FA:** 101 **PA:** 0 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Oceania Care Company Ltd.

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:12-Sep-13 End Date: 13-Sep-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXXX

# Continuous Improvement (CI) Report

Provider Name: Oceania Care Company Ltd.

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:12-Sep-13 End Date: 13-Sep-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

Staff members demonstrate knowledge and understanding of The Code of Health and Disability Services Consumer's Rights 1996 (the Code) and their obligations as part of their practice, confirmed during resident, health care assistant (HCA) and RN interviews. The service displays the Code throughout the facility, verified.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

The staff provide opportunity for explanation, discussion and clarification about the Code with residents and their family / whanau of choice where appropriate, confirmed during resident, staff and family interviews.

The service displays the Code throughout the facility, verified. The service provides residents with information about the Nationwide Health and Disability Advocacy Service information through the availability of brochures and staff members last received training on the Code, Informed consent and Advocacy presented by the National Health and Disability Advocacy Services, on 17 April 2013, sighted training records, attendance records and the content of the training session. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Staff members respect the physical, visual, auditory and personal privacy of residents and their belongings, confirmed at the resident, family and health care assistant interviews.

Residents receive services that are responsive to the needs, values and beliefs of the cultural, religious, social and ethnic groups with which the residents identify, confirmed at the resident, family and the regional clinical and quality interviews.

Resident and family / whanau confirm services are provided in a manner that maximises their independence and that their wishes are taken into consideration. Residents are being kept safe and not exposed to risks of abuse and neglect, confirmed during the resident, family / whanau and staff interviews. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service do not currently have any Maori or Pacific Island resident, however they have a Maori and Pacific Health Care Plan which includes the four main cornerstones of Maori Health Care, a list of the Maori organisations and resources in the community with contact detail for key people, a policy in recognition of Maori values and beliefs including the cultural safe practices related to Maori. The Maori Health Plan includes information on how to access interpreters to aid in providing residents with information and the contact details for the Canterbury District Health Board- Maori Advisor.

Sighted the Interpreter policy, Cultural competent services policy, Spiritual and counselling policy, The Treaty of Waitangi and an explanation of Maori principles / Tikanga.

Staff interviews confirm they understand the importance of family / whanau involvement with Maori residents, interviewed nine health care assistants (HCA) of which two are Maori. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Residents and when applicable family / whanau of their choice are consulted on their individual values and beliefs, confirmed at resident, family / whanau and RN interviews. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

Staff members maintain professional boundaries and refrain from behaviours what could benefit them at the risk or expense of residents, confirmed during the RN and regional clinical and quality manager interviews. Health care assistants confirm they understand the concept of resident discrimination or abuse and residents and family confirm they have no concerns regarding discrimination or abuse.

**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

The service provides an environment that encourages good practice through access staff access to seminars, nursing publications, education and training opportunities, subscriptions to New Zealand Nurses Organisation's (NZNO) publications, conferences and internet access to nursing journals and articles through the Otago University Library, confirmed at the acting clinical manager and the Quality improvement nurse interviews and verified internet access. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

Residents and family / whanau confirm they have the right to full and frank information and open disclosure. Review of incident / accident reports and progress notes confirm continuous communication between the provider, residents and family / whanau.

The service provides information relating to interpreter services available to residents, sighted Maori Health Plan and information packs that are given to new or potential residents. Health care assistants demonstrate their knowledge and understanding of interpreter and advocacy services, confirmed during interviews. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

The service provides information to residents and their family / whanau regarding informed consent. Consents include outings, using resident’s photos, consent for treatment, and information sharing. The service also provide opportunity to residents who have the ability, to complete advance directives and make informed decisions regarding being for resuscitation or not, sighted records and confirmed during resident, family / whanau and the charge nurse interviews. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

Residents and their family / whanau are informed of their rights to an independent advocate and how to access the advocacy services through availability of pamphlets and information from staff members. The service ensure staff members receive training regarding the advocacy services and the Maori Health Plan lists contact details for independent advocates in the community, sighted the Maori Health Plan, training records, verified availability of brochures and confirmed during staff interviews. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Residents have access to their family / whanau, confirmed at the resident and family / whanau interviews. The facility is freely accessible from 0830 in the morning until 2000 at night and visitors can still access the building after hours by ringing the front door bell, sighted the information brochure to potential residents. Residents and family / whanau confirm they have access to community resources e.g. the Palms Library, shopping centres, cafes and restaurants, health services at the local surgery in Shirley, dentists and other health services at the District Health Board ( DHB). Access is provided by the services using their 'people mover van' and staff dedicated to assist residents during trips. Family members also have the opportunity to take residents on outings, confirmed at residents, family / whanau and the regional clinical and quality manager interviews. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has an easily accessed, responsive and fair complaints process, sighted the complaints policy which include and complies with Right 10 of the Code.

The service maintains a complaints register with complaints recorded chronologically. There are two complaints recorded for 2013 and two recorded for 2012, confirmed at the regional clinical and quality manager interview.

The complaints management process includes recoding the date of the complaint, the complaint category, the summary, resolution review date and the sign off date / closing date. The service acknowledges receipt of complaints in writing. The complainant is also informed of the outcome in writing, sighted records, confirmed at staff and family interviews.

The second complaint for 2013 was an anonymous complaint to the Canterbury District Health Board (CDHB) dated 8 August 2013. The regional clinical and quality manager / acting business and care manager responded in writing to the CDHB addressing each aspect of the complaint on 21 August 2013, sighted copy of the letter. The Service Development Manager and the Director of Nursing from Older Person's Health at Planning and Funding, met with the regional clinical and quality manager and operations manager Oceania on 11 September 2013 to discuss the complaint. Each aspect of the complaint was individually addressed and the CDHB responded on 13 September 2013 with a letter stating they are 'satisfied with the information provided in response to the issues raised and appreciate the open discussion regarding recent changes at Palm Grove'. The letter was signed by the Service Development Manager. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

The purpose, values, scope, direction and goals of the organisation are clearly defined in policy. Sighted the comprehensive business and quality improvement plan for 2012 / 2013. The policies and procedures were last reviewed in April 2013, sighted documentation.

The facility manager resigned in June 2013 and the regional clinical and quality manager took over as the acting business and care manager, confirmed during interview. The service is currently on second interviews for the business and care manager role. The clinical manager of the service resigned in August 2013 due to health reasons and the charge nurse is currently acting as the clinical manager, confirmed at the clinical manager interview. The service appointed a new clinical manager who will start on Monday 16 September 2013. The new clinical manager previously worked as a facility manager for 12 months and prior to that worked for about 30 years as charge nurse and manager in different services, sighted employment records.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

During the temporary absence of the business and care manager, the regional clinical and quality manager, who is also a registered nurse, or the clinical manager will stand in for the manager, confirmed at the regional clinical and quality manager and the acting clinical manager interviews, sighted the job description for the regional clinical and quality manager. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The service has a quality and risk management system that includes monthly internal audits, clinical indicators, education and training and meetings. The clinical indicators include incident accident reporting, health and safety reporting, staff injuries, complaints and end of life reporting. The service has the following meetings: weekly management meeting for representatives from all departments, monthly quality improvement and staff meeting, health and safety meeting and infection control meeting, and RN meeting, sighted June and July 2013 meeting minutes. bi-monthly restraint meetings, and resident meetings are held every two to three months, sighted meeting minutes for the quality improvement and staff meetings for the months of July and August 2013.

The service appointed the household supervisor as the health and safety representative. The health and safety representative completes daily health and safety rounds. The hazard register is completed as soon as a new hazard is identified. The health and safety representative reports on a monthly basis to the health and safety committee. Each department has a representative on the health and safety committee. They review the hazard register, staff accident and accident forms, review reported hazards and near miss reports, staff wellness programme session is then implemented where staff do a specific training session, facility objectives are discussed, orientation and documentation is discussed, conduct plans for trial evacuations, review and update emergency procedures, maintenance programme is reviewed, policies and procedures are reviewed, manual handling is discussed, training matrix is reviewed, contractors induction records are reviewed, and annual reviews of health and safety manual by Support Office staff, sighted meeting minutes for February to August 2013.

The service has a document control system where the documents are reviewed bi-annually by Support Office where the facilities then have access to the policies and procedures through the intranet, confirmed at the regional clinical and quality manager interview.

Obsolete documents are identified by the Support Office (clinical and quality team) and once the new policies are available on the intranet the old policies are to be removed and archived.

The business and care manager reports to Support Office on all clinical indicators through monthly reports that are entered into the intranet system by the 5th of each month, sighted clinical indicators for January to August 2013, and these reports include graphs and summaries of the service's performance, presented in a comparative format.

The service conducts monthly internal audits to measure their performance against the quality improvement system. Sighted corrective action plans for raised clinical indicators, e.g. 28 January 2013 the corrective action plan for reducing falls. This corrective action plan includes an investigation, action plan, and evaluation of the outcome. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

The service documents adverse event through the incident / accident reporting. Incident / accident reports include general information regarding the event, details of the event and the injury, if applicable, corrective actions taken, treatment given, preventative and corrective actions taken, follow up actions and persons notified of the event. The incident / accident report is either signed and closed off or escalated to a serious / sentinel event status, sighted incident / accident reports for June, July and August 2013. The service completes a post falls assessment when a resident has a fall, sighted assessments and confirmed at the acting clinical manager interview.

The service provider understands their statutory and regulatory obligations in relation to essential notification reporting, sighted the reporting process and guidelines of the organisation and confirmed at the regional clinical and quality manager interview. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

The professional qualifications of staff are validated and the staff files show evidence of professional registration and scope of practice where applicable, confirmed at the RN, regional clinical and quality manager interviews and verified during the audit.

Staff members are appointed in roles that are appropriate to safely meet the needs of residents, sighted the staff skill mix policy and confirmed at interview with the regional clinical and quality manager. The staff files were checked for evidence of signed and dated individual employment agreements (IEA), Curriculum Vitaes (CV), job descriptions (JD), education and training records, induction and orientation records, reference checks, professional registration and performance reviews.

New staff members receive orientation and induction that cover essential components of the service, sighted orientation and induction for the staff files reviewed.

Staff members complete competencies for the Liverpool Care Pathway, restraint, medicines management, hand washing, and wound care, sighted.

The service have a system for identifying, planning and facilitation of education and training for all staff, sighted training records for staff member whose files were reviewed during the audit.

Internal education and training occurred throughout 2013. Medicines management training occurred 14 August 2013, Infection control training occurred 6 March and 21 August 2-13, Restraint training occurred in 18 January, 23 July and 6 September and Challenging behaviour training occurred on 4 September 2013. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

The service has an interim staffing policy covering: staffing levels, union representation, facility manager employment responsibilities, rosters, safe staffing indicators, staff competencies and skill mix for safe service provision, sighted policy, rosters and confirmed at the regional clinical and quality manager interview. Staff interviews confirm workloads are fair and manageable. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

Information is entered into the services' resident information management system. The service is currently in the process of implementing the InterRAI system. Information is accurate, timely and appropriate to the service. The database is password protected, confirmed by the administrative manager and the regional clinical and quality manager interviews and verified.

Resident folders are being kept in a locked nurses’ station and the staff files are in filing cabinets in the clinical manager’s office, verified. Records are legible, the names and designations of the service providers are legible and easily identifiable, sighted nine resident records in the rest home and hospital. Records are integrated.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

Policy and procedures for entry criteria, assessment and entry screening are recorded and implemented.

The service’s philosophy is recorded, displayed at the facility and communicated to residents, family, relevant agencies and staff.

Pre- admission enquiry form is available and lists all relevant information of the prospective resident. The service provides information to potential referral sources. This facility operates 24/7.

The admission agreement defines scope of service and includes all the contractual requirements.

Nine of nine residents' files were sampled (four rest home and five hospital). All nine residents' admission agreements sampled evidence residents' and facility representative sign off.

The acting business and care manager / regional clinical and quality manager interview confirms access and entry processes are followed. There is a facility information pack available for resident and their family. Resident information pack was sighted and contains all relevant information.

Residents' files sampled demonstrate all needs assessments (NASC) are completed for either rest home or hospital levels of care.

Related ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

Systems to decline resident entry to the service are documented. The scope of the service provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the acting business and care manager / regional clinical and quality manager. The resident will be declined entry if not within the scope of the service or if a bed is not available at the time and will be referred back to the NASC service, confirmed at the acting business and care manager / regional clinical and quality manager interview. (refer to HDSS1.1.13)

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input, is according to specified timeframes and the service is coordinated to promote continuity of service delivery.

Fourteen of 14 clinical staff (two RNs, one charge nurse and 11 health care assistants) interviews confirm residents and/or family members are involved in all stages of service provision.

Nine of nine resident (four rest home and five hospital) interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews.

Nine of nine residents' files (four rest home and five hospital) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations.

Family communication sheets are maintained, sighted in all nine residents' files reviewed.

There is a process to identify and respond to variances/trends e.g. accident / incident / unwanted events reporting system.

The auditor evidenced verbal briefing from am to pm shift.

GP interview was conducted and confirms the GP has been providing medical services for the facility since its commencement. The interview with the GP confirms that staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff.

Staff competency assessments are current and staff competency registers record competencies for clinical staff in restraint, medication, hoist, insulin administration, nebuliser and oxygen competencies. RNs complete wound competency.

Related ARC requirements are met.

Rest Home Tracer Methodology.

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

Hospital 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 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

Residents' needs, outcomes and goals are identified via the assessment process and are recorded. The organisation has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. Policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.

Residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider (NASC) assessments are available. The facility has appropriate resources and equipment. The RN interviews confirm that assessments are conducted in a safe and appropriate setting including visits from the doctor.

Nine of nine residents interviewed confirm their involvement in their assessments, care planning, review, treatment and evaluations of care.

Resident files evidence risk assessments are conducted on admission and reviewed along with the resident long term care plan at six monthly intervals or when resident's condition alters.

Related ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

The residents' files sampled evidence residents' care plans are individualised and up-to-date. The long-term and short-term goals are identified by the residents and service providers and reviewed at regular intervals, at least 6 monthly or as needs change. Residents have input into their care planning and review, confirmed at all nine resident interviews.

Fourteen of 14 clinical staff interviewed confirm that care plans are accurate and up to date.

Residents' files sampled evidence the clinical care/treatment/support or interventions that are to be provided by the staff are current, the risk assessment findings are recorded on the care plans and there is evidence of discussions and sign off by residents and family members.

The facility ensures access to regular GP care, confirmed at GP interview.

Person centred care planning audit was conducted in April 2013, and one corrective action identified has been addressed.

Related ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.

Residents' files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement.

Nine of nine residents (five hospital and four rest home) and five of five family (three hospital and two rest home) interviewed confirm their and their relatives current care and treatments they are receiving meet their needs. Family communication forms record family communications, sighted in all residents' files sampled.

Related ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

Interview with the diversional therapist (DT) confirms the DT has been previously employed at the facility for over seven years, stopped employment for approximately 20 months (worked at another residential care facility) and has returned back to Palm Grove a week ago. The DT is employed for 37 hours a week, Monday to Friday. Activities assistant is also employed to work from Tuesday to Saturday.

There is one activities programme for both the rest home and hospital residents.

The DT and the acting business and care manager / regional clinical and quality manager confirm the activities programme meets the needs of the service group and the service has appropriate equipment. Activities attendance records are maintained and were sighted.

Residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.

Residents' two monthly meetings were sighted for May and July 2013.

Physiotherapist is contracted to the service for one day a week and also oversees the physiotherapy assistant, who is employed Monday to Friday (9am to 1pm).

The physiotherapy assistant conducts daily exercises programme for the residents. Sighted 20 residents participating in the daily exercise programme on second day of audit.

Residents' files sampled demonstrate the individual activities care plans are current and record support is provided within the areas of leisure and recreation, health and well-being.

Activities audit was conducted in November 2012 and corrective actions addressed.

Activities programme questionnaire is in progress and so far seven returns have been received.

Nine of nine residents and five of five family interviewed confirm residents' and their family members' past activities are considered and there is a choice to participate in activities. Family are welcome at activities and this was evidenced at audit.

Resident and family survey was conducted in July 2012, with 20 returns and satisfaction with the activities programme.

Related ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. Care plan evaluation are conducted by the RN with input from the resident, family, health care assistants, diversional therapist, physiotherapist, physiotherapist assistant and GPs.

Family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews.

Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed.

Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. Residents' files evidence referral letters to specialists and other health professional. Multidisciplinary reviews are current.

Related ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services.

Residents’ files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. Residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented. Related ARC requirements are met.

**Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer**

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

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

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

Resident’s files evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files.

Related ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

The medication areas in the facility, evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. There are two controlled drug storage areas in the facility and they are secure. The controlled drug registers are maintained and evidence weekly checks and six monthly physical stock takes on the registers. Medicines are checked by staff upon arrival at the facility against the resident's medication chart and this is recorded, sighted. Medication reconciliation is conducted by GPs. RNs check medicines monthly for expiratory dates and expired medicines are returned to pharmacy, confirmed at RN interviews. Medication fridge temperatures are conducted and recorded.

Medication errors are reported and clinical indicators for 2013 record there are reported medication errors for January (x1); May (x5) and June (x4).

Discussion was held regarding the medication errors with the relieving clinical manager and records were reviewed. There is evidence of a staff member's reassessment of medication competency following a medication error.

Residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given).

Medication round was observed and evidences staff are knowledgeable about the medicine administered and sign off, as the dose is administered.

There are 24 staff competent to administer medicines (12 RNs, five ENs and seven senior health care assistants). All staff authorised to administer medicines have current competencies, sighted in nine of nine staff files sampled and on the staff competency register. Additional staff competencies are conducted and these include; insulin administration; oxygen administration; nebuliser use, sighted on competency registers.

Staff education in medicine management was conducted in August 2013, conducted by the pharmacy staff member and attended by 12 staff.

Twenty medicine charts were sampled (10 rest home and 10 hospital). All 20 medicine charts demonstrate residents' photo identification, allergies are recorded, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs.

There are 10 residents at the facility who self-administer medicines. Sighted 10 of 10 residents' current competency assessments to self-administer medicines. Interviews were conducted with four of 10 residents who self-administers medicines and all four interviews confirm the residents are competent and aware of the responsibilities with self-administration of medicines, sighted their completion of signing sheets and safe storage of medicines and review of the residents' files evidence medicine charts and care plans record the resident is self-administering medicines.

Sighted medication audit results for January 2013 (100% compliance), April 2013 (100% compliance) and July 2013 (identified three corrective actions and they have been addressed).

Related ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Food service policies and procedures are appropriate to the service setting with a new seasonal four weekly menu being introduced six monthly.

The menu was last reviewed by a dietitian in September 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.

The kitchen manager / cook is aware of residents who have been identified with weight loss and residents individual dietary needs. Residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review. There are current copies of residents' dietary profiles in the kitchen, sighted. Kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the kitchen manager /cook. Food safety training for kitchen staff have been conducted, sighted training register for kitchen staff. Additional snacks are available for residents, if required. Residents are offered fluids throughout the day. Food temperatures are recorded, sighted. Fridge, chiller and freezer temperatures are recorded, sighted. All decanted food is dated with expiratory dates recorded on containers. Kitchen cleaning schedules are completed, sighted.

Residents' files sampled demonstrate monthly monitoring of individual resident's weight. Resident's nutritional needs and interventions are identified and documented on the care plans sampled.

Residents interviewed are satisfied with the food service provided, report their individual preferences are catered to and adequate food and fluids are provided.

Kitchen services audit was conducted in April 2013 and corrective actions are addressed.

Resident menu satisfaction survey was conducted in July 2013, (28 returns from survey). Collated results of the survey are sighted and the required improvements are in progress. Menu audit was conducted by a dietitian in May 2013.

Related ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

The service follows documented processes for safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation, sighted the infection control and waste management policies. Staff members confirm they are familiar with the infection control and waste management policies. Interview with the household supervisor and health care assistants (HCA) confirm they use personal protective equipment (PPE) when handling waste or hazardous substances, sighted the cleaning trolleys with PPE readily available for use and verified the use of PPE during the onsite visit. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The service use BV Medical Biomedical Equipment Services to perform biomedical equipment performance verification checks for Oceania. The latest annual report was completed on 16 August 2013. The equipment checked at the service includes; air mattress pumps, aspirations, blood glucose meters, electric beds, hoists, hoist batteries, nebulisers, optical / aural, oxygen concentrators and regulators, pulse oximeters, scales, sphygmomanometers, stethoscopes, syringe pumps, thermometers and vital signs monitors.

Fire Fighting Pacific is the contractor for monthly alarm and smoke detective checks, confirmed during the maintenance man and the regional clinical and quality manger interviews. Sighted the Christchurch City Council compliance schedule which includes the sprinkler systems, emergency warning systems, automatic doors, emergency lighting checks, automatic backflow preventer checks, mechanical ventilation and air conditioning checks, the emergency power, signs and systems checks, exit door checks, fire separation and fire escape checks and evacuation information. The fire hose reels and fire extinguishers were last inspected on 9 August 2013. The fire evacuation scheme approval letter from the NZ Fire Service in Christchurch is dated 15 April 2004. The last fire evacuation drill was conducted on 15 May 2013, sighted the records.

RAPT Electrical is responsible for electrical checks last conducted on 2 July 2013.

The building warrant of fit ness expires on 14 June 2014.

The maintenance man is responsible for proactive maintenance programme which includes emergency lights, checking of fie doors, handrails, carpets, call bells and implementation of maintenance as required in the maintenance book. There are no stairs throughout the building and therefore no need for ramps. Communal areas are spacious and provide opportunity for residents to pass one-another in a safe manner.

The residents have access to three courtyards and a back garden with seating. The service also has seating at the front entrance of the facility.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

The service provides full ensuites (84) to all but one bedroom room which has a separate bathroom not directly connected to the room. This room is currently used for respite care. The service has two visitors toilets and a staff bathroom with shower and toilet, verified during the tour of the facility and confirmed at the regional clinical and quality manager interview, and sighted the floor plan. ARC requirement is met.

**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

The majority of the bedrooms are of studio size and four of the resident rooms are one bedroom apartments. Bedrooms are spacious with ample room for moving around the bed. Bedrooms can easily facilitate the use of hoists and mobility aids, verified during the tour of the facility and confirmed at the resident, acting clinical manager and the regional clinical and quality manager interviews. ARC requirements are met.

**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 manoeuvre with the assistance of their aid within their personal space/bed area.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

The service provides adequate, age appropriate and accessible communal areas for relaxation, activities and dining needs of residents. The service has three lounges and three alcoves for residents to meet in private with their visitors, there is an activities area and three dining areas throughout the building, verified during the facility tour and sighted the floor plan and confirmed at the regional clinical and quality manager interview.

ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

The interview with the household supervisor confirms methods, frequency and material used for cleaning and laundry are monitored for effectiveness. Internal cleaning and laundry audits are conducted, sighted internal audit records for March 2013 with 100% attainment and Ecolab monthly assessment and testing records, the Service Detail Report, sighted reports for July to September 2013..

The service has several areas for safe, lockable storage of chemicals and cleaning products, including a store room, two sluice rooms and a cleaning cupboard, verified during the facility tour and confirmed during the household supervisor and the regional clinical and quality manager interviews.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Fire Fighting Pacific is the contractor for monthly alarm and smoke detective checks, confirmed during the maintenance man and the regional clinical and quality manger interviews. Sighted the Christchurch City Council compliance schedule which includes the sprinkler systems, emergency warning systems, automatic doors, emergency lighting checks, automatic backflow preventer checks, mechanical ventilation and air conditioning checks, the emergency power, signs and systems checks, exit door checks, fire separation and fire escape checks and evacuation information. The Fire hose reels and fire extinguishers were last inspected on 9 August 2013. The fire scheme approval letter from the NZ Fire Service in Christchurch is dated 15 April 2004. The last fire evacuation drill was conducted on 15 May 2013, sighted the records. Staff received first aid training on 16 April 2013 and again on the second day of the audit, 13 September 2013, all staff members have current first aid training, sighted training records.

The service security systems at the facility include checks by a designated staff member every afternoon at 1800. The check includes windows and external doors as the doors are alarmed after 1800. The three security gates open at seven in the morning and close at eight at night. The service has a system to allow visitors after hours which include a security code to the gates that all residents receive on admission to the service. The service does another security check just prior to the afternoon / night shift change. Windows have stays to ensure it only opens to a certain width, verified during the facility tour.

The fire evacuation scheme approval letter from the NZ Fire Service in Christchurch is dated 15 April 2004. The service has seven fire cells and the doors are certified fire resistant doors for up to 60 minutes, verified.

The service has a battery driven emergency light system to provide two hours of light during a power outage. Emergency lighting includes ceiling lights in corridors and main areas. The service has the capability of using a generator should they need one. The service has three gas barbeques for cooking that can be used during an emergency.

The service has an appropriate call bell system which is displayed on call bell panels throughout the facility. The maintenance man does monthly call system checks and contacts a certified electrician to conduct repairs on the system, confirmed at the maintenance man interview.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

The service has air-conditioning and heat pumps throughout the facility in communal areas. Bedrooms all have under floor heating which is individually controlled to suit the needs of the residents, confirmed during resident interviews.

The service has an appropriate call bell system which is displayed on call bell panels throughout the facility, confirmed at the regional clinical and quality manager interview. The maintenance man do monthly call system checks and contacts a certified electrician to conduct repairs on the system, sighted maintenance and audit records. All resident rooms have external windows to allow natural light, verified during the facility tour. Hallways have skylights to improve internal light, verified. ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

Documented systems are in place to ensure the use of restraint is actively minimised and the use of least restrictive practices are encouraged where required. Restraint Minimisation and Safe Practice (RMSP) policy definitions of enablers and restraint align with the NZS 8134.2 Standard.

The service has an overarching risk and quality management system that demonstrates compliance with the Standard. Policies and procedures include service’s philosophy on restraint. The process of assessment and evaluation of enabler use is documented in policies and procedures to guide staff.

There are seven residents utilising restraint (five hospital residents and two rest home), all utilising bedrails. One of the seven residents utilises both bedrails and a lap belt.

There are eight residents requesting the use of enablers (three hospital and five rest home). All of the enablers utilised at the facility are bedrails.

Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques.

Staff education programme on RMSP /Enabler training was conducted in January 2013 (attended by 18 staff ); August 2013 ( attended by 20 staff); and September 2013 (attended by 22 staff).

Challenging behaviour management training/education was conducted in November 2012 with16 staff attending and in July 2013 with 10 staff attending.

Managing challenging behaviour audit was conducted in January 2013 with 100% compliance.

Restraint use audit was conducted in July 2013 with 100% compliance.

Resident files utilising enablers sampled evidence authorisation for enabler use, assessment of enablers, care plan documentation, evaluation and monitoring of enabler use. The use of enablers is voluntary.

Staff competency register records restraint competencies for all clinical staff are current.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

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

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

The service has processes in place at both governance and facility level for determining restraint approval and processes.

Restraint is used only after all less restrictive interventions have been attempted and found to be inadequate.

Interview was conducted with the past restraint co-ordinator / RN / clinical manager, who is now employed as a relieving clinical manager and is in process of orientating the new restraint coordinator to the role. The new restraint co-ordinator / RN who is in process of orientating to the position could not be interviewed on audit days. The new restraint co-ordinator / RN works full time at the facility. The new restraint's co-ordinator's staff file was reviewed and evidences signed restraint co-ordinators' position description.

Staff interviewed and residents' files sampled evidence responsibilities are clearly identified and known.

Residents' files sampled evidence there is a recorded input into the restraint approval processes from residents and /or family.

Restraint committee evidence an approval review process. The input and expertise of appropriate individuals are obtained by the restraint approval group to make these decisions. There is a documented, formal process for the approval of specific restraint processes at the policy/procedure level.

Committee meeting minutes outline actions and decisions taken by the committee -sighted for May and July 2013.

Fourteen of 14 clinical staff interviewed are aware of the restraint committee and of the restraint coordinator's responsibilities.

RMSP policy/procedures define approved restraints and alternatives to restraint. Policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement.

The orientation / induction programme includes overview of RMSP policies/procedures.

Staff education programme includes on-going RMSP training.

Related ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

Systems are in place to ensure assessment of residents is undertaken prior to restraint usage being implemented. Residents' files sampled demonstrate restraint assessment and risk processes are being followed. Policies relate to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement.

Residents' files where restraint is used evidence restraint assessment risks are documented and evaluated on a regular basis and include resident and/or family input. Multidisciplinary reviews and care plan evaluations evidence restraint assessment risks are reviewed.

Related ARC requirement is met.

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

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

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

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

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

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

(f) Maintaining culturally safe practice;

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

(h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

Appropriate systems are in place to ensure the service is using restraint safely. Restraint policies and procedures identify risk processes to be followed when a resident is being restrained. The monthly reports to the Oceania support office include a review of restraint usage.

Residents' files sampled evidence consents for restraint use, restraint assessments, the reasons for initiating the restraint, alternative interventions attempted or considered prior to the use of restraint, any advocacy/support offered, provided, or facilitated and evaluations / review of restraint goals / interventions. Residents' files sampled demonstrate appropriate alternative interventions are implemented and de-escalation attempted prior to initiating restraint, this is completed by RNs. Restraint consent by resident and/or family are current. Restraint review forms evidence current reviews.

Restraint Approval Committee review of individual restraint usage – minutes for May and July 2013 were sighted.

RMSP policy and procedures determine each episode of restraint timeframes and frequency.

Service provider's documentation evidences a restraint register is established that records sufficient information to provide an auditable record of restraint use. There are two restraint registers at the facility, one for each wing of the facility, sighted.

There are seven residents utilising restraint and eight residents requesting the use of enablers at the facility.

Related ARC requirement is met.

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

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

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

(d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

Restraint evaluation processes are documented in policy. Policies relating to strategies to minimise use of restraint and management of challenging behaviour in accordance with the requirements of the Service Agreement are documented.

Residents' files evidence that each episode of restraint is being evaluated, based on the risk of the restraint being used and residents' care plan evaluations and multidisciplinary meetings are current. Evaluations of restraint include (a) to (k) in this criterion.

Restraint Approval Group meeting minutes for the evaluation of restraint usage occurred in May and July 2013, sighted.

Restraint audit demonstrates evaluation of restraint usage is occurring - July 2013 (100% compliance).

Sighted one resident's file who was requiring restraint (commencement date of restraint is July 2013) and restraint evaluation occurred in August 2013. The evaluation identified the restraint was no longer required. The resident's file evidences the evaluation of restraint and discontinuation of restraint, care plan evaluation and documentation of the discontinuation of restraint, progress notes and communication with family form evidence communication with family in respect of the discontinued restraint. Interview with the past restraint co-ordinator /clinical manager who now is a relieving clinical manager confirms the resident restraint evaluation indicates restraint is no longer required and all documentation and communication with family occurred.

Related ARC requirement is met.

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

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

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

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

(d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

The restraint monitoring and quality reviews are documented. The acting business and care manager / regional clinical and quality manager reports monthly to the Oceania support office and the reports include information on restraint use. Restraint and enabler use is also discussed at facility meetings. The RMSP policies and procedures include monitoring and quality review processes.

Restraint Approval Group meeting minutes evidence monitoring and review of restraint usage for the facility - May and July 2013 sighted. Meeting minutes evidence individual resident restraint evaluation. There is evidence of discontinuation of restraint following restraint evaluation when this was no longer required.

Restraint audit demonstrates procedural compliance - July 2013 (100% compliance).

Related ARC requirement is met.

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control (IC) policy meets the needs of the organisation and provides information and resources to inform the service providers on infection prevention and control, confirmed at staff interviews.

The delegation of infection control matters throughout the organization is clearly documented along with an IC co-ordinator job description. There is documented evidence the governing body (Oceania support office) receives regular reports on infection related issues by monthly reporting systems from the acting business and care manager / regional clinical and quality manager.

The IC programme is reviewed annually by the IC committee with input from managers and IC nurses.

Related ARC requirement is met.

**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 infection control programme meets the needs of the organisation and provides information and resources to inform and guide staff.

The IC co-ordinator is the charge nurse /RN of the hospital wing, who has been appointed to the IC position recently. Interview with the IC co-ordinator was conducted and confirms orientation to the position is in progress and support from the past IC co-ordinator/ IC practitioner. Interview with the past IC co-ordinator / IC practitioner was conducted and also confirms orientation and support of the newly appointed IC co-ordinator.

Staff and IC co-ordinator have access to relevant and current information, which is appropriate to the size and complexity of the organization, including but not limited to; IC manuals, internet, access to experts (DHB and Lab), and on-going in-service education.

Related ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

Policies and procedures on the prevention and control of infection include written material that is relevant to the organisation and reflects current accepted good practice and relevant legislative requirements. Policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interview.

The IC policies and procedures are developed and reviewed regularly in consultation and input from medical officers, pharmacists and microbiologists and Infection Disease Consultant. IC policies and procedures identify links to other documentation in the organisation e.g. health & safety, quality and risk.

Related ARC requirement is met.

**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

Service provider's documentation evidences that infection control education is provided to all staff, as part of their initial orientation and is provided as part of the on-going in-service education programme.

Staff interviewed advise that clinical staff identify situations where IC education is required for a resident such as; hand hygiene, cough etiquette, multi-resistant micro-organisms and education is conducted.

In 2012 staff education was provided in November 2012 by a microbiologist, attended by 11 staff.

Staff education was provided in March 2013 (attended by 21 staff ) and August 2013 (attended by 19 staff). Both the education sessions in 2013 were presented by the RN /quality improvement nurse /infection control practitioner and were followed by IC competency assessments and quizzes.

All education sessions have evidence of staff attendance, content of the presentations and evaluations of presentations.

Related ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

The IC programme / policy details surveillance processes, including the surveillance objectives, priorities and methods at a level of detail relevant to the service setting and its complexity. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes.

Infection control monthly data is completed for each resident and includes type of infection, lab results, sensitivities, antibiotics prescribed, dose, duration, intervention, review and outcome. Infection log is maintained.

Numbers of infections are collated at the end of each month by the clinical manager and reported as a clinical indicator to management and to staff at meetings. Care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, and daily handovers. Daily handover was observed and evidences staff are notified of resident's infections and any change in resident's condition.

Infection Control Compliance audit was conducted in May 2013 with 100% compliance.

**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:**