**Y&P NZ Limited - Deverton House Rest Home**

**Current Status:** **12-Aug-13**

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

**General overview**

Deverton House Rest Home is a 21 bed rest home. There are 20 residents present at the time of audit and this includes two residents admitted for a short stay. Seven of the residents speak limited or no English.

Since the last audit there have been no significant changes made to the land or building with the exception of some landscaping at the front entrance. The clinical nurse manager and coordinator were employed prior to the previous audit. A new General Practitioner (GP) has been contracted who visits fortnightly.

At this audit there are three areas identified as requiring improvement. These relate to ensuring policies/documents developed by Deverton House Rest Home are reviewed and have document control processes identifiable; caregiver orientation competency assessments/records are completed; and ensuring the activities programme is planned and communicated to residents in a timely manner and resident feedback from meetings is actioned.

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

Standards have been assessed and summarised below:

**Key**

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

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

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

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

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

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

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| **Infection Prevention and Control** | Day of Audit  12-Aug-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Audit Results AS AT** **12-Aug-13**

**Consumer Rights**

Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (Code of Rights). Residents and their families are informed of their rights at admission and throughout their stay. Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs.

Available throughout the facility are copies of the Code or Rights posters and information relating to the Nationwide Health and Disability Advocacy Service,and available in languages as required from the web site.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services. The residents receive many family visitors as part of the Chinese culture, as family and food is major component of their culture.

Evidence is seen of informed consent and open disclosure in residents' files reviewed. The staff receive education on informed consent and residents rights as part of the education plan. All staff interviewed are able to verbalise knowledge of residents' rights.

**Organisational Management**

The clinical nurse manager has worked at Deverton House Rest Home for approximately six months. She is a registered nurse, who is experienced in working in the aged care sector. The clinical nurse manager participates in ongoing training related to managing an aged care facility, as required to meet the provider's contract with Waitemata District health Board (WDHB). She is on site weekdays and is otherwise on call. There are documented arrangements for who covers the clinical nurse manager during leave. Deverton House Rest Home has identified the values, goals and philosophy of care. This is documented in a business plan and reviewed on at least a three monthly basis.

Deverton House Rest Home uses an external company's quality and risk management system and policies and procedures which have been localised to reflect the specific needs of Deverton House Rest Home. A number of documents sighted that have been developed within the facility do not have evidence of document control processes and/or regular review. This is an area requiring improvement.

The quality programme includes compliments, complaints, patient and staff satisfaction surveys, incident/accident reporting, internal audits, and identification and management of hazards and risk. A service review meeting occurs on a three monthly basis where quality and risk information is analysed and discussed. Where required, corrective actions are planned, implemented and monitored for effectiveness. Deverton House Rest Home participates in a benchmarking programme for residents with infections and incidents/accidents.

Staff are provided with an appropriate orientation programme. Records are not available to verify that all applicable staff have completed the competency requirements for the caregiver role and this is an area identified as requiring improvement. There is ongoing relevant training provided for staff which is well attended and attendance records are being maintained.

There are documented guidelines, which are implemented, that detail staffing levels and skill mix. There is at least one staff member on duty at all times who holds a current first aid certificate.

Residents' records are documented in accordance with current accepted standards.

**Continuum of Service Delivery**

Deverton House Rest Home has pre-entry and entry services which are organised by the owner and clinical nurse manager. These are supported by policies and entry information material. Included, is the referral process with assessments being performed by the Needs Assessment Co-ordination Service.

The residents' records reviewed demonstrate evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. The provider works with the GP along with other health service providers. The GP was available for telephone interview during the audit.

Medicines are managed safely and appropriately and meet all legislative requirements. Education and medicine competencies are completed by all staff responsible for the administration of medicines. The medication records reviewed include documentation of allergies and sensitivities. One resident self-administer medicines and evidence is seen of the correct paperwork.

The activities programme is overseen by an activities co-ordinator/caregiver who works twenty hours a week, and other caregivers support the programme at other times. The activities coordinator is on special leave at the time of audit and relief staff are assisting. There is an area requiring improvement relating to the monthly activity planner which is not being completed in advance, and informing the residents what activities are available daily. Community activities are encouraged, outings are arranged on a regular basis and family/whanau are welcome to join in with these activities. Residents meetings are held bi-monthly and these are minuted. There is an area requiring improvement relating to no evidence of the agenda items raised at the residents' meetings having been actioned.

The food service policies and procedures are appropriate for residents requiring rest home level care. All residents' individual needs are identified, documented and choices are available and provided. Meals are well presented and homely. The residents have a seasonal menu. Evidence is seen of the menu being reviewed by a qualified dietitian and suggested changes being implemented. The cooks have completed appropriate food hygiene education.

**Safe and Appropriate Environment**

The building is multi-levelled. All resident rooms/areas are located on the ground floor. The basement and upstairs areas are used by staff only. The building has a current building warrant of fitness. Fixtures and fittings are appropriate for the service. Most clinical equipment is less than 12 months old or has evidence of performance monitoring checks being completed within the last year. Electrical safety tests of appliances is undertaken. The gas appliances also have a current certificate evidencing ongoing monitoring.

All residents have single rooms with ensuites that contain a toilet and hand basin. There are two 'all resident use' showers and two separate toilet's near the lounge. The hot water is being monitored and is within required temperature range. There is adequate space for residents to mobilise within their room and communal spaces, including if they are using a mobility device. Residents have access to appropriate external areas.

There are documented procedures in place for cleaning, laundry services and waste management. Appropriate personal protective equipment is available for staff. Residents and family interviewed confirm the facility is well ventilated, warm, clean and residents personal linen is washed and returned promptly.

There are call bells in the residents' bedrooms and ensuites which are being tested monthly. The organisation has an approved fire evacuation plan. Staff receive training on managing emergencies and fire evacuation drills are being held six monthly. All staff (except two) have current first aid certificates. There are adequate supplies, including food, water and access to utilities for use in an emergency. Security cameras are also utilised on site.

**Restraint Minimisation and Safe Practice**

There are adequately documented guidelines on the use of restraints and enablers and management of challenging behaviours. There are no restraints in use. There are two residents voluntarily using an enabler to help them get in and out of bed. Assessments, consents and reviews are documented.

**Infection Prevention and Control**

There is a documented infection prevention and control programme which is approved and facilitated by the clinical nurse manager and an external quality consultant.All required infection prevention and control policies and procedures are available for staff.

The clinical nurse manager participates in relevant on-going infection prevention and control education. Relevant education is provided to staff. Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, clinical nurse manager and caregivers in a timely manner. Overall infection rates and trends are discussed at monthly staff meetings and bench-marked with an external quality consultant.

**Deverton House Rest Home**

Y&P NZ Limited

Certification audit - Audit Report

Audit Date: 12-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Y&P NZ Limited |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Deverton House Rest Home | 634 Eastcoast Rd | Pinehill | Auckland |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 12-Aug-13 **End Date:** 13-Aug-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXXX | RN, Infection Preventionist, NZ 8086 | 12.00 | 8.00 | 12-Aug-13 to 13-Aug-13 |
| Auditor 1 | XXXXXXXX | RN, NZ 8086 and BHSc | 12.00 | 8.00 | 12-Aug-13 to 13-Aug-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 | XXXXXXXX | Document review |  | 4.00 |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX | RN,MBA, NZQA US 8086 |  | 3.00 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 24.00 | **Total Audit Hours off site** *(system generated)* | 23.00 | **Total Audit Hours** | 47.00 |
| **Staff Records Reviewed** | 5 of 20 | **Client Records Reviewed** *(numeric)* | 5 of 20 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 5 |
| **Staff Interviewed** | 9 of 20 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 6 of 20 | **Number of Medication Records Reviewed** | 10 of 20 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 11 day of October 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Deverton House Rest Home | 21 | 20 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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1.1 Consumer Rights

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1.4 Safe and Appropriate Environment

The building is multi-levelled. All resident rooms/areas are located on the ground floor. The basement and upstairs areas are used by staff only. The building has a current building warrant of fitness. Fixtures and fittings are appropriate for the service. Most clinical equipment is less than 12 months old or has evidence of performance monitoring checks being completed within the last year. Electrical safety tests of appliances is undertaken. The gas appliances also have a current certificate evidencing ongoing monitoring.

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2 Restraint Minimisation and Safe Practice

There are adequately documented guidelines on the use of restraints and enablers and management of challenging behaviours. There are no restraints in use. There are two residents voluntarily using an enabler to help them get in and out of bed. Assessments, consents and reviews are documented.

3. Infection Prevention and Control

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The clinical nurse manager participates in relevant on-going infection prevention and control education. Relevant education is provided to staff. Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, clinical nurse manager and caregivers in a timely manner. Overall infection rates and trends are discussed at monthly staff meetings and bench-marked with an external quality consultant.

Summary of Attainment

* 1. Consumer Rights

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

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

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Low | 0 | 7 | 1 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 5 PA Neg: 0 PA Low: 2 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:20 PA:2 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | PA Low | 0 | 0 | 1 | 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: 11 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:20 PA:1 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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

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

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 5 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:0 FA:1 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:** 5 **CI:** 0 **FA:** 42 **PA Neg:** 0 **PA Low:** 3 **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:** 90 **PA:** 3 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Y&P NZ Limited

Type of Audit: Certification audit

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

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.3 | 1.2.3.4 | PA  Low | **Finding:**  There are a number of documents that have been developed by Deverton House Rest Home that provide guidance for staff on components of care. These documents do not have identification as to when these documents were developed, by whom, how many pages the document should be and when they are due for review. 2) There are a number of documents including some procedures and staff task lists which are dated as being last reviewed in 2007.  **Action:**  Ensure document control processes are implemented for policies developed by Deverton House Rest Home and that all documents are reviewed in a timely manner. | Six months |
| 1.2.7 | 1.2.7.4 | PA  Low | **Finding:**  Three new staff have been employed as caregivers (including casual) since 12 July 2013. All components of the orientation component have been completed with the exception of the competency assessment check list. The CNM advises these topics are discussed with staff, however records have not been maintained to assess if staff are competent for tasks including blood glucose testing, taking a blood pressure, taking a resident's temperature and use of manual handling aids. One of the new staff is working on her own.  **Action:**  Ensure all components of the orientation are completed, including the competency assessment process and that records are maintained. | Six months |
| 1.3.7 | 1.3.7.1 | PA  Low | **Finding:**  There is inconsistent completion of activity planning in advance. The activity coordinator is on special leave at the time of audit and temporary staff are assisting. Evidence is seen of minutes of bi-monthly residents' meetings but there is no evidence of corrective actions for issues that arise at these meetings.  **Action:**  Ensure monthly planning of activities is implemented consistently in advance. Provide documented evidence of corrective actions for issues that arise at residents' meetings. | 6 months |

# Continuous Improvement (CI) Report

Provider Name: Y&P NZ Limited

Type of Audit: Certification audit

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

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

Nine of the nine staff interviewed and clinical nurse manager (CNM) are able to demonstrate knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation (sighted). It is also included in the annual in-service education programme (2013 education schedule sighted).

Residents' rights are upheld by staff (e.g., staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names).

The six residents and three relatives interviewed report that they are treated with respect and understand their rights. 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

Document review: The code of rights policy references the Health and Disability Commissioner's Code of Rights. The policy notes that the Code of Rights brochure is included in the new admission welcome pack which is given prior to or on admission and an opportunity is provided for discussion. Copies of the Code are available in other languages from the H&DC website.   
Opportunities for discussion and clarification relating to the Code are provided to residents and their families (as confirmed by interview with the CNM). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (e.g., with the resident in their room). Education was held in September 2013 by the Nationwide Health and Disability Advocacy Service and is held annually.

The Nationwide Health and Disability Advocacy Services information is include in the Resident Information Pack given prior to or on admission to the service. Information about the Advocacy Service, including contact details, is available to residents and their families at the entrance to the facility (sighted).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

Document review: The residents' rights policy includes the residents' right to personal, physical, auditory privacy (including personal phone calls) and to choose and wear their own personal clothes. The policy notes that individualised care will be provided to meet individual cultural, religious and social values and needs. The resident's preferred name will be identified and used. The policy notes care should maximise the resident's independence and this is facilitated by the development of resident's goals. The resident's need for assistance may change from day to day depending on their level of wellness. Guidance is provided for staff on how independence can be maximised.

Evidence is seen in five of the five files reviewed of the residents' goals which are personalised and reviewed every six months. Two of the five files reviewed show evidence of goals which include maintaining independence physically by walking, which is a favourite pastime.   
The policy notes that residents will not suffer abuse or neglect and requires staff to report any concerns to the manager in a timely manner and requires staff be trained on abuse and neglect. Financial, sexual, emotional and physical types of abuse are detailed along with abuse of freedom of choice and neglect. Examples are provided for staff and reporting process, including to external agencies as essential notifications are included.  
Nine of nine staff interviewed report knowledge of residents' rights and understand dignity and respect.  
Residents are addressed in a respectful manner and by their preferred names (confirmed in interviews with six of six rest home residents and three of three family members). 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

Document review: The residents' rights policy notes the principals of Whare Tapu Wha and details spiritual, physical, whanàu and mental wellbeing are linked. The policy notes any potential barriers for Maori residents accessing services will be eliminated where possible. Methods to assist this includes:

- extending visiting times

- making private areas available for overnight stay if whanau live far away

- providing meals and refreshments for visitors

- gaining trust

- recognising individuals by name

- pronouncing Maori names correctly and remembering them.

Maori residents with no one to advocate for them should be referred to a Maori support service.  
The policy notes that Tangata Whanau will be consulted where necessary.

The CNM reports on interview that there are no residents of Maori culture at present in the facility but the Tangata Whanau would be contacted when required. Education was given to staff on the Treaty of Waitangi in July 2013 and nine staff interviewed report that they understand the Treaty of Waitangi and attend the education annually.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The residents' right policy notes that staff are to discuss with residents and their family and identify individual values and needs during care planning process. This includes age, ethnicity, gender, spiritual affiliation, and abilities/disabilities.

Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided (confirmed in interviews with six of six rest home residents and three of three relatives interviewed) and review of satisfaction survey.

Nine of nine staff interviewed report on the need to respect individual culture and values.   
  
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

The employment position descriptions define professional boundaries as part of employment contract. Nine of nine staff interviewed verbalise they would report any inappropriate behaviour to the CNM. The CNM reports she will action formal disciplinary procedure if there is an employee breach of conduct. There is no evidence of any behaviour that requires reporting and interviews with six residents and three relatives indicate no concerns.ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

The CNM maintains a portfolio and attends education at the WDHB which includes infection control, depression in the elderly, 'head to toe' assessment and first aid (evidence sighted). There are no areas that require further education. Caregivers are provided with regular in-service education which meets all requirements (2013 education programme sighted and staff files). An external consultant ensures policies are kept to date with best practice annually or as required (Refer CAR 1.2.3.4). The nine staff interviewed report they attend education sessions as provided by management. 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

The clients rights policy notes where interpreters can be accessed from and preferably this is done prior to admission for new residents who have limited or no understanding of English. Assistance with on-going communication can also be obtained by staff:

- using key workers fluent in the client’s own language where ever possible

- using family members as interpreters

- using sign and body language

- using pictures & posters.

Staff are identifiable by their name badge. Staff introduce themselves to residents upon entering the resident's room (observed).

Evidence of open disclosure is documented on the incident and accident form. It is also documented in the resident's file. Residents and family confirm communication with staff is open and effective (verified in six resident and three family interviews).

Policies identify that all aspects of care and service provision are discussed with the resident and their family/whanau prior to/or at the admission meeting. Staff make adequate time to talk with residents and families (confirmed in interviews with six of six staff and the CNM). There is sufficient space in each single room to permit private discussions and a telephone is available in each room for the resident’s use.

Family members are frequently used as interpreters, where appropriate, and with prior consent. If necessary, an interpreter within the community or staff is sought (confirmed in interview with the CNM).

All ARC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

Document review: The informed consent policy details what informed consent is, what is required for a consent to be valid, competence, the right to withdraw consent. The facility has a documented consent form and advanced directives form. Only trained staff are able to obtain the resident's consent and the resident needs to understand what is being agreed to. Consent form is sighted in five of files reviewed. Residents will be asked if they have appointed anyone as enduring power of attorney or welfare guardian and guidance is provided on who can legally sign what documents.  
There are guidelines in the policy for advanced directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. The CNM discusses information on informed consent with the resident and family/ whanau on admission. An advance directive enables a resident to choose if they would like active medical treatment to prolong life, transfer to base hospital for on-going treatment or comfort cares. The advance directive is filled out in consultation with the resident's doctor. The consent or non-consent to be revoked at any time. The five files reviewed have signed advance directive forms which meet legislative requirements.  
Family members and residents are actively involved and included in care decisions as evidenced in five of five residents' files. The three family and six resident interviews reported consultation.

All ARC contract 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

Document review: The Resident Right's Policy identifies the consumer's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner’s office if they feel their rights have been breached and have not been dealt with in a satisfactory manner.

Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons (confirmed in interview with six residents and three relatives).

Education from the Nationwide Health & Disability Advocacy Service was given in September 2013. The six staff interviewed report knowledge of resident’s rights. 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

Document review: The residents' right policy notes residents have the right to visitors of their choice and that visiting times are not rigid. If family have travelled long distances they will be assisted to find somewhere to stay if necessary. The policy notes that links with the community will be maintained.

Evidence is of community involvement is seen by external visits to restaurants and concerts. The six residents and three relatives report that there is adequate outings, particularly in the summer. There are two telephones available in the lounge/hall area for residents to call family/whanau or receive calls from family/whanau members or they can have their own in their room. There is also a portable phone which is taken to the residents as required.

Policy includes procedures to be undertaken to assist residents to access community services and a van is available.

Evidence in five of five files showed attendance at Northshore Hospital (WDHB) for appointments as required.

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

Document review: The residents' rights policy notes residents have the right to complain and complaints must be acted upon. and where possible to address the issue immediately. Complaints are to be documented on a complaints form. The complaint is be investigated and prioritised the same day. The manager is to be informed of all serious complaints. Complaint outcomes are to be recorded on the reverse of the complaints form. The complaints form explicitly notes complaints must be acknowledged within 5 working days. The policy notes investigations and responses should be completed within 14 days and communicate with the resident at least monthly if the complaint is taking time to resolve. Complaints are to be discussed at the three monthly service review meeting. The organisation's complaints policy and procedures has documented time frames in line with Right ten of the Health and Disability Commissioner’s (HDC) Code of Rights. The process for lodging a complaint and complaints forms are available in the manager's office and in the resident’s folder, held in each resident's room (sighted in four of four residents’ rooms). Five of the five residents’ files sighted included a complaints form if required.

A complaints register includes the date the complaint was received, the date it was acknowledged and the date of feedback or closure after the investigation.

The CNM report there have been no complaints that they are aware of that have been lodged with HDC. Six of the six residents and three of the three relatives report the have been made aware of the complaints process and are satisfied with the services that are in place .Nine of nine staff interviewed verbalised the process for dealing with a complaint should it occur.

**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 business and strategic plan (2013 to 2015) was developed following the purchase of the business and utilises an external quality advisers framework, which has been localised to reflect the needs of Deverton House Rest Home. The scope of service is rest home level care. The mission statement is 'we promote the dignity and self-worth of all our residents, and strive to promote an excellent quality of life'. Deverton House identifies that the service 'encourages resident group decision-making through our residents' meetings, access to most areas in our home, self-choice in activities, social events and our menus'. 'Deverton House is not just a care giving facility - it becomes the home and community of our residents'. The business plan also states a slogan 'to provide a happy place where residents can enjoy their twilight years and where staff enjoy coming to work'.

Values:

-value staff their skills and opinions

- providing a fair living wage

-well-structured rosters (with adequate English speaking staff on each duty)

-clear duties as written in job descriptions

- home like environment for residents with freedom of choice.

The strategic goals of the organisation for 2013 are documented and displayed on the staff notice board (sighted) and includes:

- full occupancy and happy resident

-enough staff (staff safe and happy)

- great reputation. Maximise business inefficiencies

- improve gardens and buildings

- good community links.

There are documented workplace goals which includes:

-reduce resident falls

- to promote least medication use

- review quality systems quarterly

- to document ongoing improvements at each review meeting and focus on the most needed areas.

The coordinator advises progress in achieving the business and strategic plan is a component of the quarterly service review meetings.

Eight anticipated problems/challenges to achieving the goals are identified and the supporting factors which are being implemented to reduce the risks. The organisation has identified what success through the eyes of staff, funders and the community would look like and problems or negative indicators for each of these groups are identified as well.

Quality indicators and benchmarking of data including (but not limited to): medication problems, infection rates, falls, development of pressure ulcers, complaints, unintended weight loss, episodes of challenging behaviour and hospital admissions are included in the benchmarking programme. The benchmarking programme reports events per 1000 resident days. Monitoring of the organisation's performance towards meeting the objectives, and business / strategic directions of Deverton House Rest Home is monitored via the service review meetings (three monthly) and benchmarking of quality indicators.

The clinical nurse manager (CNM) is a RN with a current annual practising certificate (APC) expires 31 March 2014 and certificate sighted. She started in this role in March 2013. The CNMs curriculum vitae identifies she has worked for over 10 years at Northshore Hospital in a variety of roles. She has also experience working as a practice nurse, nursing agency/ bureau (including aged care services) and RN in a dementia service (four months in 2012). The CNM's CV notes she has worked for periods as a RN in other aged care facilities between 1996 and 1998 and 1989 to 1991. The CNM has completed the Deverton House orientation programme,

A letter sighted dated 9 April 2013 from a Senior Adviser at HealthCERT (MoH) identifies the CNM meets the MoH requirements of 'suitably qualified and experienced manager'. A signed job description on file for the role of RN and manager includes ARRC contract requirements for the RN role and responsibility for residents' every day care needs.

The CNM has attended more than eight hours of education in the last 12 months relevant to managing an aged care facility. Topics include four hours of management training with a quality systems adviser, in-service on employment law, enduring power of attorney, 'first do no harm' and cultural diversity/palliative care, falls prevention, arthritis and pain. The CNM has also attended the residential aged care leadership forum at Waitemata DHB on 13 August 2013. Certificates of attendance for the above education are sighted.

The ARCC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

The CNM and the coordinator advise in the CNMs absence the previous nurse manager is responsible for service delivery. An agreement has been developed between Deverton House and the second in charge for the role of 'casual relief manager'. This is dated 10 May 2013. There is a documented job description which details the acting manager's role and responsibilities. This has been signed by the relief manager. The relief manager has a current annual practising certificate (expiry 31 March 2014) and a current first aid certificate (dated 6 February 2013). The CNM advises she liaises with the temporary manager when services are required.

A copy of the temporary manager's curriculum vitae (CV) is on file and details roles and responsibilities in a number of residential aged care and dementia services since 1996.

The temporary manager has completed the Deverton House orientation requirements and records are sighted.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

Document review:

The 2013 quality plan includes:

- surveys (including meals, satisfaction, staff surveys)

- complaints/compliments monitoring and management

- audits

- monitoring staff and contractors practising certificate expiry dates

-hazard identification/health and safety assessments including of new equipment

- accident and incident reporting

- monitoring bed occupancy

-monitoring hospital admissions

- civil defence and emergency planning

- monitoring resident infections, challenging behaviours, medication problems, falls, staff and resident injury, serious problems

- planning for safe staffing

- staff training

- policy and procedure review

- compliance with legislation

There is a business risk management plan sighted dated as last reviewed in September 2013 by the CNM. This is also reviewed at the service review meetings. The business risk management plan includes sixteen specific risks related to finance, contracts, staffing/skill mix, natural disasters, clinical care and incidents/events. The business risk management register includes information on the likely impact of these events and the likelihood of it happening. Preventative actions to minimise the risk are documented. Appropriate risks are communicated to residents/family members and includes signage such as 'wet floor' (sighted in use during audit).

The health and safety policy notes Deverton House has a significant hazard register. This is used as an induction tool for staff and contractors, volunteers and possibly visitors. This document is dated as being last updated in January 2013. Eighteen staff and managers have signed this register (between April and September 2013) to verify awareness of the hazards. A monthly facility review is undertaken to identify maintenance issues and new hazards. Records for 2013 year to date sighted. Items identified on this hazard audits includes light bulbs that need replacing. (Refer to1.4.2.1)

The majority of policies and procedures are developed (and reviewed at least annually) by an external consulting company and localised where necessary for Deverton House Rest Home. The coordinator advises the consulting company places the audits in a drop box and emails to alert the facility of the changes. The documents are then localised and released. There are a number of Deverton House Rest Home developed documents that do not have document control details noted. There are a number of other documents which are dated as last reviewed in 2007. This is an area requiring improvement.

Six template forms are to be used for the recording and reporting of information. The forms are specific for the type of event being reported; opportunity for improvement/complaints/compliments form; accident/incident form; serious problem form; infection form; challenging behaviour form; and medication problems (refer to 1.2.4). The number of reported events are benchmarked per 1000 occupied days with other facilities.

There are staff meetings which are held normally every month and the meeting schedule is displayed on the staff notice board. Service review meetings (which is where quality and risk is reviewed), occurs three monthly. This meeting is attended by the owner, the CNM, and the external quality consultant attends some meetings. The minutes of a three monthly (and annual) quality and service review meeting held in May 2013 and August 2013 are sighted. The minutes of these meetings includes discussion on occupancy and bed availability, a review of the organisation's goals, a review of incidents and accidents and complaints, per category/type of event, and how Deverton House Rest Home incidents compares with other benchmarked facilities. Hazard identification and review, staffing, policies and procedures (developed or reviewed), education, emergency preparedness, capital equipment required, changes to signage, and facility maintenance are discussed.

The minutes of monthly staff meetings dated 7 May 2013, 23 May 2013, 2 July 2013, 6 August 2013 and 3 September 2013 are sighted. The minutes includes discussions on evaluating the organisation's progress in achieving goals, new residents, incidents/accidents, hazard identification, use of the yellow envelope when patients are transferred to hospital, resident with infections, resident feedback and staff training.

Three of three caregivers and another employee interviewed are able to identify the type of events that are required to be reported via the incident reporting process. The four staff confirm they are provided with information on the number and types of reported events at the staff meetings.

There is an internal audit calendar for Deverton House Rest Home. A review of the audit calendar identifies what audits/surveys are to be undertaken and when. There are a few audits scheduled for March and September 2013. There are template audit reports used which have been developed by the external quality consultant. The calendar notes all required audits (except one) have been completed year to date. The following audits are selected for review during audit:

- staffing levels (10 May 2013). This is undertaken by the owner, CNM and the external quality consultant. The service meets the requirements of the ARRC contract and the responsibilities for second in charge have been clarified.

- patient satisfaction survey (May 2013). Ten residents provided feedback indicating a high satisfaction with staff care. Two residents felt more time should be allowed for meals and beverages and one resident identified they did not choose their own bedtime. Discussion with the coordinator and the CNM identify a review of the survey wording is required,. The wording of several questions is very confusing and the face symbols associated with ratings are contradictory. The coordinator advises the survey will be rewritten and repeated in October 2013.

- audit of laundry services (4 September 2013). Four areas for improvement identified. Three have been addressed and one remains under consideration.

- audit of cleaning services (one area for improved identified and new waste bin noted to have been ordered).

- availability of fluids audit (9 September 2013). The findings identify compliance with the organisations policies.

- consent form audit (4 September 2013) notes all areas identified as requiring review during the May 2013 audit have been addressed.

- call bell audit (monthly May to August 2013). Identifies all call bells are tested each month and functioning with the exception of one call bell in June 2013 which has been fixed.

- a staff satisfaction survey has just been completed and the coordinator is in the process of evaluating the responses.

Where areas are identified as requiring improvement following complaints, incidents and audits, the improvements are planned, implemented and monitored. The exception being evidencing that follow-up has occurred in a timely manner for events raised by residents during residents' meetings. This is raised as an area for improvement in 1.3.7.1.

The ARRC requirements are being 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:** PA **Risk level for PA/UA:** Low

The majority of policies and procedures are developed (and reviewed at least annually) by an external consulting company and localised where necessary for Deverton House Rest Home. The coordinator advises the consulting company places the audits in a drop box and emails to alert the facility of the changes. The documents are then localised and released. The coordinator advises she is responsible for ensuring the documents are updated. There are a number of documents sighted at audit including night shift cleaning guideline, cleaning laundry guideline, tea duty (4.00 pm to 1030 pm), use of oxygen regulators, and use of nebuliser guidelines. None of these have document control details included. There are a number of other documents including cleaning dentures guideline, taking blood pressure, dressing a resident, care of feet, procedures to tidy a bedroom and ensuite, face and hands ('top and tail'), personal hygiene for residents, and the procedure for showering and bathing a resident which are dated as last reviewed in 2007. This is an area requiring improvement.

**Finding Statement**

There are a number of documents that have been developed by Deverton House Rest Home that provide guidance for staff on components of care. These documents do not have identification as to when these documents were developed, by whom, how many pages the document should be and when they are due for review. 2) There are a number of documents including some procedures and staff task lists which are dated as being last reviewed in 2007.

**Corrective Action Required:**

Ensure document control processes are implemented for policies developed by Deverton House Rest Home and that all documents are reviewed in a timely manner.

**Timeframe:**

Six months

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

Document review: Accidents and incidents are documented on their respective forms:

- serious Injury review & review of the Significant Hazard Register

- staff Injuries (any staff injury is considered for review)

- falls (categorized with fracture, harmed or unharmed)

- medication Problems

- challenging Behaviours

- infections & development of ulcers

- hospital Admissions (counted & compared to others & to previous years)

This data is entered into the nationwide benchmarking statistics programme. Statistical analysis in graphical form is supplied by the external quality adviser to aid Deverton House Rest Home management reviewing responses. Where Deverton House Rest Home is not comparing favourably with other like providers outside expertise can be sought. The CNM advises this could be from the DHB gerontology nurse specialists if applicable.

At audit three of three caregivers and three other staff interviewed are able to identify the type of events that are required to be reported. The caregivers report they are provided with information on resident related incidents at staff handover and noted in the communication book referring staff to read the residents progress notes. Discussion on the overall number and type of reported events is discussed at monthly staff meetings as verified by staff during interview and evidence in meeting minutes sighted. A review of the reportable events folder demonstrates that staff are reporting a variety of events (including near misses). A review of seven reportable events (medications related, falls and skin tears) selected from the folder verifies all events are investigated, corrective actions taken as appropriate/required and monitored for effectiveness. Three of the reported events are recorded in the resident's file and there is evidence of open disclosure occurring. The three family members interviewed verify staff keep them informed of falls, infections and other events in a timely manner.

The three monthly service review meetings includes a review of all reported events, and compares Deverton House Rest Home rates with those reported by other facilities within the benchmarking programme. There is detailed evaluation of the factors thought to have contributed to these reported events as well as solutions to address the issues. The two most recent service review reports (May 2013 and August 2013) are sighted.

The owner and the CNM during interview advise there have been no events requiring essential notifications since the last audit. The CNM is able to identify the type of events which must be reported to meet legislative and ARRC contract requirements.

The ARRC requirements are being 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:** PA Low

Document review: The good employer policy has a flowchart that details the recommended recruitment process including advertising the position, receiving application forms and curriculum vitaes, interviewing, reference checks, agreeing on the job description and employment conditions. Induction/training is to occur, staff are to sign the declarations, including confidentiality and then start work.

Processes are in place to ensure that employed and contracted staff retain current annual practising certificates where this is required for their role. The current APCs are sighted for the NM, relief NM, three general practitioners, dietitian, podiatrist, pharmacist and physiotherapist.

A review of five staff files demonstrates that staff are required to complete an application forms. Reference checks and interview records are noted for all staff except one (employed by the prior owners). Police checks are on file for all staff or evidence police checks have been requested for the three staff employed since 22 August 2013. All staff employed for more than one month have a performance appraisal on file. These occurred at four to six weeks following employment and at least annually. Two staff whose records are reviewed have been employed for less six weeks.

All staff are provided with an orientation to Deverton House, that includes the facility/environment, staff roles and responsibilities, organisation policy and procedures, fire and emergency procedures, waste and hazardous substances, security and resident care needs. The three care staff interviewed and one other employer verify new staff are buddied with a senior caregiver for at least one full shift (more if required). All components of the orientation component have been completed in the caregivers' files reviewed (employed since July 2013) with the exception of the competency assessment check list. The CNM advises these topics are discussed with staff, however records have not been maintained to ensure staff are competent for tasks, including blood glucose testing, taking a blood pressure, taking a resident's temperature and use of manual handling aids. One of the new staff is working on her own (night shift). This is an area requiring improvement.

Staff are provided with ongoing education on a monthly basis. There is a training plan for 2013 and 2014 which includes all the requirements to meet the ARCC contract requirements and H&DS Standards. The in-services are provide by the CNM, a gerontology nurse specialists (GNS) from Waitemata District Health Board (WDHB) and guest speakers. A review of the training/education records verifies that staff have attended the following training:

- chemical safety and usage (15 March 2013): eight staff attended

- head to toe assessment (April 2013): eight staff attended

- back care and safe manual handling (May 2013): nine staff attended- provided by the physiotherapist.

- depression (20 June 2013): 11 staff attended - provided by GNS

- cultural diversity, Treaty of Waitangi, death and dying (5 July 2013):7 staff attended

- fire evacuation and safety drill (2 August 2013): eight staff attended

-disaster planning (6 August 2013):10 staff attended

- basic first aid (26 August 2013): 10 staff attended

- independent advocacy service and the Code of Rights, and sexuality in the older person (2 September 2013): eight staff attended. The in-service is provided by the HDC advocate.

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

All staff are provided with an orientation to Deverton House that includes the facility/environment, staff roles and responsibilities, organisation policy and procedures, fire and emergency procedures, waste and hazardous substances, security and resident care needs. The three care staff interviewed and one other employer verify new staff are buddied with a senior caregiver for at least one full shift (more if required). The staff advise they are orientated to each shift they are rostered to work to ensure they are familiar with requirements and routines and differences for the various shifts. Three new staff have been employed as caregivers (including casual) since 12 July 2013. All components of the orientation component have been completed with the exception of the competency assessment check list. The CNM advises these topics are discussed with staff, however records have not been maintained to assess if staff are competent for tasks including blood glucose testing, taking a blood pressure, taking a residents temperature and use of manual handling aids. One of the new staff is working on her own. This is an area requiring improvement. The risk rating is noted as low as the staff involved are noted to be overseas trained registered nurses who are working in New Zealand as caregivers.

**Finding Statement**

Three new staff have been employed as caregivers (including casual) since 12 July 2013. All components of the orientation component have been completed with the exception of the competency assessment check list. The CNM advises these topics are discussed with staff, however records have not been maintained to assess if staff are competent for tasks including blood glucose testing, taking a blood pressure, taking a resident's temperature and use of manual handling aids. One of the new staff is working on her own.

**Corrective Action Required:**

Ensure all components of the orientation are completed, including the competency assessment process and that records are maintained.

**Timeframe:**

Six months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

Document review: The organisation management policy details the staffing requirements and skill mix to meet the ARRC contract. There is to be at least one caregiver on duty at all time and someone on call.

During interview with the CNM, assistant manager and two care staff it is verified there is at least one staff member on duty at all times and one on call. It is verified there is always a staff member on duty who has a current first aid certificate.

The current roster is sighted:

The CNM works Monday to Friday day time (minimum 34 hours per week) and is on call when not on site.

The coordinator works on site weekdays from 9am to at least 4.30pm.

There is a senior caregiver on duty from 7am to 3pm and a junior caregiver from 7am to 1.30 pm daily.

There is a senior caregiver on duty from 3pm to 11pm and a junior caregiver from 4pm to 10.30 pm daily.

There is a senior caregiver on duty from 11 pm to 7am daily.

The activities coordinator works from 10.30am to 3 pm - currently three days a week.

The cook is rostered 6.30 am to 2pm daily.

The cleaner is rostered 9 am to 1.30 pm. There are additional hours (8.30 am to 12.30 or 1 pm) allocated for laundry services and kitchen hand duties.

The two owners also work in the rest home doing maintenance, gardening and meeting with residents and family members.

The six residents and three family members confirm there are sufficient staff on duty to meet the individual resident's care needs in a timely manner.

ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

Resident's information is stored securely and is not on public display. The CNM office has a locked door when the office is empty and files cannot be seen through the window. The resident's name and date of birth and NHI are used as the unique identifier on all resident's information sighted. Clinical notes are current and accessible to all clinical staff in an integrated file. On the day of admission all relevant information is entered into the resident's file by the CNM following an initial assessment and the doctor when he visits.

The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, national health index number (NHI), the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers are all completed as sighted in five of five residents' files reviewed.

**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

Document review: The organisation management policy details the process for documenting and managing enquiries. Residents are required to have a needs assessment prior to entry. The care planning policy notes residents will be selected who are the best fit for the facility and existing residents. Residents must be assessed as requiring rest home level care, able to weight bear, be 'a good fit' with other residents and Deverton House can meet the prospective resident's special/disability needs.

An 'Admissions Policy' is sighted and includes the procedure to be followed when a resident is admitted to the home. The NZACA standard Resident's Services Agreement is provided. Policy identifies that entry screening processes are documented and communicated to the resident and their family/whanau or representative.

The residents and family report the admission agreement is discussed with them prior to admission and all aspects are understood. All 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

Document review: The care planning policy notes the communication process when a prospective resident is declined entry to the service. They must be informed of the reason. The prospective resident is to be referred back to the referring agency and the resident advised of other back to the service and suggestions for other providers can be given. All communications must be documented.

The CNM reports that the needs assessment team at WDHB usually ring and a telephone discussion verifies the suitability for admission before the family visits, if the resident is in hospital. There is a folder which contains documentation of all enquiries (sighted) and the action taken if the admission is declined. This includes contacting the referral agency.

**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

Document review: The care planning policy notes that care for each resident will be:

- Supportive and user friendly from first enquiry to last farewell!

- Goal directed and according to the resident's own hopes and wishes

- According to residents' assessed needs

- Planned, evaluated and reviewed - asking are we meeting the goals set

- Monitored by a person capable of providing additional support when it is needed

- Shared with family & support networks of the resident

- That exit or discharge may be considered from day one

The care planning policy details that patients must be assessed on admission, and an initial care plan developed within 24 hours of admission. The resident must be seen by the GP within two days of admission. A long term care plan must be developed within 3 weeks and reviewed on at least a six monthly basis.

The assessments include:

- falls risk & prevention strategies

- risk of infection or developing pressure area

- risk of challenging behaviours including leaving without telling anyone

- risk to themselves and other

- nutrition risk

- continence assessment where needed

- risk from communication problems

- risks associated with dementia or intellectual disability

- risks at end of life

- risks related to self-administration of medications

- pain assessment.

Service delivery is overseen by the clinical nurse manager(CNM). Assessments and care plans are completed as required for all residents according to the policy. All five files reviewed show evidence of resident or family/whanau consultation. Evidence is seen of resident or family/whanau contact in progress notes. This includes six residents and three family who report during interview that they are consulted regarding service provision.

The initial nursing assessment is completed on admission within the first 48 hours. The long term care plan is developed within three weeks and evaluated every six months or earlier if an unexpected event occurs. Relevant assessment tools are completed. These include falls risk, skin integrity, continence and behaviour management.

Informal family/whanau meetings are held as required with the CNM and the GP. Evidence of this is sighted in all five files reviewed. A system has been implemented to ensure that residents are reviewed every three months and evidence of this is sighted on the days of audit.

Handover at the beginning of each shift is undertaken in the CNM's office for privacy. The GP visits fortnightly or at other times if required. The six staff interviewed report that they are given information concerning service delivery at handover and any other time if there is a change in service delivery requirement.

Evidence is seen of visits from the Mental Health Service for the Older Person (MHSOP), dietician from the WDHB, contracted physiotherapy and occupational therapy as required.

Tracer Methodology:

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

All ARC contract requirements are met.

**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

Document review: There is a comprehensive assessment required to be undertaken on admission and reviewed three monthly. This includes (but is not limited to) a falls assessment, use of mobility devices and type, Norton Scale, continence assessment, pain assessment (and Abbey pain assessment if applicable), self-administration of medication assessment, oral health assessment, identification of dietary needs and allergies.

The initial nursing assessment includes good use of clinical tools and these include falls risk, pressure area, and mental assessment. Referral letters are sighted from external agencies, including WDHB clinics, and there is evidence of family/whanau involvement in the assessment process. Evidence is sighted in all five files reviewed that assessments are conducted within the specified timeframes. In all five files reviewed, the assessment information is used as part of care plan development.

The CNM reports that she oversees all care plans and residents and family are included. All 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

In all five files reviewed evidence is sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include falls risk, pressure area risk and mental capacity. Clinical risk tools are used as part of the intervention process and towards measuring achievement of desired outcomes.

All health professionals document in the resident's individual clinical file and have access to care plans and progress notes. Documentation in all five files reviewed include nursing notes, medical reviews and hospital correspondence. The residents report that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff report that at changeover and any time there are changes to care plans.

The CNM accompanies the doctor on his rounds and documents the outcome in the resident's notes. Evidence is also seen of letters from WDHB clinics. The care plan is written in a language that is user friendly and able to be understood by all staff. Care staff are told of any changes in the care plans at changeover of shifts. In all five residents' files reviewed there is evidence to demonstrate involvement in care planning of the family/whanau. All 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

In all five files reviewed there is evidence of the interventions relating to the residents' assessed needs and desired outcomes. The six clinical staff interviewed report they are informed of all care plan issues at hand over and have relevant in-service education if required. One resident reports on admission she wants to improve her walking and reduce her falls. Since admission with an assessment from physiotherapist she is able to use her walker confidentially and has had no falls. The three relatives spoken to express satisfaction with the service their family/whanau member is receiving.

All ARC contract 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:** PA Low

There is one activities coordinator employed at Deverton House Rest Home to provide activities for all residents. She has worked at the rest home for two years and works 20 hours a week. She on special leave at the time of audit and other staff are assisting.

There is an area for improvement relating to the planned activities schedule not being consistently available in advance and the residents knowing what activities are planned daily. The monthly activity plan for August includes exercises, 'happy hour', van drives and church singers.There are minutes available of bi-monthly resident meetings. An area for improvement is required relating to no evidence of corrective actions being implemented for issues that arise at the residents' meetings.

Church visitors spend time with the residents but a church service is not held (visited during audit).

Chinese residents have their culture recognised with monthly 'yum char' dinners and the Chinese festivals. A telephone interview with one of the Chinese resident's relatives reports that the Chinese residents are taken out of for meals or the family visit with meals.

All ARC contract 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:** PA **Risk level for PA/UA:** Low

The August activity plan includes exercise, 'happy hour', celebrating birthdays, van drives, and church singers. The residents report that they enjoy activities of outings in the van and the exercises in the morning. There is inconsistent completion of activity planning in advance. The activity coordinator is on special leave at the time of audit and temporary staff are assisting. Evidence is seen of minutes of bi-monthly residents' meetings but there is no evidence of corrective actions for issues that arise at these meetings.

**Finding Statement**

There is inconsistent completion of activity planning in advance. The activity coordinator is on special leave at the time of audit and temporary staff are assisting. Evidence is seen of minutes of bi-monthly residents' meetings but there is no evidence of corrective actions for issues that arise at these meetings.

**Corrective Action Required:**

Ensure monthly planning of activities is implemented consistently in advance. Provide documented evidence of corrective actions for issues that arise at residents' meetings.

**Timeframe:**

6 months

**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

Evidence is seen of documentation when an event occurs that is different from expected and requires changes to service delivery. Long-term care plans are reviewed every six months or earlier as required. Evidence of this is sighted in the five files reviewed. Progress notes are signed once every duty by the caregivers. Evidence is seen of the family/whanau involvement in the care reviews and the three relatives report they are consulted regarding care reviews. The six residents interviewed report they are involved in their care and the six clinical staff interviewed have knowledge of the care plan documentation requirements.

All ARC contracts 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

Residents admitted to Deverton House Rest home are given the choice of retaining their own GP or using the GP contracted to the facility. All six of the residents interviewed are seen by the GP contracted to the rest home. The GP was available for interview during the audit and has no concerns relating to Deverton House Rest Home. The six residents interviewed report they are given the choice of retaining their own GP but usually change as it is easier to see the GP when he visits. The CNM and the owner report that residents are given the choice of changing facilities if they are not happy and also if their health needs change. All 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

The stated objective in policy is that residents will have access to appropriate external treatment and support services and will be referred in a timely fashion. All referrals are clearly documented in the progress notes and in the diary as required. The resident's family will be notified of the upcoming appointment and will be invited to attend and assist. Should a resident require transition, exit, discharge or transfer this will be planned and undertaken with the resident and applicable family. In two of five files reviewed there is evidence of the process of transfer to Northshore hospital and the communication with families.

The CNM is responsible to ensure that residents are referred to appropriate external services and the transfer process is within policy requirements regarding safety and risk management. All ARC requirements are 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

Document review: The documented goals of the medicine management programme are:

- ensure residents are fully informed about the medicines they are taking.

- medicines are given safely.

- have a medicine management team and all members know their roles and responsibilities.

- staff giving out medicines are well trained & competent.

- errors are realised, rectified, reported, counted and analysed to minimise re-occurrence.

- medicines are given in timely fashion when needed.

-the use of medicines is seen as associated with illness and minimised whenever possible.

- the use of medicines is guided by the latest best practice guidelines.

- medicine usage is reviewed for each resident for therapeutic and rehabilitative effect.

- wherever possible, decisions about the use of medicines is shared with the resident.

The 2013 medication policy details the medicines management system as required to meet these standards. This includes medication errors, prescribers responsibilities, safe storage, administration and documentation. Details of what medications may be administered by caregivers after being assessed as competent. Medication errors are required to be reported.

Deverton House Rest Home uses a blister pack medicine system whereby medicines are delivered fortnightly or as required. These are checked individually on arrival and before being given to the resident. Controlled drugs are prescribed for individual residents and no stock is held on site. There is evidence in all ten medication charts reviewed of three monthly reviews by the GP. Evidence is seen of this process overseen by the CNM. There are no standing orders in place at this facility.

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The GP reports that he works with the pharmacy but he is responsible for all medicines administered to his residents. The CNM and qualified caregivers responsible for medicine management have an annual competency review prior to administering medicines. Evidence is seen on seven of fifteen staff files. The caregiver was observed during the lunchtime medicines round and correct procedures were followed. The gerontology nurse specialist for the WDHB also gives in service education relating to safe medication procedures in aged care.

A self-administration of medicines policy, including a form to be signed by the GP is available. One resident is assessed as competent and wished to self-administer their medications there is a process in place including a locked drawer.

Medicine sheets are signed in ink as required following administration. All six rest home residents spoken with report the GP discusses their medicine requirements with them.

All ARC contract 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

Document review: The infection control programme includes guidance for staff on how to protect the critical points during food preparation and service. This includes staff personal hygiene, preventing contamination during preparation, defrosting, cooking, storage and reheating of foods. Rotation of food is required. The temperature parameters for the refrigerator and freezer are detailed as well as the required temperature cooked food is required to reach. The seasonal menu is appropriate and varied. Evidence is seen of the summer and winter menu being reviewed two yearly by an approved dietician.

An individual dietary assessment is completed on admission which identifies individual needs and preferences. This is carried out in consultation with the family/ whanau as required. Likes and dislikes are discussed with the staff and as the facility is small, staff are able to identify if the meals are meeting the residents' choices. There are lists on the fridge in the kitchen which identifies special dietary needs, likes and dislikes. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans. The cook reports that she is always made aware by the CNM of any specific dietary requirements for residents.

All aspects of food requirements are within legislative requirements. Evidence is seen of completed cleaning schedules and there are adequate supplies for emergency requirements.

Resident survey support the meals are satisfactory and individual needs are recognised. There is evidence of initial dietary assessment identifying specific needs and the kitchen is notified accordingly. This can include vegetarian diets, diabetic diets or cultural requirements.

The lunch time meal was observed on the day of the audit and residents spoken to are happy with the meals provided. Policy identifies that additional or modified nutritional requirements or special diets are part of the care planning process.

All ARC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

Document review: The infection control policy includes how to dispose of waste safely to meet legislative requirements. The following categories of waste are detailed:

- hazardous waste

- soiled disposable waste

- body fluids

- sharps.

A guideline for managing needle stick injuries is detailed. Staff have training on handling waste and hazardous substances including during the orientation programme. Staff have access to appropriate personal protective equipment (aprons, gloves, eye protection and masks) and are sighted to be using appropriately. Staff report PPE has become more accessible. Four of four staff interviewed are aware of the need to report exposures to waste and hazardous substances via the incident reporting procedure. Chemicals are sighted to be stored in manufacturer original labelled bottles in secure cupboards/areas. Material data safety wall charts are available for products in use and are sighted. The service meets the requirements of the ARRC contract.

**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

There is a building warrant of fitness (WOF) dated as expiring 27 July 2014. The WOF is issued by Auckland Independently Qualified Persons Ltd

(A.IQP). There is a building warrant of fitness log which includes records of on-going activities to ensure the building warrant of fitness requirements are maintained. Sighted ongoing checks to maintain the building WOF are occurring and records sighted. The emergency warning systems for fire and other dangers, automatic fire doors, signage, means of escape, hose reels and other required checks are dated as occurring each month since the WOF is issued in 2013.

There is a form that staff fill in if there are any maintenance issues identified. List sighted at audit and most requests have been signed as being actioned and completed within 24 hours of request. In addition two staff (including the coordinator) undertakes a walk about every month and make a list of hazards or maintenance issues which require addressing. Completed lists sighted for July 2013, August 2013 and September 2013. The list includes (but is not limited to) hallway lighting requiring review, light bulbs not working, an area of the fence requires painting, a tap washer needs replacing in the visitor toilets and a gas element on the stove not working.

Some clinical equipment sighted has stickers verifying the equipment has been calibrated and checked by an external contractor. The certificate expiry date is 17 September 2013. Equipment sighted includes a nebuliser machine and scales. A new tympanic thermometer, electronic sphygmomanometer and pulse oxymeter has been purchased within the last twelve months. The external contractor provides the CNM/owner with a list of equipment tested and the last report sighted dated September 2012. The CNM advises retesting is scheduled to occur.

Gas heaters have been checked and serviced on 10 January 2013 and records sighted. Electrical items including heaters, television set and extension cords have test and tag labels with identified due date for next check as 21 January 2014.

Hot water temperatures are monitored monthly. Records sighted demonstrate regular monitoring (33 occasions) since 1 May 2013. All temperatures are sighted to be under 45 degrees Celsius.

There is a ramp outside (from the hairdressing room) which is rarely used. There is a deck off the television lounge which extends the length of the building to the dining room. There are outdoor chairs on this deck and staff report some clients do go out onto the deck as weather permits. One resident waters the plants on the deck. There is a ramp exit to the ground. Staff report this ramp is rarely used by residents. Residents and family currently enter and exit via the front door. This is flat and there is outdoor furniture for residents to use and the owner has been landscaping this area to improve the outlook for residents. This area is sunny as is reported by staff to be the most common area for residents to go who wish to sit outside.

Hand rails are present on one side of the corridor. The floor is flat with no undue gradients or ridges. Grab bars are present in the toilet and bathroom areas. Residents are sighted to be mobilising independently or with assistance of staff or family.

**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

All 21 residents' bedrooms have ensuites that contain toilets and hand basins. Two 'all resident use' showers and toilets are clearly identified. Three of three caregivers interviewed identify this is sufficient as staff normally provide assistance or oversight of residents while showering. There are adequate hand washing facilities for staff and residents. Waterless hand gel is also available. Staff advise the hand gel has been made more accessible since the last audit with wall mounted stations placed. The CNM verifies more wall mounted hand hygiene dispensers have been installed in the last four months.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

There is adequate space within residents' bedrooms to enable them to move around including using walking or mobility aids. A number of residents are sighted at audit moving within their bedroom and to and from the dining room at one end of the building and the lounges at the other end of the building.

A number of residents are using mobility frames and one resident is sighted using a walking stick. Two residents interviewed who mobilise with a frame and one resident who uses a walking stick confirms they can manoeuvre in their bedrooms and bathrooms on their own as there is sufficient space. They also all confirm being able to mobilise throughout the facility independently including outside when they want. The residents advised if they required supervision or assistance staff willingly provide this. One staff member is observed supervising a resident mobilising to the front lounge. The staff member has a transfer belt around the resident’s waist.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

There is a dining area at the rear of the building with sufficient space and dining room furniture to enable all residents to eat in the dining room if they choose. At the front of the building there is a quiet lounge (with coffee and tea making facilities) and a separate lounge with a television and an organ. There is a hair salon which is attached to the quiet lounge. The hair salon is open on a Tuesday morning for residents to access hair dressing services. The activities programme is currently being facilitated by the hairdresser two days a week while the current activities person is on leave. The CNM and the coordinator are also currently assisting with activities. The communal areas are adequate to meet the needs of the residents. This is verified during interview with six of six residents interviewed and three of three family members.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

Document review: There is a Deverton House specific guideline which details the cleaning of isolation rooms. The policy details which rooms currently have residents with a multi-drug resistant organisms that requires specific cleaning. The policy notes chemicals are to be stored securely and the location of material data safety sheets. Chemicals are sighted to be stored securely in a locked room or a locked cupboard in the laundry during audit.

Monitoring of the effectiveness of the cleaning and laundry services is undertaken via the internal audit programme. Refer to 1.2.3 for results of cleaning audits. Residents are also asked for feedback as a component of the patient satisfaction survey.

All six residents and all three family members at interview verify the facility is kept clean and tidy and their personal washing is washed and returned is a timely manner (often the same day).

The laundry employee advises a drying rack is used to dry residents personnel woollen items to minimise risk of damage. A caregiver irons residents garments (when required).

The cleaner advises separate mops and buckets have been obtained to clean the rooms of residents who have a multi-drug resistant organism. The rooms the mops and buckets are to be used in are readily identifiable (and sighted during audit).

**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

Document review: There is an emergency management policy. This identifies the goals of the emergency preparedness programme:

1. We strive to ensure residents receive appropriate & timely response in emergency situations

2. To take “all practical steps” to keep everyone safe

3. This includes keeping active our Fire Evacuation Plan

4. To make all staff are aware of the civil defence part of this emergency

5. To have health & safety representatives who help us and alert us to workplace dangers

6. To assess hazards & within the buildings & our grounds & to control these hazards.

7. To regularly review and audit our program [at least quarterly] so that we are well prepared should the worst happen?

8. To induct new employees to our emergency situation response prior to their starting work.

9. To regularly review and audit our program [at least quarterly] so that we are well prepared should the worst happen?

10. To familiarise our residents & visitors with emergency procedures through drills, handouts & good signage.

The policy notes at least one staff member with a current first aid certificate is to be on site at all times. This is verified to be implemented at audit. All staff and managers (except two) have a current first aid certificate and records sighted to verify this.

There are call bells in all residents' bedrooms, ensuites/bathrooms and lounge and dining rooms areas. Three calls bells tested during audit have an audible sound and a light illuminates outside the area. Three of three caregivers advise the facility is secured at approximately 6 pm each evening. There is a door bell that visitors can ring to be granted access. The caregivers advise they check who is at the door prior to opening. There are security cameras monitoring the front entrance and main corridor, the kitchen and the car park area. The coordinator advises the footage is archived for approximately two weeks before it automatically over writes. The security camera footage is displayed in real time in the coordinators office.

Staff have received training on the management of disasters at the staff meeting dated 6 August 2013. Ten staff are sighted as attending. A copy of the lesson plan and template questions for staff use to prompt discussions is also sighted.

The organisation has a fire evacuation plan which is dated as approved by the New Zealand Fire Service (NZFS) on 28 August 2012 and this plan is sighted. The most recent fire evacuation drill occurred on 2 August 2013 and eight staff attended. The evacuation was overseen by an external fire consulting company and records sighted identify the evacuation took 3 minutes and 10 seconds. There are adequate supplies including food and access to utilities for use in emergency. There is a gas hob and gas bottle for cooking. There is a civil defence disaster box containing rope, reflectors, rain ponchos, masks, batteries, torches, a radio and gloves (sighted). There are sufficient supplies of drinking water (18 x 10 litre bottles and 5 x 15 litre bottles) in the basement and these are dated. There are spare duvets/blankets in the linen cupboard. The CNL and coordinator have cell phones that can be used in emergency. There are supplies of continence products upstairs. Hot water and heating is currently provided by gas. The service meets the requirements of the ARRC contract.

**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

Policy identifies that the facility is heated during the winter months. Wall mounted gas heaters are located strategically in the hallways and communal areas and in each patient room. Heating is via a combination of gas and electrical heating. The ambient temperature at audit is warm. All six residents and all three family members at interview verify the facility is kept appropriately warm. All resident bedrooms have a window that opens for ventilation. Five bedroom windows reviewed at random are sighted to have window stays fitted.

There are currently no residents who smoke.

**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

Deverton House Rest Home uses no restraints and there is no evidence of restraint use during the audit. Two residents have an enabler attached to their bed to help them get in and out with ease. Assessments and consents for the use of the enablers are sighted (signed by the resident). One of the residents is receiving respite care and confirms the enabler is in place at the resident's request. All two enablers are documented in the restraint/enabler log. Monitoring the use of enablers is also a component of the three monthly service review meetings.

There are adequately documented guidelines on the use of restraints and enablers as detailed in the managing challenging behaviours and no use of restraint policy (January 2013). Definitions are congruent with the requirements of the Health and Disability Services Standards. There are also guidelines on the management of challenging behaviours and staff receive adequate training. An in-service was last held for staff on the 19 April 2013 which is attended by 11 staff. There have been no reported incidents related to the use of restraints or enablers. Three of three caregivers interviewed are able to describe that enablers must be voluntary and promote independence. The staff advise restraints are not used.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

Document review:The infection control programme details the goal of preventing infections for residents, staff and visitors. There are five objectives which includes preventing infections, that use of antibiotics is appropriate, referring residents to other services as required, providing timely treatment, and undertaking surveillance for residents with infections and benchmarking the infection rates with other facilities. The policy details the role and responsibilities of the RN, manager and all staff. Infection surveillance data is to be analysed and discussed three monthly at the service review meeting.

An annual review of the infection control programme is required to be undertaken. The policy focuses on hand hygiene and describes the processes for quality reviews and benchmarking. An infection control committee is established. There is an infection control programme which is dated September 2012. The programme includes all requirements as detailed in the policy. Deverton House Rest Home infection control programme identifies that the IC programme is developed in consultation with the CNM and the owner. The CNM (who is the infection control coordinator) confirms she has approved the programme. The programme is reviewed at least annually. A copy of the annual review of the IC programme undertaken by the CNM evaluates progress in achieving the 2012 goals and objectives and established priorities for 2013.

The roles and responsibility for the infection control coordinator is defined in a position description (sighted). Six of the six clinical staff interviewed confirm that they are required to report residents who are suspected of having infections to the CNM promptly. Six of the six staff interviewed are able to identify the importance of hand hygiene and using standard precautions. ARC requirements are 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

Document review: The infection control programme identifies that infection prevention and control support will be obtained where required from the general practitioner, diagnostic laboratory, gerontology or wound care nurse specialists at the DHB and a nutritionist.

Education undertaken during 2013 includes the Infection Control Specialist for the WDHB and in-house education by the CNM. In case of an outbreak advice will be sought from GP and laboratory services. The CNM is responsible for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation. The CNM advises at interview she would contact the general practitioner, or WDHB infection prevention and control nurse specialists, or the laboratory if infection control advice is required. The CNM confirms she attended an in-service provided by the WDHB. ARC requirements are 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

Document review:The infection control policies have been developed by an external consultant and are dated as last reviewed in January 2013. The policies are clear, referenced and meet current accepted practice. All required policies to meet the standard are present.The CNM reports she meets with the external qualified consultant to ensure all policies are up to date and are of best practice.Six of the six clinical staff interviewed are aware of where the infection prevention and control policies are located. ARC requirements are 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

Infection prevention and control education was provided to all staff in 2013. This included standard precautions and management of incontinence. A record of attendance is maintained and a copy of the presentations held on file (sighted). Six of the six clinical staff interviewed confirm attending this in-service education. Education is provided to residents (and / or family members) related to hand hygiene and isolation, if there is an infection outbreak.

ARC contract requirements are 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

Document review: The infection control policy (2013) notes that surveillance for residents with infections will be ongoing. The types of infections included is appropriate to the service setting and includes:

-chest infections

- influenza / colds

- diarrhoeal disease

- skin and wound infections including fungal, scabies and head lice

- multi drug resistant organisms

-ear infections

- eye infections

- oral infection

- nasal infections

- urinary tract infection.

Definitions of the infections included in the surveillance programme are present.

A template form is provided for the reporting of infections which are evaluated and reported per 1000 occupied bed days. Infection rates are to be recorded onto the external consultant's electronic benchmarking programme and sighted. Six of the six clinical staff report they receive information on infections at handover or at staff meetings.

An annual summary of the number and type of infections per month is maintained and sighted for 2012 and 2013. A register is kept of all residents who develop infections, the type of infections, results of cultures (where obtained) and details of treatment provided. The register notes whether further follow-up is required. One resident is noted to have repeated urinary tract infections secondary to underlying health conditions.

**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:**