Ilam Lifecare Limited

CURRENT STATUS: 17-Sep-13

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

GENERAL OVERVIEW

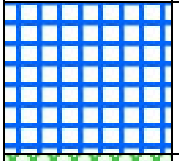
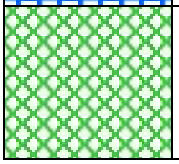
Ilam Lifecare provides rest home, dementia and hospital level care for up to 121 residents. On the days of audit 77 residents were accommodated, 26 rest home (20 rest home unit and six in serviced apartments), 31 hospital and 20 dementia residents. The facility is managed by a facility manager (registered nurse) who reports to the general manager. The service is privately owned shareholding with a board of directors. The rest home and hospital units are managed by registered nurses and the dementia unit is managed by an enrolled nurse with oversight from the rest home coordinator. All unit managers are supported by care staff, ancillary and administration staff. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family interviewed all spoke positively about the care and support provided.

Improvements are required whereby advanced directives are signed by the GP, the results of resident and family surveys are reported, outbreaks are notified to reporting bodies in a timely manner, residents are seen by GP monthly unless assessed as being stable, controlled drug stock take is completed six monthly, decanted foods are dated, medical equipment is regularly serviced and calibrated, and the carpet area in the hospital lounge is repaired to minimise risks to residents and staff.

AUDIT SUMMARY AS AT 17-SEP-13

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained

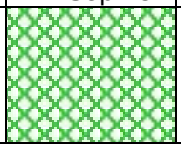
Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	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

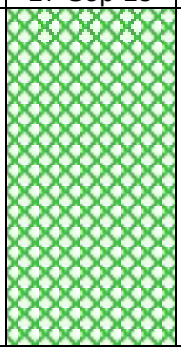
Consumer Rights	Day of Audit 17-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		**Some standards applicable to this service partially attained and of low risk**

Organisational Management	Day of Audit 17-Sep-13	Assessment
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		**Some standards applicable to this service partially attained and of low risk**

Continuum of Service Delivery	Day of Audit 17-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		**Some standards applicable to this service partially attained and of low risk**

Safe and Appropriate Environment	Day of Audit 17-Sep-13	Assessment
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		**Some standards applicable to this service partially attained and of low risk**

Restraint Minimisation and Safe Practice	Day of Audit 17-Sep-13	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		**Standards applicable to this service fully attained**

Infection Prevention and Control	Day of Audit 17-Sep-13	Assessment
Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		**Standards applicable to this service fully attained**

AUDIT RESULTS AS AT 17-SEP-13

Consumer Rights

Ilam Lifecare strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Improvements are required around advance directives. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are actively managed and well documented and logged in a complaints register.

Organisational Management

Ilam Lifecare is owned by a private company and with governance provided by a board of directors. A general manager is employed. The facility manager is responsible for the implementation of the quality and risk management programme with support from a quality manager, a clinical manager and the unit clinical coordinators. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality and health and safety meetings; monthly restraint and infection control meetings and two monthly unit staff meetings. Corrective actions are implemented, documented and followed through to

resolution. Residents and families are surveyed annually and through resident meetings. Improvement is required whereby the results of the surveys are communicated back to residents and families. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are managed. Discussions with families identified that they are fully informed of changes in health status. An improvement is required whereby notification of outbreaks is conducted in a timely manner. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Education, training and competencies are completed. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of Service Delivery

Ilam Lifecare has a documented entry criteria, which is communicated to residents, family and referral agencies. Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into care planning and access to a typical range of life experiences and choices. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. Residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs. A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Residents and family interviewed confirm their participation in these evaluations. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. There is one area requiring improvement around GP exemption forms for three monthly assessments for rest home and dementia residents.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. There are three activities programme for the facility. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. There is an appropriate medicine management system in place. Staff responsible for medicine management have attended in-service education for medication management and have current medication competencies. There are no residents self-administering medicines. There is one area requiring improvement around six monthly stocktaking of controlled drugs. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Ilam Lifecare has a central kitchen and on site staff that provide the food service. Kitchen staff have completed food safety training. The menu has been reviewed by a dietician. There is positive feedback from residents about the food service. There is one area requiring improvement around dating of decanted foods.

Safe and Appropriate Environment

The facility has a preventative and reactive maintenance plan. There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. There are appropriate monitoring systems to evaluate the effectiveness of these services. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is protective equipment and clothing provided and is used by staff. There is evidence of compliance regarding safe and hygienic storage areas of cleaning equipment, soiled linen and chemicals. All residents' rooms at the facility are of single occupancy. Rooms are adequate to allow for the use of mobility aids as well as a staff member. All bedrooms in hospital and rest home have full ensuite and dementia wing bedrooms have toilet en suites. There are an adequate number of communal toilet and shower facilities. There are two areas requiring improvement around medical equipment and hoists to be checked /calibrated and floor coverings in the hospital wing to be in good order.

Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service currently has five hospital residents assessed as requiring restraint (bedsides and one lap belt), and no enablers. There is a restraint and enablers register. There are comprehensive restraint/enabler documentation completed including assessment, consent, individual planning, monitoring and review. Staff are trained in restraint minimisation and in managing challenging behaviours. Restraint minimisation is linked to the quality and risk management system

Infection Prevention and Control

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

Ilam Lifecare

Ilam Lifecare Limited

Certification audit - Audit Report

Audit Date: 17-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Ilam Lifecare Limited

Premise Name	**Street Address**	**Suburb**	**City**
Ilam Lifecare	28 Ilam Road	Riccarton	Christchurch

Proposed changes of current services (*e.g. reconfiguration*)**:**

Type of Audit	Certification audit and (*if applicable*)	
Date(s) of Audit	**Start Date:** 17-Sep-13	**End Date:** 18-Sep-13
Designated Auditing Agency	Health and Disability Auditing New Zealand Limited	

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXX	RCpN, Health auditor, AdDipBusMan, CertQA	15.00	5.00	17-Sep-13 to 18-Sep-13
Auditor 1	XXXXXXX	RN, Health auditor	15.00	4.00	17-Sep-13 to 18-Sep-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXX			2.00	

Total Audit Hours on site	30.00	**Total Audit Hours off site** *(system generated)*	11.00	**Total Audit Hours**	41.00
Staff Records Reviewed	11 of 82	**Client Records Reviewed** *(numeric)*	10 of 77	**Number of Client Records Reviewed using Tracer Methodology**	3 of 10

Staff Interviewed	22 of 82	**Management Interviewed** *(numeric)*	3 of 3	**Relatives Interviewed** *(numeric)*	7
Consumers Interviewed	11 of 77	**Number of Medication Records Reviewed**	30 of 77	**GP's Interviewed (aged residential care and residential disability)** *(numeric)*	1

Declaration

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

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

Dated this 16 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

				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 Residential Care**	Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Ilam Lifecare	121	77	0	☐	☒	☐	☐	☐	☐	☐	☒	☒	☐	☐	☐	☐

Executive Summary of Audit

General Overview

Ilam Lifecare provides rest home, dementia and hospital level care for up to 121 residents. On the days of audit 77 residents were accommodated, 26 rest home (20 rest home unit and six in serviced apartments), 31 hospital and 20 dementia residents. The facility is managed by a facility manager (registered nurse) who reports to the general manager. The service is privately owned shareholding with a board of directors. The rest home and hospital units are managed by registered nurses and the dementia unit is managed by an enrolled nurse with oversight from the rest home coordinator. All unit managers are supported by care staff, ancillary and administration staff. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family interviewed all spoke positively about the care and support provided.

Improvements are required whereby advanced directives are signed by the GP, the results of resident and family surveys are reported, outbreaks are notified to reporting bodies in a timely manner, residents are seen by GP monthly unless assessed as being stable, controlled drug stock take is completed six monthly, decanted foods are dated, medical equipment is regularly serviced and calibrated, and the carpet area in the hospital lounge is repaired to minimise risks to residents and staff.

1.1 Consumer Rights

Ilam Lifecare strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Improvements are required around advance directives. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are actively managed and well documented and logged in a complaints register.

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1.4 Safe and Appropriate Environment

The facility has a preventative and reactive maintenance plan. There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. There are appropriate monitoring systems to evaluate the effectiveness of these services. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is protective equipment and clothing provided and is used by staff. There is evidence of compliance regarding safe and hygienic storage areas of cleaning equipment, soiled linen and chemicals. All residents' rooms at the facility are of single occupancy. Rooms are adequate to allow for the use of mobility aids as well as a staff member. All bedrooms in hospital and rest home have full ensuites and dementia wing bedrooms have toilet en suites. There is an adequate number of communal toilet and shower facilities. There are two areas requiring improvement around medical equipment and hoists to be checked /calibrated and floor coverings in the hospital wing to be in good order.

2 Restraint Minimisation and Safe Practice

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belt), and no enablers. There is a restraint and enablers register. There are comprehensive restraint/enabler documentation completed including assessment, consent, individual planning, monitoring and review. Staff are trained in restraint minimisation and in managing challenging behaviours. Restraint minimisation is linked to the quality and risk management system

3. Infection Prevention and Control

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

Summary of Attainment

1.1 Consumer Rights

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

Consumer Rights 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 48):	CI:0	FA:22	PA:1	UA:0	NA: 0			

1.2 Organisational Management

		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	PA Low	0	1	1	0	0	4
Standard 1.2.7	Human resource management	FA	0	4	0	0	0	5
Standard 1.2.8	Service provider availability	FA	0	1	0	0	0	1
Standard 1.2.9	Consumer information management systems	FA	0	4	0	0	0	10

Organisational Management Standards (of 7):	N/A:0	CI:0	FA: 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

1.3 Continuum of Service Delivery

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

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 9	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	
Criteria (of 51):	CI:0	FA:18	PA:3	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

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

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

Criteria (of 36): CI:0 FA:15 PA:2 UA:0 NA: 0

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	FA	0	1	0	0	0	6
Standard 2.2.1	Restraint approval and processes	FA	0	1	0	0	0	3
Standard 2.2.2	Assessment	FA	0	1	0	0	0	2
Standard 2.2.3	Safe restraint use	FA	0	3	0	0	0	6
Standard 2.2.4	Evaluation	FA	0	2	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	FA	0	1	0	0	0	1

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

Criteria (of 21): CI:0 FA:9 PA:0 UA:0 NA: 0

3 Infection Prevention and Control

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

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

Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0

Total Standards (of 50) **N/A:** 0 **CI:** 0 **FA:** 43 **PA Neg:** 0 **PA Low:** 7 **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:** 93 **PA:** 8 **UA:** 0 **N/A:** 0

Corrective Action Requests (CAR) Report

Provider Name: Ilam Lifecare Limited
Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:17-Sep-13 End Date: 18-Sep-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.1.10	1.1.10.7	PA Low	**Finding:** Three of nine advance directive forms sighted in the resident's files were not signed by the GPs. **Action:** Provide evidence of GP sign off on advance directives as per facility policy.	6 months
1.2.3	1.2.3.6	PA Low	**Finding:** The outcomes and corrective actions identified as a result of the surveys has not been communicated to residents or families. **Action:** Provide feedback to residents and families on the outcomes of the annual resident and family surveys.	3 months
1.2.4	1.2.4.2	PA Low	**Finding:** The service did not notify Public Health of a Norovirus outbreak until after the outbreak had subsided. **Action:** Ensure that notification of any/all reportable events occurs in a timely manner.	3 months
1.3.3	1.3.3.3	PA Low	**Finding:** There is no recorded evidence of GP three monthly exemption for rest home and dementia residents. **Action:** Provide evidence of GP three monthly exemption form for rest home and dementia residents.	3 months

1.3.12	1.3.12.1	PA Low	**Finding:** There was recorded evidence of a six monthly stocktake of controlled drug Book but not the controlled drugs. **Action:** Provide evidence of mandatory stocktaking of controlled drugs.	6 months
1.3.13	1.3.13.5	PA Low	**Finding:** Visual inspection evidences decanted foods are not dated. **Action:** Provide evidence that decanted foods are dated.	6 months
1.4.2	1.4.2.1	PA Low	**Finding:** There is no recorded evidence of medical equipment and hoist checks /calibrations. Sighted a blood pressure machine in hospital wing, that was due to be checked in September 2012 and one hoist in hospital wing that had a sticker indicating check was due in March 2013. The other two hoists in the hospital wing did not have any stickers to indicate when they were last checked. One oxygen concentrator used in the hospital wing did not have a sticker to indicate when it was last checked. Sit on scales were calibrated on first day of audit. The facility manager interview confirms medical equipment and hoist require checks. **Action:** Provide evidence medical equipment and hoists are routinely checked /calibrated by authorised technician.	3 months
1.4.2	1.4.2.4	PA Low	**Finding:** Carpet in hospital lounge and hallway (by the hospital lounge) is stretched and wrinkled causing a trip hazard. **Action:** Provide evidence floor coverings are in good order and do not pose a hazard to residents, staff and visitors.	3 months

Continuous Improvement (CI) Report

Provider Name:	Ilam Lifecare Limited
Type of Audit:	Certification audit
Date(s) of Audit Report:	Start Date:17-Sep-13 End Date: 18-Sep-13
DAA:	Health and Disability Auditing New Zealand Limited
Lead Auditor:	XXXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

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

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

The code of health and disability rights is incorporated into care. Discussions with 10 caregivers (two dementia, three rest home, three serviced apartments and two hospital) identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with 11 residents (eight rest home and three hospital) and seven family members (one rest home, four dementia and two hospital) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in February 2012.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.

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

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

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

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

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

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

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

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

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated.

The Ilam Lifecare's mission statement states: To provide our residents with responsive, effective care, nursing, allied health and support services in partnership with families/whanau, carers and other relevant professional groups." The service strives to promote independence, respects the rights of residents, have open communication and to be a leader in the provision of services for the elderly. There is a policy that covers abuse and neglect and staff have completed training in November 2012.

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

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

E4.1a Four dementia unit families interviewed that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

D4.1a 10 of 10 resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified (three rest home, one rest home in serviced apartment, three hospital and three dementia.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

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

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

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

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

There are current policies and procedures for the provision of culturally safe care for Māori residents. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. Cultural safety training occurred as part of the annual in-service education programme in June 2012.

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

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

The service's philosophy focuses on residents' right to be accepted as an individual and being given the opportunity to enhance the values in their lives thereby enables residents to be individuals. This flows through into each person's care plan and could be described by 10 caregivers (two dementia, three rest home, three serviced apartments and two hospital) interviewed. During the admission process, the registered nurses along with the resident and family/whanau complete the documentation. Regular reviews are evident and the involvement of family/whanau is recorded in the resident care plan. Seven family members (one rest home, four dementia and two hospital) interviewed advised that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day.

D3.1g The service provides a culturally appropriate service by implementing the Ilam Lifecare philosophy of care.

D4.1c 10 of 10 care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

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

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

There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct and staff sign a copy of the house rules. Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment. Performance appraisals are conducted and staff receive supervision. Discussions with 11 residents (eight rest home and three hospital) identify that privacy is ensured. Discussions with 10 caregivers described how professional boundaries are maintained.

Discussions with the facility manager, the clinical manager, the quality manager, one hospital charge nurse, one rest home clinical coordinator, one enrolled nurse and a review of complaints identified no complaints of this nature.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

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

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

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

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

There is an internal audit schedule. Benchmarking of infections, wounds and falls occurs with three other facilities. Target rates are set for these areas and comparisons made and trends noted. Staff are provided with information via meetings minutes and graphs. Eleven residents (eight rest home and three hospital) and seven family members (one rest home, four dementia and two hospital) interviewed spoke very positively about the care provided.

D1.3 All approved service standards are adhered to.

D17.7c. There are implemented competencies for the care givers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

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

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

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

There is an open disclosure policy, a complaints policy, and an incident/accident policy and adverse events policy. Eleven residents (eight rest home and three hospital) and seven family members (one rest home, four dementia and two hospital) members stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur three monthly in each unit and the general manager, the facility manager, the clinical manager and the unit coordinators have an open-door policy.

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

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

D16.4b The seven family members (one rest home, four dementia and two hospital) interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.10 Informed Consent

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

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

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

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

The service provides information to residents and their family regarding informed consent. Signed informed consents include but not limited to; outings, using resident's photos, consent for treatment, and information sharing. There is opportunity for residents (who are competent) to complete advance directives and make informed decisions regarding being for resuscitation or not, sighted records and confirmed during resident, family and senior staff interviews.

D13.1 There were ten admission agreements sighted and all ten had been signed on the day of admission.

D3.1.d Discussion with family identified that the service actively involves them in decisions that affect their relatives lives.

There is one area requiring improvement around advance directives.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

There is a policy on advance directives that states resident's GP assists the resident to complete an advance directive. There are two different advanced directive forms used by the facility, sighted in the residents' files sampled. Six of nine advance directive forms sighted in the resident's files were signed by the GPs.

Finding Statement

Three of nine advance directive forms sighted in the resident's files were not signed by the GPs.

Corrective Action Required:
Provide evidence of GP sign off on advance directives as per facility policy.

Timeframe:
6 months

STANDARD 1.1.11 Advocacy And Support

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

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

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

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

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

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy training was provided in May 2013.

D4.1d; Discussion with 11 residents (eight rest home and three hospital) and seven family members (one rest home, four dementia and two hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.

D4.1e: Ten of ten resident files reviewed includes information on residents family/whanau and chosen social networks

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

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

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

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

D3.1h Discussion with the charge nurse from the hospital, clinical coordinator from the rest home, the enrolled nurse from dementia, clinical manager, 10 caregivers (three rest home, three serviced apartments, two dementia, two hospital), 11 residents (eight rest home and three hospital) and seven family members (one rest home, four dementia and two hospital) identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e Interviews with the two diversional therapists described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping, church services, family outings. Entertainers are included in the activities programme. The diversional therapists described how outings in the facility owned van are tailored to meet the interests of the residents.

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.13 Complaints Management

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

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

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

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

The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments register is maintained electronically. All corresponding documentation is maintained in a folder. The facility manager, quality manager and general manager manages the complaints process.

On review of the complaints folder there have been three complaints received for 2013. The quality manager also adds feedback from the residents and relatives survey to the complaints folder (four areas of improvement identified from these surveys). One formal complaint was received in February via the DHB from the family of a rest home resident. The letter of complaint was sent directly to the DHB who forwarded it on to the facility manager to address the areas of care and concerns documented. A full investigation was conducted and involved the clinical manager, facility manager, general manager, registered nurses and caregivers. There is evidence of correspondence to the complainants including letters, and family meetings. Advised by the facility manager that the resident was difficult to manage as a rest home resident as she displayed behaviours more aligned with requiring dementia specific care. Care issues identified by the family included communication, supervision of care, and personal hygiene of the resident. Advised by the facility manager that the resident was very upset on admission and never really settled, refused care and was aggressive and resistive when showering. The GP had been involved and medication management was discussed with family. The service has implemented corrective actions a result of the complaint and include extra caregiver hours in the evening, addition of organisation structure in all resident information packs and a call bell system for family at reception in rest home area. The

resident was transferred to another facility to receive dementia specific care. The complaint still lies with the Health and Disability commissioner. The service has provided all documentation required to the commissioner's office and they await a response. One rest home resident residing in a serviced apartment was reviewed with similar cognitive issues. The resident has been assessed as rest home level care. Behaviours include confusion, and resistance to cares. Behaviour assessment and monitoring has been conducted. The resident does not wander. A short term care plan is in place for behaviour management. The resident was referred to the Psychiatric services for the elderly in July 2013 and was seen by a psychiatrist on 3-Sept-2013. He concludes that the resident requires dementia specific care when staff are no longer able to manage the resident. Family have been involved in the referral process and subsequent review and are aware of care issues. Staff advised that they are currently able to manage the resident and are knowledgeable in regards to her behaviour management, diversional activities, and the need to not over stimulate her. The resident manages better in small groups or one to one rather than large group activities.

Complaints registers demonstrate that both verbal and written complaints are actively managed. Eleven residents (eight rest home and three hospital) and seven family members (one rest home, four dementia and two hospital) advised that they are aware of the complaints procedure and how to access forms.

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

E4.1biii. There is written information on the service philosophy, complaints process and practices particular to the Cressy dementia unit included in the information pack. There is a comprehensive information in the pack regarding restraint minimisation and behaviour management.

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

Ilam Lifecare is privately owned by a group of shareholders who employ a general manager to oversee the running of the facility. The service is managed by a facility manager (registered nurse) who has been in the role since October 2011. The facility manager has a Bachelor of Nursing and qualifications in aged care and health auditing. The service provides dementia specific, hospital and rest home care. Rest home care is provided in a rest home unit and in serviced apartments. The dementia unit is run by an enrolled nurse with oversight by the rest home clinical coordinator and clinical manager. The hospital is managed by a registered nurse (charge nurse) and the serviced apartments are coordinated by a village coordinator. The quality and risk management programme is managed by the facility manager, a quality manager and the clinical manager. The facility manager reports to the general manager who in turn reports to the shareholders board of directors. The vision for the facility is to be a leading provider of residential care services within the aged care sector. The service aims to achieve this through innovative practices and processes based on quality and sustainability. Ilam Lifecare provides care for up to 121 residents in a 20 bed rest home unit, a 20 bed dementia specific unit, a 34 bed hospital wing and in 45 serviced studio and one bedroom apartments. There is facility for married couples in the one bedroom apartments. On the days of audit there were 77 residents - 20 rest home, 20 dementia, 31 hospital and six rest home residents in serviced apartments.

The service has a current strategic plan 2013 - 2015 and a quality and risk management plan for 2013. The quality programme is managed by the facility manager and a part time quality manager with assistance from the clinical manager and staff. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table. Quality improvement activities are identified from audits, meetings, benchmarking, staff, resident and family feedback and incidents/accidents. The service holds quality and health and safety meetings, restraint and infection control meetings, management meetings, clinical management meetings, unit staff meetings, registered nurse meetings and residents and family meetings. There are clearly defined and measurable goals developed for the strategic plan and quality plan.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.2 Service Management

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

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

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

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

During a temporary absence of the facility manager, the clinical manager provides temporary facility management with support from the general manager. In the absence of any of the unit managers, the units are covered by the another unit manager or the clinical manager. The service has well developed policies and procedures at a service level and a strategic plan and quality improvement plan that are structured to provide appropriate safe quality care to people who use the service including residents that require rest home, dementia and hospital level care.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

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

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

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

The service has a quality and risk management plan for 2013 which is being implemented. There is an internal audit schedule and internal audits are completed. Key performance indicators have been developed around restraint use, infection rates, falls and wounds. Progress with the quality and risk management plan is monitored through monthly quality/health and safety meetings, and fortnightly management meetings. The quality/health and safety team meeting occurs monthly (minutes sighted for 14-Aug-2013) and discussion is held around staff incidents/accidents, hazards, training, audits, staffing reports, complaints, policy and procedures, corrective actions, survey results and maintenance. A restraint and infection control meeting is also held monthly (minutes sighted for 21-Aug-2013) to discuss restraint use, performance against key performance indicators, infection rates, trends, evaluation, audits, prevention and outbreak management. Each unit holds a two monthly staff meeting with discussion around infection control, housekeeping, general business, education, laundry, meals, residents cares, communication. Unit meeting minutes sighted for hospital - 10-Sept-2013, rest home 31-Jul-2013, dementia unit 30-July-2013. Minutes are maintained and easily available to staff. Registered nurse meetings are held two monthly (19-Aug-2013) and twice a year a combined staff meeting is held to welcome new staff and to discuss complaints and compliments. Minutes include actions to achieve compliance where relevant. Corrective actions are developed following audits, meetings, complaints, hazard identification, feedback from staff and incidents and accidents. This, together with staff training, demonstrates Ilam Lifecare's commitment to on-going quality improvement. Discussions with registered nurses, enrolled nurse and 10 caregivers (who work across the facility) confirm their involvement in the quality programme. Resident/relative meetings take place three monthly in each unit. An annual resident satisfaction survey is conducted (March 2013) and an annual family satisfaction survey is conducted (March 2013). Results of the surveys have been collated and four shortfalls have been added to the complaints register for action. The outcomes of the surveys have not been communicated to residents or families. Improvements are required in this area.

Audits for 2012 and 2013 have been completed and there is documented management around non-compliance issues identified. Finding statements and corrective actions have been actioned, completed and reported to the appropriate staff via meeting minutes, communication books and handover times.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

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

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

D5.4 The service has policies/ procedures to support service delivery and align with the residents care plans. Policies are reviewed by the facility manager, the quality manager and signed off by the general manager. The service conducts regular updates. The quality/health and safety committee is responsible for policy review.

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

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

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

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

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the registered nurse who completes the follow up. All incident/accident forms are seen by the clinical manager and the facility manager who completes any additional follow up and collates and analyses data to identify trends. Results are discussed with staff through the unit staff meetings, the fortnightly management meeting, fortnightly clinical management meetings and monthly quality/health and safety meetings .

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

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

Resident/relative meetings take place three monthly in each unit. An annual resident satisfaction survey is conducted (March 2013) and an annual family satisfaction survey is conducted (March 2013). Results of the surveys have been collated and four shortfalls have been added to the complaints register for action. The outcomes of the surveys have not been communicated to residents or families.

Finding Statement

The outcomes and corrective actions identified as a result of the surveys has not been communicated to residents or families.

Corrective Action Required:
Provide feedback to residents and families on the outcomes of the annual resident and family surveys.

Timeframe:
3 months

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:** PA Low

There is an incident accident policy which includes reporting and management of all incidents, accidents and near misses. Exception reports are completed for all incidents and accidents which are then investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at monthly quality/health and safety meetings and two monthly unit staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with the exception of a recent Norovirus outbreak. Improvements are required to the policy and procedures in this area.

There is an open disclosure policy and seven family members (one rest home, four dementia and two hospital) interviewed stated they are informed of changes in health status and incidents/accidents. Incident reports for August 2013 were reviewed and include 27 incident relating to falls with injury, falls with no injury, residents incidents and accidents, resident property. There were no medication errors for August 2013. Caregivers commence the exception reporting form, with RN assessment and care management. Each unit clinical coordinator completes follow up and ensures that all necessary actions have been documented and completed. The reports are then reviewed by the clinical manager and the facility manager. Ten exception reports were reviewed as related to two rest home residents and two dementia residents. All evidenced that family notified as appropriate, assessment and care provided by registered nurse, appropriate referrals made for acute care, wound care, GP review, further care or reassessment. Incidents are recorded in progress notes. Monthly incident/accident collation and analysis occurs with subsequent annual summary and analysis. Falls are graphed monthly. Benchmarking of falls incidents occurs with three other facilities.

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

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

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

A recent outbreak of Norovirus was confined to the rest home unit with four residents and three staff members affected. On review of outbreak data collected, it is noted that the service did not notify the Public Health office until after the outbreak. The outbreak commenced on the 4-Aug-2013 until the 12-Aug-2013. The facility manager advised the Public Health office on the 13-Aug-2013 that they had had three residents confirmed as having Norovirus. As per MOH guidelines, notification should occur as suspected cases arise. The service's policy also states that notification should occur after an outbreak and not at the beginning.

Finding Statement

The service did not notify Public Health of a Norovirus outbreak until after the outbreak had subsided.

Corrective Action Required:
Ensure that notification of any/all reportable events occurs in a timely manner.

Timeframe:
3 months

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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

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

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

The staff rostering and skill mix policy includes staffing levels, skill mix, recruitment and staff selection processes. Reference checks are conducted to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurses, general practitioners, dietitian, podiatry, and pharmacists is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eleven staff files were reviewed and included the chef, three caregivers (one from each unit), the housekeeper, the rest home clinical coordinator, one diversional therapist and one DT assistant, one enrolled nurse from dementia unit, one clinical manager and the facility manager. Advised that reference checks are completed before employment is offered as evidenced in all 11 staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Ten caregivers (three rest home, two dementia, three serviced apartments and two hospital) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. All staff (new and existing) have completed induction/orientation training. Orientation checklists evident in 11 of 11 staff files reviewed.

Discussion with the facility manager, clinical manager, quality manager, two registered nurses, one enrolled nurse, and 10 caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Ten caregivers interviewed have either completed the ACE training programme or are working towards completion. The registered nurses are able to attend external training including conferences, seminars and sessions provided by the local DHB.

Education completed for 2013 includes manual handling, dietitian and weight loss, medication management, advocacy and code of rights, open disclosure, dementia and challenging behaviours, infection control, waste management, asthma and COPD, syringe driver, CPR, bleeding and choking, chemical handling, back care. Education in 2012 included Liverpool Care Pathway, code of rights and informed consent, medications, challenging behaviours, advanced directives, cultural safety and Maori culture, CPR, infection control, syringe driver, continence, restraint, elder abuse and neglect. Fire evacuation drill last conducted 7-Aug-2013.

On review of 11 staff files, annual performance appraisals have been conducted for all 11 staff.

Annual competencies are completed for care staff with medication administration responsibilities, restraint questionnaires and infection control questionnaires. An ACE assessor is employed to the manage the programme and facilitate caregivers completing the unit standards. Self learning tools have been developed

based on policies and procedures and include documentation, infection control, death and dying. Registered nurses also complete an annual medication competency, syringe driver competency with local Hospice, and a restraint competency.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); restraint, medication, hoist, insulin administration, nebuliser and oxygen competencies. RNs complete wound competency.

E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

E4.5f There are nine caregivers in the Cressy dementia unit, seven have completed the required dementia standards, one caregiver is in the process of completing the unit standard and one is yet to start (commenced employment within the last six months). The enrolled nurse coordinator has completed a one year course 'walking in their shoes' programme.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

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

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

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

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

Staff rostering and skill mix policy is in place. Sufficient staff are rostered on to manage the care requirements of the rest home, serviced apartments, dementia and hospital unit residents. There is at least one registered nurse rostered on at any one time with another RN on-call if required. Registered nurses are rostered on 24/7 in the hospital unit and provide after hours and week end cover to the rest home, serviced apartments and dementia units. Rosters are and can be adjusted to reflect occupancy and resident acuity. The facility manager and clinical manager are responsible staff recruitment and for managing the roster. The facility manager is employed full time. The quality manager works one day per week. The clinical manager works three days per week. The hospital charge nurse, the rest home clinical coordinator and the enrolled nurse in the dementia unit work full time.

In the hospital unit there is a registered nurse rostered on every shift with seven caregivers in the morning working long and short shifts, six caregivers in the afternoon working long and short shifts, and two caregivers overnight. One of the night shift care givers provides assistance to service apartment residents as required.

In the rest home there is a team leader (senior caregiver), plus one other short shift caregiver in the morning, one team leader and one caregiver in the afternoon and one caregiver on overnight.

In the dementia unit there is an enrolled nurse or team leader on duty and two caregivers in the morning, three caregivers in the afternoon working long and short shifts and one team leader overnight.

There is diversional therapist or diversional therapist assistant rostered on in each unit Monday to Friday and a designated caregiver facilitates activities in the dementia unit in the weekends. Bureau staff are occasionally used (RN's) and there is an emergency procedures manual and a manual for Bureau staff. All bureau staff receive an orientation to the facility.

Other staff include maintenance, laundry staff, housekeeping staff, receptionist, hairdresser and village coordinator.

Interviews with 10 caregivers (two dementia, three rest home, three serviced apartments and two hospital), 11 residents (eight rest home and three hospital) and seven family members (one rest home, four dementia and two hospital) identify that staffing is adequate to meet the needs of residents.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

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

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

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

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

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being stored securely in the three nurse’s stations. Informed

consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.1 Entry To Services

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

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

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

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

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

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

Ten of ten residents' files (three hospital, three dementia and four rest home including one resident in the serviced apartments) were sampled. All residents' admission agreements sampled evidence residents' and facility representative sign off.

The facility manager interview confirms access and entry processes are followed. There is a facility information pack available for resident and their family. Resident information pack was sighted and contains all relevant information. Information packs are also available on line via the facility's website.

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

Interview with 11 of 11 residents (eight rest home and three hospital) and seven of seven family members (one rest home, two hospital and four dementia) confirm the admission process was conducted by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.

Admission audit was completed in July 2013 with 100% compliance.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

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

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

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

E3.1 Three of three resident files reviewed and all three include a needs assessment as requiring specialist dementia care.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.2 Declining Referral/Entry To Services

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

ARHSS D4.2

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

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

Systems to decline resident entry to the service are documented. The scope of the service provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the facility manager. The facility manager states resident will be declined entry if not within the scope of the service or if a bed is not available at the time. The facility manager states the resident will be referred back to the NASC service. Advised that no residents have been declined admission since facility manager commenced employment October 2011.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.3 Service Provision Requirements

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

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

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

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

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

Thirteen of 13 clinical staff (two RNs (one hospital and one rest home), one EN (dementia), eight health care assistants and one team leader (rest home) and one village co-ordinator) interviews confirm residents and/or family members are involved in all stages of service provision.

Eleven of 11 resident (eight rest home and three hospital) interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews.

Ten of 10 residents' files (four rest home, three hospital and three dementia) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations.

Family communication sheets are maintained, sighted in all 10 residents' files reviewed.

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

The auditor evidenced verbal briefing from am to pm shift.

GP interview was conducted and confirms staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff.

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

D16.2, 3, 4: Ten resident files reviewed, identify that in all files reviewed for residents admitted within last three years an assessment was completed within 24 hours and identify that the long term care plan was completed within three weeks of admission. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. All ten care plans evidence evaluations are completed at least six monthly.

D16.5e: Resident files reviewed identified that the GP had seen the resident within two working days. There is no recorded evidence for rest home and dementia residents' files reviewed that the GP has assessed the resident as stable and is to be seen three monthly.

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); continence, pain, falls and skin assessments. There is one area requiring improvement around GP assessments of resident as stable and clinical reviews to be conducted three monthly.

Tracer Methodology Rest Home;

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

Tracer Methodology Hospital.

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

Dementia Tracer Methodology

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

D16.2, 3, 4: Ten resident files reviewed, identify that in all files reviewed for residents admitted within last three years an assessment was completed within 24 hours and identify that the long term care plan was completed within three weeks of admission. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. All ten care plans evidence evaluations are completed at least six monthly.

D16.5e: Resident files reviewed identified that the GP had seen the resident within two working days. There is no recorded evidence for rest home and dementia residents' files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. Hospital residents are reassessed by the GP monthly, sighted in the hospital resident's files reviewed. Rest home and dementia residents are clinically assessed three monthly, however there is no evidence of GPs exemption form to indicate the rest home and the dementia residents are stable and able to be reviewed three monthly, as per ARC contract.

Finding Statement

There is no recorded evidence of GP three monthly exemption for rest home and dementia residents.

Corrective Action Required:
Provide evidence of GP three monthly exemption form for rest home and dementia residents.

Timeframe:
3 months

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.4 Assessment

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

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

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

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

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

Residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider (NASC) assessments are available. The facility has appropriate resources and equipment. The RN / clinical co-ordinator (rest home) and RN / charge nurse (hospital) and EN (dementia) interviews confirm that assessments are conducted in a safe and appropriate setting including visits from the doctor.

Eleven of 11 residents interviewed confirm their involvement in their assessments, care planning, review, treatment and evaluations of care.

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

Related ARC requirements are met.

E4.2; Three of three resident files reviewed include an individual assessment identifying diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed for dementia residents, sighted in three of three files sampled.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.5 Planning

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

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

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

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

The residents' files sampled evidence residents' care plans are individualised and up-to-date. The long-term and short-term goals are identified by the residents and service providers and reviewed at regular intervals, at least 6 monthly or as needs change. Residents have input into their care planning and review, confirmed at all 11 resident interviews.

Thirteen of 13 clinical staff interviewed confirm that care plans are accurate and up to date.

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

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

Care plan audit was conducted in September with 100% compliance.

E4.3 Three of three resident files reviewed identify current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, Short term care plans are in use for changes in health status.

D16.3f; All 10 resident files reviewed identify that family are involved.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.6 Service Delivery/Interventions

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

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

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

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

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

Residents' files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. GPs documentation and records are current.

Eleven of 11 residents and seven of seven family interviewed confirm their and their relatives current care and treatments they are receiving meet their needs. Family communication sheets record family communications, sighted in all residents' files sampled.

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

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for six residents (four hospital and two rest home). Wound management audit was conducted in January 2013 with 100% compliance.

The Registered Nurses interviewed describe the referral process and related form should they require assistance from a wound specialist or continence nurse.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.7 Planned Activities

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

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

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

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

There is one qualified diversional therapist (DT) for the activities service, who is employed Monday to Friday and oversees the activities program for the facility. There are three DT assistants (two part time and one full time). There is an activities programme for each area; hospital, rest home and dementia unit. Interview with the diversional therapist (DT) and two DT assistants was conducted.

The rest home and hospital activities programme is provided Monday to Friday and the dementia unit programme is provided seven days a week. DT staff confirm the weekend activities programme is run by the team leader in the dementia unit and residents' attendance /participation is recorded.

The DT staff confirm the activities programme meets the needs of the service group and the service has appropriate equipment. Activities attendance records are maintained and were sighted for all three areas.

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

Residents' three monthly meeting minutes were sighted for February, May and August 2013. Each area conducts separate residents' meetings. Family members are invited to all meetings, confirmed at DT staff interview.

There is a library / computer room, that residents use, sighted.

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

Diversional /quality of life programme and care plan documentation audit was conducted in March and June 2013 and corrective actions are addressed. Eleven of 11 residents and seven of seven family interviewed confirm residents' and their family members' past activities are considered and there is a choice to participate in activities.

Relative and resident survey was conducted in March 2013 and indicates the activities programme at 88.37 %. Residents and family newsletter sighted for March and August 2013.

D16.5d and D16.5c.iii; Resident files reviewed identify that the resident's activity plan is reviewed at care plan review.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

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

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

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

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

Residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes.

Evaluations are conducted by the RN with input from the resident, family, health care assistants, diversional therapist and GPs.

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

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

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

Related ARC requirements D16.3c and D16.3d are met.

Relative and resident survey was conducted in March 2013 and indicates consultation of relatives changes in condition at 90.70%.

D16.4a ; Residents' are plans are evaluated six monthly or more frequently when clinically indicated.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

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

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

Residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. Residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented. Related ARC requirements (D16.4d; D20.4) are met.

D16.4c; The service provide an example of where a resident's condition changed and the resident was reassessed for a higher level of care.

D 20.1 Discussions with registered nurses identifies that the service has access to NASC; district nursing; laboratory services; radiology services; specialist medical services and podiatry services.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

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

ARC D21 ARHSS D21

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

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

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

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

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

The three medication areas in the facility, evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug storages in the facility are secure. The controlled drug registers are maintained and evidences weekly checks, however six monthly physical stock takes have not been conducted, this identified as requiring improvement.

Medication fridge temperatures are conducted and recorded.

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

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

There are 28 staff competent to administer medicines (seven RNs, two ENs and 19 health care assistants). All staff authorised to administer medicines have current competencies, sighted in staff files sampled and on the staff competency register. Additional staff competencies are conducted and these include; insulin administration; oxygen administration; nebuliser use, sighted on competency registers.

Staff education in medicine management was conducted in April 2013.

Thirty medicine charts were sampled (10 rest home, 10 hospital and 10 dementia). All 30 charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs.

There are no residents who self-administer medicines.

Sighted medication audit result for March 2013 indicated 100% compliance and in June 2013 with 100% compliance;

Medication errors sighted for April (x3), May (x3), June (nil); July (x1); August (Nil).

Related ARC D1.1g; D15.3c; D18.2; D19.2d requirements are met.

D16.5.e.i.2; Thirty medication charts reviewed identify that the GP has reviewed the resident's medication charts 3 monthly and the medication chart was signed.

There is one area requiring improvement around stocktaking of controlled drugs.

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

Audit Evidence

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

The three medication areas in the facility, evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Medication fridge temperatures are conducted and recorded. The controlled drug storages in the facility are secure. The controlled drug registers are maintained and evidences weekly checks, however six monthly physical stock takes have not been conducted, Six monthly CD reconciliation audit was conducted in June 2013 with 100% compliance. This audit was conducted by the quality manager and included checking of the CD register only, no CD medicines were checked during this audit. The CD registers (one in rest home, one in hospital and one in dementia unit) all record this was conducted in June 2013, and entry records "6 monthly check", however there is no signature entry of the staff member performing this audit. The facility manager interview confirms the CD registers were checked, however the counting and measuring of stock was not conducted during this audit. Interview was conducted with the contracted pharmacist and discussion was held in respect of the six monthly CD stocktakes.

Finding Statement

There was recorded evidence of a six monthly stocktake of controlled drug Book but not the controlled drugs.

Corrective Action Required:
Provide evidence of mandatory stocktaking of controlled drugs.

Timeframe:
6 months

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

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

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

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

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

The menu was last reviewed by a dietitian in July 2012.

The chef interview confirms awareness of residents who have been identified with weight loss and the resident's individual dietary needs.

Residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review. There are current copies of residents' dietary profiles in the kitchen. Kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the chef.

Food safety training for kitchen staff have been conducted.

Additional snacks are available for residents when the kitchen is closed. Residents are offered fluids throughout the day.

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

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

Food temperatures are recorded, sighted. Fridge, chiller and freezer temperatures are recorded, sighted.

Kitchen services audit was conducted in January 2013, with 100% compliance. Food services (kitchen) environmental audit was conducted in July 2013 and corrective action addressed.

Relative and resident survey was conducted in March 2013 and indicates the meal service at 95.35%.

ARC requirements D1.1a; D15.2b; D19.2c are met.

E3.3f, : There is evidence that there is additional nutritious snacks available over 24 hours.

There is one area requiring improvement around dating of decanted foods.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Food temperatures are recorded, sighted. Fridge, chiller and freezer temperatures are recorded, sighted. Kitchen services audit was conducted in January 2013, with 100% compliance. Food services (kitchen) environmental audit was conducted in July 2013 and corrective action addressed. Visual inspection evidences decanted foods are not dated.

Finding Statement

Visual inspection evidences decanted foods are not dated.

Corrective Action Required:
Provide evidence that decanted foods are dated.

Timeframe:
6 months

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

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

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

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

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

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

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

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

Documented processes for the management of waste and hazardous substances are in place.

Chemical container labels are in line with legislation; are clear, accessible to read and are free from damage. Material safety data sheets are available and accessible for staff. Hazard Register is current, sighted.

Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and chemical safety at orientation and on-going education. Last education session on waste and hazardous substances was conducted in June 2013 and chemical safety training was provided in September 2012.

Protective clothing and equipment is appropriate to the risks associated with waste or hazardous substance being handled. For example; goggles/visors, gloves, aprons, footwear, and masks viewed in sluice rooms. Sluice facilities are available for the disposal of waste and hazardous substances. Protective clothing / equipment was sighted to be used by service providers.

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:** PA Low

There is a current Building Warrant of Fitness (WoF) displayed that expires on 1st September 2014. Two lifts at the facility have current certificates conducted in June 2013.

Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.

Interview with the maintenance person confirms there is a maintenance programme in place. Preventative and reactive maintenance systems are in place and reviewed along with evidence of electrical testing and tagging stickers in place on electrical equipment.

There is safe storage of medical equipment. Corridors allow residents to pass each other safely, equipment does not clutter passageways.

Floor surfaces/coverings are appropriate to the resident group and setting and are maintained in good order, except for carpet in upstairs hospital lounge and adjoining hallway, which is stretched and this is identified as requiring improvement. The facility manager states new carpet has been ordered and is being replaced in five weeks' time. There have been no incidents reported in respect of the stretched carpet.

Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

There are external areas and gardens that the residents and family may utilise. A separate secure external area and gardens are provided for dementia residents. Residents are protected from risks associated with being outside, e.g.: safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade, and ensuring a safe area is available for recreation or evacuation purposes.

Clinical staff interviewed confirm that they have access to appropriate equipment, and they are competent to use the equipment.

There is no recorded evidence that medical equipment and hoists have been checked/ calibrated and this requires an improvement.

Vehicle audit was conducted in February 2013 with 100% compliance.

Safe and appropriate environment audit was conducted in April 2013 with corrective actions addressed.

Resident and relative survey was conducted in March 2013 and indicates the environment is at 100%.

ARC requirements section D:service specifications-General are met.

E3.2 and E3.4a are met.

E3.4d; The lounge area is designed so that space and seating arrangements provide for individual and group activities.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; There is a safe and secure outside area that is easy to access.

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

Audit Evidence

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

There is a current Building Warrant of Fitness (WoF) displayed that expires on 1st September 2014. Two lifts at the facility have current certificates conducted in June 2013.

Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.

Interview with the maintenance person confirms there is a maintenance programme in place. Preventative and reactive maintenance systems are in place and reviewed along with evidence of electrical testing and tagging stickers in place on electrical equipment.

Finding Statement

There is no recorded evidence of medical equipment and hoist checks /calibrations. Sighted a blood pressure machine in hospital wing, that was due to be checked in September 2012 and one hoist in hospital wing that had a sticker indicating check was due in March 2013. The other two hoists in the hospital wing did not have any stickers to indicate when they were last checked. One oxygen concentrator used in the hospital wing did not have a sticker to indicate when it was last checked. Sit on scales were calibrated on first day of audit. The facility manager interview confirms medical equipment and hoist require checks.

Corrective Action Required:
Provide evidence medical equipment and hoists are routinely checked /calibrated by authorised technician.

Timeframe:
3 months

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

Floor surfaces/coverings are appropriate to the resident group and setting and are maintained in good order, except for carpet in upstairs hospital lounge and adjoining hallway. Carpet in hospital lounge and hallway (by the hospital lounge) is stretched and wrinkled causing a trip hazard. The facility manager and the quality manager state this has been discussed at quality meetings (sighted in meeting minutes) and corrective action around this is in progress. There have been no incidents around this hazard. The facility manager states new carpet has been ordered and is being replaced in five weeks' time. There have been no incidents reported in respect of the stretched carpet.

Finding Statement

Carpet in hospital lounge and hallway (by the hospital lounge) is stretched and wrinkled causing a trip hazard.

Corrective Action Required:
Provide evidence floor coverings are in good order and do not pose a hazard to residents, staff and visitors.

Timeframe:
3 months

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 residents' bedrooms are of single occupancy. Rest home and hospital bedrooms all have full ensuite facilities and the dementia unit bedrooms all have toilet ensuites. There are adequate number of communal toilet and shower facilities.

Toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and washbasin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. There is also a safe locking system that provides for privacy, but allows service providers access in the case of emergency. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Hot water temperatures are monitored monthly and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).

ARC E3.3d requirement is met, as dementia residents at this facility have separate living, dining, bathing, toilet and outdoor areas from other residents receiving other services at the facility.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.4 Personal Space/Bed Areas

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

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

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

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

All bedrooms are of single occupancy. The bedrooms have adequate space for personal possessions and furniture and allow residents and staff to move around within the room safely.

ARC E3.3b and E3.3c requirements do not apply, as there are no dementia residents sharing a room.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

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

ARC E3.4b ARHSS D15.3d

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

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

There is adequate access provided to communal lounges and dining rooms. Residents observed moving freely within these areas. The facility has a library / computer room, salon and a shop. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in these activities. Activities were sighted to be conducted in an activities room, located downstairs for rest home and studio apartments.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.6 Cleaning And Laundry Services

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

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

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

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

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

All linen is washed on site in the laundry and there is adequate dirty / clean flow. One laundry staff member interviewed and describes management of laundry including transportation, sorting, storage, laundering, and return to residents. Three cleaning staff members interviewed (two cleaners and one housekeeper) confirm awareness of cleaning and infection control practices and following the planned cleaning schedules.

The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning reviewed. Housekeeping audit was conducted in March 2013 with 100% compliance and in May 2013 with corrective actions addressed. Laundry audit was conducted in May 2013 with corrective actions addressed. Combined laundry and cleaning audit was conducted in May 2013 with 100% compliance. Ecolab also conduct monthly audits of these services.

Safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets are available; appropriate facilities exist for the disposal of soiled water/waste - i.e. sluice room/facilities; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Residents interviewed state they are satisfied with the cleaning and laundry service. Resident and relative survey was conducted in March 2013 and indicates the laundry service results are at 95.35%.

ARC D15.2c, D15.2d and D19.2e requirements are met.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.7 Essential, Emergency, And Security Systems

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

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

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

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

The service has an emergency manual. There is currently a trained person with a first aid certificate on each shift. Ilam Lifecare has a NZFS approved fire evacuation scheme, dated 11-Oct-2005. A call bell light alerts staff to the area in which residents require assistance and each care staff member wears a pager. A call bell panel is visible in each corridor. There is one main entrance in to the facility at reception, one at the side of the dementia unit and one at the side of the down stairs serviced apartment area. Visitors and contractors must sign in before entering the facility. Fire drill last conducted in 7-Aug-2013. Civil defence kits are stocked and available in each unit and are checked three monthly. Water is stored - sufficient for at least three days. Alternative heating and cooking facilities are available. Call bell system evident and in use in the resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure and a security company is contracted to conduct twice nightly checks. Emergency manual includes fire and evacuation procedures, civil defence emergencies, a disaster plan including food and supplies, earthquake response, bomb threat, civil defence kits, resident lists, and missing resident procedures. All registered nurses and some caregivers have current first aid and CPR certificates.

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.8 Natural Light, Ventilation, And Heating

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

ARC D15.2f ARHSS D15.2g

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

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

Documentation and visual inspection provides evidence that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

The service is responsive to resident and family feedback in relation to heating and ventilation. Relative and resident survey was conducted in March 2013 and indicates the temperature of the facility results are at 88.37%. Room temperatures are monitored monthly by the maintenance person, sighted. Residents interviewed confirm the facilities are maintained at an appropriate temperature.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service currently has five hospital residents assessed as requiring the use of restraint - four with bed rails and one with bed rails and a lap belt. There are no enablers. The restraint management plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessments are completed as required. Policy dictates that enablers should be voluntary and the least restrictive option possible and the registered nurses, care givers and clinical manager are familiar with this. The clinical manager is the service's restraint coordinator. The service is actively reducing the number of residents on restraint - down from 25 residents in 2012 to five residents in 2013. All restraint in use is for falls prevention.

Staff received training around restraint minimisation and the management of challenging behaviours in October 2013. Restraint questionnaires are completed for all care givers and registered nurses complete a restraint competency. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 2.2 SAFE RESTRAINT PRACTICE

Consumers receive services in a safe manner.

STANDARD 2.2.1 Restraint approval and processes

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

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

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

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

Responsibilities and accountabilities for restraint are outlined in the restraint policy that includes responsibilities for key staff. The restraint co-ordinator (clinical manager) was able to describe the role and responsibilities. Approval for each form of restraint is reviewed at a frequency as determined by organisational Restraint Minimisation policy and resident safety. Three hospital resident files were reviewed - two with bed rails and one with bed rails and a lap belt. All three files reviewed evidenced consent forms completed appropriately. Restraint discussion is conducted at fortnightly registered nurse meetings, at unit staff meetings and at restraint/infection control monthly meetings (restraint approval group). Restraint use is reviewed at resident level as part of care plan review (or more often as needed).

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.2 Assessment

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

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

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

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

The restraint minimisation and safe practice policy outlines the service's approach to managing restraint. The policy includes the steps for assessment and use of restraint, role of the restraint coordinator, involvement of family and GP, risk assessment, the need to attempt to modify behaviour prior to the use of restraint, resident advance directives, previous tolerance of restraint application, resident medical and social history, cultural considerations, alternatives to restraint use and the goals of the restraint intervention. Three restraint files reviewed all documented that an in-depth assessment had taken place which included the consideration of alternatives. Family/whanau input and consent is required prior to the application of any forms of restraint at Ilam Lifecare.

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

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

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

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

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

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

(f) Maintaining culturally safe practice;

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

(h) Possible alternative intervention/strategies.

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.3 Safe Restraint Use

Services use restraint safely

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

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

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

Restraint policy states that the need for restraint use is monitored and reviewed as part of the care plan reviews and multi-disciplinary team meetings. This is well documented on three restraint files reviewed. Bed rails are monitored two hourly overnight and the lap belt for one resident is monitored hourly. Monitoring signing sheets on the three files were reviewed. The service reviews all restraint use as part of the individual resident medical review, monthly as part of restraint approval group meetings (restraint/infection control) and at RN and clinical meetings and unit staff meetings. Restraint is only used at Ilam Lifecare as a last resort after all other alternative techniques to modify behaviour or manage resident safety has been exhausted. Advised that all restraints currently in use is for safety measures to prevent falls. This is outlined as policy requirements in the restraint minimisation and safe practice policy. The policy requires that a restraint register is maintained with all residents' names and restraint details included. The restraint register is maintained and updated by the restraint coordinator (clinical manager) as required. Staff training records are maintained and individual participation in restraint training is identified. Restraint questionnaire and competencies are completed by all care staff and registered nurses.

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

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

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

(d) The outcome of the restraint;

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.4 Evaluation

Services evaluate all episodes of restraint.

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

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

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

The use of restraining devices is evaluated by the restraint coordinator (clinical manager) and registered nurses as part of the care planning review process in conjunction with the resident, their family/whanau and GP. Points a) to k) in 2.2.4.1 are considered as part of this review. On review of three residents files with restraint, all have been reviewed three monthly as per policy. Restraint use is discussed at the registered nurse meetings, clinical meetings, and monthly restraint approval group meetings (restraint/infection control management meeting).

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

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

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

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

(d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.5 Restraint Monitoring and Quality Review

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

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

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

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

Ilam Lifecare reviews the use of restraint as part of its internal audit processes (last audit November 2012). The results of the restraint audit are discussed at the registered nurses meeting, clinical management meeting, quality/health and safety meetings, restraint/infection control meeting, and unit staff meetings. Any corrective actions identified are actioned through these forums. The restraint approval group sets annual goals for the service in relation to restraint minimisation - a) to be restraint free and b) provide education and competency for staff on restraint minimisation

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

STANDARD 3.1 Infection control management

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

ARC D5.4e ARHSS D5.4e

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

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

Ilam Lifecare has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical manager is the infection control nurse. There is a restraint/infection control meeting which meets monthly and includes discussion and reporting of infection control matters and consequent review of the programme. Documented annual review of the programme was conducted in July 2013. Infection rates are part of the organisations key performance indicators for 2013 which includes target rates for over all infections and urinary tract infections. Minutes of restraint/IC meetings are available for staff. Graphs and trends are posted in staff room notice board. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff.

The service had a small outbreak of Norovirus in August 2013. It was contained to the rest home unit. Four residents and three staff were involved in the outbreak with three confirmed cases of Norovirus. Assistance and support was obtained from the local laboratory infection control expert, the unit restricted visitors, cleaning processes were increased and the outbreak was contained. The facility manager notified Public Health after the event (link #1.2.4).

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

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

ARC D5.4e ARHSS D5.4e

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

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

The clinical manager at Ilam Lifecare is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains her practice by attending annual infection control updates (last attended an infection control seminar in 2012 and has attended a session on management of urinary tract infections in June 2013. The IC nurse and IC team (comprising a cross section of staff) has good external support from the local laboratory infection control team and IC nurse consultant. The infection control team is representative of the facility.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.3 Policies and procedures

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

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

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

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

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

D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The facility has purchased Bug control policies alongside their own suite of infection prevention and control policies. Last review conducted July 2013 following infection control programme review. Ilam Lifecare's infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; outbreak management; cleaning, disinfecting and sterilising; single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.4 Education

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse with expert support from external providers who provide the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. The IC nurse attends training annually - last session in June 2013. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Education for staff was provided in June 2013. One resident has an MRSA wound infection. Advise and support has been provided for the management of the infection and includes information for staff in the resident's files around prevention of transmission and wound care.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.5 Surveillance

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

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

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

Infection surveillance is an integral part of the infection control programme and is described in Ilam Lifecare's infection control surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. Each unit collects data for the month which is then collated and evaluated monthly and annually. Outcomes and actions are discussed at the monthly restraint/infection control management meetings, registered nurses, clinical

management and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager, clinical manager and unit coordinators.

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: