**Ripponburn Holdings Limited**

**Current Status:** **26-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**

Ripponburn Home and Hospital provides residential care for up to 46 residents who require hospital level care, and rest home level care. Occupancy on the day of the audit was at 45. The facility is operated by Ripponburn Holdings Limited and is a family business. Residents and family interviewed report the care provided is of a high standard. Staffing is stable with minimal turnover, and hours are increased if required to meet the needs of residents.

**Audit Summary AS AT** **26-Sep-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  26-Sep-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit  26-Sep-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  26-Sep-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Standards applicable to this service fully attained** |

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| **Safe and Appropriate Environment** | Day of Audit  26-Sep-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  26-Sep-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  26-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** **26-Sep-13**

**Consumer Rights**

Residents and family interviewed report that services are provided in a manner that is respectful of their rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs. Residents and family interviewed state they are happy with the service provided and report that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and of any significant change in the resident's condition. Visual inspection provides evidence the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is readily displayed along with complaint forms.

During interviews, staff demonstrate an understanding of informed consent and informed consent processes. Residents and family interviewed confirm they have been made aware of and understand the informed consent processes and confirm that appropriate information is provided. The general/facility manager is responsible for complaints and a complaints register is maintained. Residents can use the complaints forms or bring issues up at the residents' meetings.

**Organisational Management**

Ripponburn Holdings Limited is the governing body and is responsible for the service provided at Ripponburn Home and Hospital. Quality and risk management systems are fully implemented and embedded at Ripponburn Home and Hospital, and documented scope, direction, goals, vision, and mission statement reviewed. Systems are in place for monitoring the service provided at Ripponburn Home and Hospital. The general/facility manager owns Ripponburn Home and Hospital with other family members, and is a very experienced registered nurse who has worked in the aged-care sector for the past 25 years, and has been in their current position for 21 years. The general/facility manager is supported by an experienced nurse manager who was appointed to their current position in 2004. The general/facility manager and nurse manager have current annual practising certificates.

A 'Quality Policy', a 'Quality Improvement and Risk Management Plan' and 'Quality Audit Schedule' are used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Review of quality improvement data provides evidence the data is being collected, collated, analysed for trends, and is reported to the quality improvement committee, the annual general meeting, as well as to staff via various meetings. Quality improvement meetings, registered nurses meetings, carers meetings, support staff meetings, and residents meetings, are held two monthly. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Copies of meeting minutes are available for staff to review in the nurses' stations.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RN), pharmacist, physiotherapist, occupational therapist and general practitioners (GPs) is occurring. There is evidence available indicating an inservice education programme is provided for staff including the provision of inservice education sessions at least twice a month. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the ACE education programme, and on line learning. Review of staff records evidences human resource processes are followed e.g. reference checking, criminal vetting, interview questionnaires are completed, and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one registered nurse and two carers. The general/facility manager and the nurse manager are on call after hours. All care staff interviewed report there is adequate staff available and that they are able to get through their work.

Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

**Continuum of Service Delivery**

Entry criteria is identified in the information pack, that is given to new and potential residents that enter the service. The service provides care to residents who either require hospital or rest home levels of care.

Each stage of service provision is undertaken by suitably qualified and experienced staff members who are competent to perform the function. Care plans are completed by the RN's. The service employs an occupational therapist who completes assessments which focus on strengthening residents' current abilities and rehabilitation. Where needed the physiotherapist completes assessments for manual handling and the resident's mobility abilities. Each stage of service provision is provided within the timeframes that safely meet the needs of the residents. The needs, outcomes and goals of the residents are identified through assessment processes and are documented to service as the basis for the long term care plan. Residents' long term care plans are focussed on their needs, integrated and promote continuity of service delivery.

Activities are planned and facilitated to develop and maintain the skills and strengths of residents, sighted seven diversional care plans. The diversional therapist prepares a weekly programme for the hospital and the rest home, a regular activities programme for residents and family members, and special activities for the month which residents and their families can participate in.

Residents are given choices and are advised of options to access other health and disability services where requested or when needed. Risks associated with resident transition, exit, discharge or transfers are identified through assessment processes, documented and minimised.

The service has a medicines management system implemented to manage safe and appropriate dispensing, administration, review, storage, disposal and reconciliation of medicines. Staff members who are responsible for medicines management and administration complete competencies to ensure safe and appropriate practice. Self-administration of medicines is included in the medicines management policy, however there are no resident currently self-administering medicines. All the medicine charts reviewed show timely reviews by the GP, entries are signed and dated, discontinued medicines are signed off and dated, all charts have photo identification, allergies and sensitivities are recorded and entries are legible.

Residents' food preferences and their individual food, fluid and nutritional needs are met. Residents who have additional or modified nutritional needs have their needs met.

All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislative requirements and guidelines.

**Safe and Appropriate Environment**

Bedrooms provide double and single accommodation and all bedrooms have hand basins. One of the hospital bedrooms and two of the rest home bedrooms each have an ensuite. There is an adequate number of communal toilet and shower facilities. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as a carer. There are four lounges and two dining areas available. External areas are available for sitting and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and protective equipment and clothing is provided and is used by staff. Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site in a laundry with separate clean and dirty areas. Cleaning and laundry systems include appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. Visual inspection provides evidence of compliance regarding safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals.

**Restraint Minimisation and Safe Practice**

The responsibility for the restraint process is clearly defined with lines of accountability for restraint use.

The assessments of residents who may need to use restraint includes risk assessments, considering the possible reasons for relevant behaviour that may lead to residents having to use restraint and reviewing restraints and the need for on-going restraint use. Assessments and review include cultural considerations and the service consider alternative intervention or strategies to restraint.

Each episode of restraint is documented and includes the date, the time, the type of restraint, the duration of the restraint, the outcome and observations made during the period of restraint. Episodes of restraint is evaluated in collaboration with the resident and their family. The service currently have five restraints and three enablers in place. The service regularly review restraints and restraint practices. The multi-disciplinary team review occurs three monthly or when required.

**Infection Prevention and Control**

The facility is managed to minimise the risk of infection to residents, staff members and visitors. There is a sign on the front entry to the facility reminding people who suffer from infections to please refrain from contact with residents due to their susceptibility.

The responsibility for infection control is assigned to the infection control coordinator, a registered nurse, who has a specific position description guiding the role.

The infection control committee comprises of the infection control coordinator and the nurse manager with the expectation that all staff will contribute to infection control and prevention. The infection control committee reports to the quality committee every two months.

Infection surveillance includes completing a monthly infection control register with the name of the resident, the type of infection and the organism. The statistics also include a summary of the type of infections, the number of the infections, the organisms, the number of infections from a specific organism, whether the infection was resolved or if it is still on-going.

The service has written policies and procedures for the prevention and control of infection which comply with the relevant legislation and accepted good practice. Infection control training for staff members occurs throughout the year.

Ripponburn Home & Hospital

Ripponburn Holdings Limited

Certification audit - Audit Report

Audit Date: 26-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Ripponburn Holdings Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Ripponburn Home & Hospital | 94 Kawarau Gorge Road, RD 2 |  | Cromwell |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 26-Sep-13 **End Date:** 27-Sep-13 |
| **Designated Auditing Agency** | Health Audit (NZ) Limited |

# Audit Team

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| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | RN, BN, Lead Auditor | 12.00 | 8.00 | 26-Sep 13 to 27 Sep-13 |
| Auditor 1 | XXXXXXXX | RN, LA, RABQSA | 12.00 | 4.00 | 26- Sept-13 to 27-Sept-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX | RN, Lead Auditor, BHSc |  | 2.00 | 05-Oct-13 |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 24.00 | **Total Audit Hours off site** *(system generated)* | 14.00 | **Total Audit Hours** | 38.00 |
| **Staff Records Reviewed** | 8 of 60 | **Client Records Reviewed** *(numeric)* | 7 of 45 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 7 |
| **Staff Interviewed** | 14 of 60 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 5 |
| **Consumers Interviewed** | 5 of 45 | **Number of Medication Records Reviewed** | 14 of 45 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 04 day of October 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

# Services and Capacity

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ripponburn Home & Hospital | 46 | 45 | 0 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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1.1 Consumer Rights

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All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislative requirements and guidelines.

1.4 Safe and Appropriate Environment

Bedrooms provide double and single accommodation and all bedrooms have hand basins. One of the hospital bedrooms and two of the rest home bedrooms each have an ensuite. There is an adequate number of communal toilet and shower facilities. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as a carer. There are four lounges and two dining areas available. External areas are available for sitting and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and protective equipment and clothing is provided and is used by staff. Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site in a laundry with separate clean and dirty areas. Cleaning and laundry systems include appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. Visual inspection provides evidence of compliance regarding safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals.

2 Restraint Minimisation and Safe Practice

The responsibility for the restraint process is clearly defined with lines of accountability for restraint use.

The assessments of residents who may need to use restraint includes risk assessments, considering the possible reasons for relevant behaviour that may lead to residents having to use restraint and reviewing restraints and the need for on-going restraint use. Assessments and review include cultural considerations and the service consider alternative intervention or strategies to restraint.

Each episode of restraint is documented and includes the date, the time, the type of restraint, the duration of the restraint, the outcome and observations made during the period of restraint. Episodes of restraint is evaluated in collaboration with the resident and their family. The service currently have five restraints and three enablers in place. The service regularly review restraints and restraint practices. The multi-disciplinary team review occurs three monthly or when required.

3. Infection Prevention and Control

The facility is managed to minimise the risk of infection to residents, staff members and visitors. There is a sign on the front entry to the facility reminding people who suffer from infections to please refrain from contact with residents due to their susceptibility.

The responsibility for infection control is assigned to the infection control coordinator, a registered nurse, who has a specific position description guiding the role.

The infection control committee comprises of the infection control coordinator and the nurse manager with the expectation that all staff will contribute to infection control and prevention. The infection control committee reports to the quality committee every two months.

Infection surveillance includes completing a monthly infection control register with the name of the resident, the type of infection and the organism. The statistics also include a summary of the type of infections, the number of the infections, the organisms, the number of infections from a specific organism, whether the infection was resolved or if it is still on-going.

The service has written policies and procedures for the prevention and control of infection which comply with the relevant legislation and accepted good practice. Infection control training for staff members occurs throughout the year.

Summary of Attainment

* 1. Consumer Rights

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

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

* 1. Organisational Management

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

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

* 1. Continuum of Service Delivery

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

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

* 1. Safe and Appropriate Environment

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

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

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 50 **PA Neg:** 0 **PA Low:** 0 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 101 **PA:** 0 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Ripponburn Holdings Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:26-Sep-13 End Date: 27-Sep-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXX

# Continuous Improvement (CI) Report

Provider Name: Ripponburn Holdings Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:26-Sep-13 End Date: 27-Sep-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

Seven of seven care staff (four carers - two working morning shifts and two working afternoon shifts - working all areas; three registered nurses - two working morning shifts and one working afternoon shifts), the general/facility manager/registered nurse, and the nurse manager demonstrate a knowledge of the Code of Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. All care staff interviewed confirm they have received recent education on the Code. Review of education records and staff files (eight) evidences education provided on the 6 September 2013.

Visual observations during the audit indicates staff are respectful of residents and incorporate the principals of the Code in their practice. Staff observed knocking before entering resident's bedrooms, and making sure curtains are pulled across in the double bedrooms.

Residents interviewed (two rest home, three hospital), and family members (two rest home, three hospital) confirm that staff respect their and their relatives rights and could recall receiving a copy of the Code.

Relative/resident satisfaction survey was completed in July-August 2013 and collated results indicate residents and their family are very satisfied with the amount of involvement in decisions affecting their care, their privacy is respected and staff treat them with dignity and respect.

Copies of the Code observed at the entrances and are displayed in the corridors. All residents are provided with an information pack on admission and this includes information on the Code.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

Resident meetings are held two monthly confirmed during review of resident meeting minutes and during interviews of residents. Minutes reviewed also indicate feedback from residents on various aspects of service delivery including the residents making suggestions concerning meals, laundry and activities programme. Residents and family interviewed report they are informed of their rights by both pre-admission and admission information being provided. All residents are provided with an information pack on admission and this includes information on the Code and complaints processes. The Code - including large print posters, and advocacy details are displayed throughout the facility, and copies are available and accessible and residents are given opportunity for discussion regarding these. Admission Agreements reviewed and includes information on the Code of Residents’ Rights. Signed Admission Agreements are on residents files, stored securely in the administration area.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Residents and family interviewed confirm they or their relative is receiving services appropriate to their needs and that staff treat them with respect and dignity. Residents confirm they have a choice of what to do with their day and have a right to refuse if they do not want to participate. Residents also confirm their privacy is respected and they are able to be as independent as they desire/are able. Residents confirm they wear their own clothing and they have appropriate storage facilities in their rooms. They also confirm that Ripponburn is a comfortable place to live in and their rights are respected, including any spiritual and cultural needs. These findings supported during review of residents' and family satisfaction surveys completed in July - August 2013.

Visual inspection of the facility provides evidence that bedrooms are single, apart from six double bedrooms in the hospital area and two double bedrooms in the rest home. Privacy in the double bedrooms is appropriate. Residents have dedicated areas to keep their personal property and possessions and the rooms are as personalised as residents want them to be. Separate private areas are also available for residents to meet with family members, if required. There is a suitable environment available for caring for a dying resident and their family. Communal hygiene facilities display appropriate signage and a safe locking system.

Residents' files reviewed demonstrate residents' access to the spiritual and/or cultural care of their choice is recorded in the resident's admission documentation, which details spiritual affiliations and cultural aspects of care, and in the RN assessment and care plans which identifies spiritual needs. Admission Agreement reviewed and includes information on the residents’ responsibility for safety, security and insurance cover of their personal belongings.

Church services are held on site as part of the activities programme.

Care staff interviewed confirm residents’ physical, visual, auditory and personal privacy is being maintained and they respect residents' spiritual and cultural needs. Care staff also confirm education on the Code of Rights and this finding confirmed during review of the 2012 and 2013 inservice education programme and staff education records.

Appropriate policies and procedures are in place including policies to guide service providers acting on advance directives and maximising independence when they are caring for people where this is likely to be an issue. Policies and procedures also reviewed for cultural safety, spirituality, death and dying, and abuse and neglect.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Service provider's documentation reviewed includes a 'Māori Health Plan Guidelines', 'Cultural Responsiveness Maori’, ‘Cultural Awareness-Whare Tapa Wha' . Access to Māori support and advocacy services is available if required via the Kaua for the facility, who also takes cultural awareness education for staff. Cultural support and advice is also available from one staff member who speaks Te Reo.

Systems are in place to allow for review processes including input from family, where appropriate, for any resident who identifies as Māori. All residents' have a section on cultural needs in their care plans and was reviewed on residents' files. The file for one resident who identifies as Māori was reviewed and includes a 'Māori Health Care Plan', and indicates their family are involved in this resident's care. Interview of this resident confirms their cultural needs are met.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education provided 20 August 2013.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Service provider's documentation provides evidence appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Policies list access details to appropriate expertise (e.g. cultural specialists, and interpreters).

Residents' files reviewed demonstrate that admission documentation identifies ethnicity, cultural and spiritual requirements and family/whanau contact details. All residents have a cultural assessment completed as part of the care planning process.

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. These findings supported during review of resident/relative satisfaction survey completed in July-August 2013. Church services are held on site on a regular basis as part of the activities programme.

Care staff interviewed confirm an understanding of cultural safety in relation to care, and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and house rules that include codes of conduct. Policies and procedures which address any conflict of interest issues (e.g. the accepting of gifts and personal transactions with residents) were reviewed. Expected staff practice is outlined in job descriptions and 'House Rules' and job descriptions and employment contracts detail responsibilities and boundaries. A review of the accident/incident reporting system, complaints register and interview of the facility/general manager indicates there have not been allegations made against staff alleging unacceptable behaviour.

Residents and family interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.

**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

Systems are in place to ensure service providers receive a range of opportunities which promote good practice within the facility. Service provider’s documentation evidences that policies and procedures are based on evidence-based rationales. Education by specialist educators is provided as part of the in-service education programme and this was confirmed during review of education records and interview of the general/facility manager and nurse manager who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. The nurse manager advises DHB specialist nurses provide education and support for the clinical staff as needed.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

Open disclosure procedures are in place to ensure service providers maintain open, transparent communication with residents and their families. Residents' files reviewed (three rest home and four hospital) provide evidence that communication with family members is being documented in residents' records. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the individual resident's files.

Residents and family interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff who are responsible for their care.

The general/facility manager advises access to interpreter services is available if required via the DHB and interpreter services.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The general/facility manager, nurse manager and RNs report informed consent is discussed and recorded on the resident's admission to the facility.

Residents/family are provided with various consent forms on admission for completion as appropriate. Resident files reviewed have copies of EPOA documents for those residents who have named EPOA’s.

Staff interviewed (four care givers, three RN's, the general/facility manager and nurse manager) demonstrate a good understanding of informed consent processes. Residents and family interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.

Residents' files (three rest home and four hospital) reviewed demonstrate written and verbal discussions on informed consent have occurred and all residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the Code of Rights as part of the regional study days (confirmed by staff and manager interviews).

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

The service has appropriate policies regarding advocacy/support services that specify advocacy processes and how to access independent advocates.

Resident meetings are held two monthly and provide evidence of discussion on the Code.

Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they attended education on the Code of Right, advocacy, complaint management as part of the inservice education programme. This was confirmed during review of staff education records. The general/facility manager advises that a minister provides advocacy services as needed, including blessing resident's rooms.

Residents and family interviewed confirm that advocacy support is available to them if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission. Visual inspection provides evidence the independent and H&D Advocate details are displayed along with advocacy information brochures. Admission pack reviewed and provides evidence advocacy, complaints and Code of Rights is included.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service (e.g. visitors are required to sign in and out via registers). The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs, including reading of the newspaper each day.

Residents and family members interviewed confirm they can have access to visitors of their choice, and confirm they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and two vans are available to take residents on community visits. Some residents go out independently on a regular basis. Residents' files reviewed demonstrate that activity plans identify support/interest groups.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has appropriate systems in place to manage the complaints processes. A complaints register is maintained at the facility, and there are two complaints recorded in the complaints register for 2013. Reporting of complaints occurs at the two monthly meetings and via the two monthly quality reports. The general/facility manager reports there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents / their families as part of the admission process. Residents and family interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held two monthly and review of these minutes provides evidence of residents ability to raise any issues they have, and this was confirmed during interviews of residents.

A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of quality improvement meeting minutes, staff meeting minutes, evidences reporting of complaints.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

Ripponburn Holdings Limited, the governing body, has established systems in place which defines the scope, direction and goals of the organisation, the Ripponburn Home and Hospital, as well as the monitoring and reporting processes against these systems.

'The Facility and Organisation Business Plan 2013 - 2014' with goals, mission statement, philosophy of care, and standards of care reviewed. Also reviewed a written 'Quality Improvement and Risk Management Plan' identifying the organization’s quality goals, objectives, scope of service delivery, and includes statements about quality activities and review processes.

The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring people to the service. Meeting schedules and minutes reviewed, two monthly quality, and resident meetings and monthly staff meetings (general staff meetings one month, and designation specific meetings the next month - (RNs, carers, and support staff) . Meeting minutes are available for review by staff along with clinical indicator reports, graphs, and various service reports. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.

Ripponburn Home and Hospital is managed by one of the owners, a registered nurse (RN) with a current annual practising certificate who has worked in the aged-care sector for 25 years and has been in their current position for 21 years. The general/facility manager is supported by a nurse manager who is an experienced registered nurse who was appointed to their current position in 2004.

Review of the two managers' personal files and interview of the genera/facility manager and nurse manager indicate the managers undertake education in relevant areas.

Ripponburn Home and Hospital is certified to provide hospital level care and rest home level care and there are 46 beds provided (21 rest home and 25 hospital). On the days of this audit there are 25 hospital residents and 20 rest home residents.

Ripponburn Holdings Limited have contracts with the DHB to provide aged related residential care (rest home and hospital services), day support and respite care.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

There are appropriate systems in place to ensure the day-to-day operations of the service continues should the manager be absent. The nurse manager, who is responsible for clinical care relieves the general/facility manager as required and assumes responsibility. Twenty four hour RN cover is provided. Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the general/facility manager and nurse manager confirm their responsibility and authority for their roles.

The requirements of the ARC are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

A 'Quality Policy', a 'Quality Improvement and Risk Management Plan' and 'Quality Audit Schedule' are used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits are the responsibility of a RN, who has recently completed an auditing course. Review of quality improvement data provides evidence the data is being collected, collated, analysed for trends, and is reported to the quality improvement committee, annual general meeting, as well as to staff via various meetings. Quality improvement meetings are held two monthly, registered nurses meetings, carers meetings, support staff, and residents meetings, are each held monthly. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Copies of meeting minutes including graphed clinical indicators are available for staff to review in the nurses’ stations, and support staff areas.

Internal audits, accident/incident forms, and meeting minutes reviewed provide evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed to address the issue/s that require/s improvement. There is documented evidence available indicating that issues identified as requiring follow through at meetings are discussed at subsequent meetings.

Staff interviewed report they are kept well informed of quality and risk management issues including clinical indicators.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed that are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. The general/facility manager is responsible for reviewing policies and procedures. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.

Health & Safety Manual available that includes relevant policies and procedures. There is a Hazard Reporting system available and a Hazard Register. Chemical Safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and reviewed, and all biomedical equipment has appropriate performance verified stickers in place.

The requirements of ARC are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

The adverse event reporting system evidences a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are collated and filed in resident files. 2013 data reviewed includes summaries and registers of various clinical indicators including falls - injury and nonjury, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff indicates appropriate management of adverse events.

An 'Accident/Incident Summary' is used to document all incidents, is reviewed monthly, and is provided to the quality improvement committee meetings.

There is an open disclosure policy. Resident files reviewed (four hospital and three rest home) provide evidence of communication with families following adverse events involving the resident, or any change in the residents condition, confirmed by family interviews. Communication with family is documented in the resident's progress notes.

Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions; policies and procedures; and professional codes of conduct, which was confirmed via review of staff files and other documentation. Policy and Procedures comply with essential notification reporting e.g., health and safety, human resources, infection control etc.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

The monthly in-service education programme for 2012 and 2013 reviewed and provides evidence of planned in-service education. The nurse manager is responsible for oversight of the in-service education programme. Review of documentation provides evidence that staff are receiving inservice education sessions at least twice a month, as well as access to on line education provided by 'Clinical Update NZ Limited'. The Otago Hospice also provides education. Staff are also supported to complete the ACE programme.

Written policies and procedures in relation to human resource management are available and reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (eight of eight) along with employment agreements, completed criminal vetting, reference checking, completed orientations and competency assessments. Individual records of education are maintained for each staff member and copies reviewed. Also viewed competency assessment and education spread sheets.

There are policies and procedures on human resources management and the validation of current annual practising certificates for RNs, dietitian, pharmacist, occupational therapist, physiotherapist, and general practitioners (GPs) is occurring. All practising certificates are current.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Orientation for staff covers the essential components of the service provided i.e.: The quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation’s vision, values and philosophy.

An appraisal schedule is in place and current staff appraisals sighted on all staff files reviewed.

Carers and RN's interviewed confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is a documented rationale, 'Rostering Policy' for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one registered nurse and two health care assistants. The general/facility manager and the nurse manager are both available on-call after hours. Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. Residents interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirms adequate staff cover is provided.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

Resident information is entered in an accurate and timely manner into a register (electronic and hard copy) that is appropriate to the service and is in line with the requirements of NZHIS. Interview of the general/facility manager confirms resident's data is entered on the day of admission to the facility. Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed.

A visual inspection of the facility evidences that residents' information is stored in staff areas and is held securely and is not on public display. Clinical notes are current and accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifier. Resident documentation indicates staff record their name and designation and staff sign each entry in resident documentation.

Seven of seven clinical staff interviewed (three RNs and four carers) and the general/facility manager confirm they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

Entry criteria is identified in the information pack that is given to new and potential residents that enter the service, sighted the hospital and home information booklet and confirmed at the registered nurse (RN) and the nurse manager interviews.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

Interview with the nurse manager confirms that residents who have needs beyond the scope of practice of the service are declined entry, sighted the entry criteria for the service as stated in their information booklet. The service provides care to hospital and rest home levels of care, confirmed during the physiotherapist, the occupational therapist and the nurse manager interviews.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

Each stage of service provision is undertaken by suitably qualified and experienced staff members who are competent to perform the function, confirmed at the nurse manager, the RN and the GP interviews. Care plans are completed by the RN's.

The service employs an occupational therapist who completes assessments which focus on strengthening residents' current abilities and rehabilitation. Where needed the physiotherapist completes assessments for manual handling and the resident's mobility abilities.

Each stage of service provision is provided within the timeframes that safely meet the needs of the residents, sighted long term care plan assessments and confirmed during the nurse manager the diversional therapist and the GP interviews. The GP confirm that staff implement treatment in a timely manner and contact the surgery when a resident needs to be seen by a doctor. The GP confirm that four of the doctors from the surgery do weekly rounds at the facility to ensure residents are seen frequently.

The service is coordinated in a manner that promotes continuity of service and promotes a team approach. This is facilitated through handovers between shifts, the use of communication books, progress notes and medical and allied service notes that are all integrated into one file for the resident.

ARC requirements are met.

Tracer methodology in the rest home:

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

Tracer methodology in the hospital:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

The needs, outcomes and goals of the residents are identified through assessment processes and are documented to service as the basis for the long term care plan, sighted risk assessments for seven residents. Risk assessments include, continence, nursing, pain, cultural, nutritional, falls, skin integrity, mini mental and physiotherapy assessments, confirmed at the nurse manager, the physiotherapist and the RN interviews.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

Residents' long term care plans are focussed on their needs, integrated and promote continuity of service delivery, sighted long term care plans and confirmed at the RN interview.

The care plans describe the required support and the interventions to achieve the desired outcomes, sighted seven long term care plans, and confirmed at the nurse manager interview.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

The provision of services and interventions are consistent with and contribute to meeting residents' assessed needs and their desired outcomes as identified in the long term care plans, sighted seven long term care plans and confirmed at the resident and the nurse manager interviews.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

Activities are planned and facilitated to develop and maintain the skills and strengths of residents, sighted seven diversional care plans and confirmed at the diversional therapist (DT), the occupational therapist and the physiotherapist interviews. The nurse manager confirms that activities are aimed to be meaningful to residents and the DT keeps attendance records for all residents. The diversional care plan is evaluated six monthly (sighted) and the residents sign that they approve the plan.

The diversional therapist prepares a weekly programme for the hospital and the rest home, a regular activities programme for residents and family members, and special activities for the month which residents and their families can participate in e.g. morning tea at a café, special entertainment and dancing, exhibitions, line dancing and music night, luncheons, boat trip, sing-along and other outings. The different programmes are enlarged to A3 size and displayed on the different notice boards throughout the facility.

The DT keeps an annual programme record with 'wish lists' from residents and an evaluation form to ascertain what works and what does not work.

Church service are held weekly, different denominations present services e.g. Catholic Mass on the first Friday of the month, the Anglican Church holds services on Sundays and the Presbyterians do the service on the third Thursday of the month.

All residents have an opportunity to go on outings. Once a month the residents go on a daytrip that includes lunch somewhere. The trip includes two vans with about 13 residents and three staff members.

The service Ipads available for use by the residents for Skyping their families and friends and it is used for playing games and other entertainment, verified.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Evaluations are documented, resident focussed and indicate the degree of achievement regarding the progress towards meeting the desired outcomes, sighted seven long term care plans and confirmed at the RN and the nurse manager interviews.

The nurse manager confirms that where progress is different from the expected outcome, long term care plans are changed to reflect the current status of the resident, sighted long term and short term care plans. ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Residents are given choices and are advised of options to access other health and disability services where requested or when needed, sighted referral records to other services e.g. specialist and other appointments. Residents and family / whanau confirm they are given options regarding access to other health services.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

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

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

Risks associated with resident transition, exit, discharge or transfers are identified through assessment processes, documented and minimised, confirmed at the nurse manager and the RN interviews.

The transfer document includes; personal information, it identifies the enduring power of attorney (EPOA), gives the reason for the transfer, list the medicines the resident is using, identifies allergies, states if the resident is a smoker or not, whether the resident drinks alcohol and the units per week, whether the resident have any multi-resistant organisms, whether the resident has wounds, if the resident uses oxygen, the residents' mobility status, whether the resident needs assistance, the cognition status, what prompts the resident may need, the resident's continence status, mood, ability to perform own personal cares, sleeping habits, dietary needs, preferences regarding drinks, abilities relating to feeding, the resident's weight, ability to communicate, visual status, what personal items are with the resident during transfer, opportunity for comments and the transferring nurse signs and dates the document.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

The service has a medicines management system implemented to manage safe and appropriate dispensing, administration, review, storage, disposal and reconciliation of medicines, sighted during the medicines chart reviews and confirmed at the nurse manager and the pharmacist interviews. The facility's systems are aligned to comply with legislation, protocols, and guidelines, sighted the medicines management policy and attended the lunch medicines round in the hospital.

Staff members who are responsible for medicines management and administration complete competencies to ensure safe and appropriate practices, sighted competencies for ten registered nurses and twenty three health care assistants.

Self-administration of medicines is included in the medicines management policy, however there are no resident currently self-administering medicines, confirmed a the GP and the nurse manager interviews. Controlled drugs are appropriately locked away in a safe within a lockable cupboard and the service use a controlled drug register for monitoring controlled drug use.

Fridge temperatures are monitored daily, sighted records.

Medicines management information is recorded to a level of detail and communicated to residents at a frequency and detail that comply with legislative and other requirements. All the medicines charts reviewed show timely reviews by the GP, entries are signed and dated, discontinued medicines are signed off and dated, all charts have photo identification, allergies and sensitivities are recorded and entries are legible.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Residents' food preferences and their individual food , fluid and nutritional needs are met, confirmed at the nurse manager and the cook interviews. The service complete a dietary assessment for each resident on admission, sighted assessments for all the reviewed resident files. The food, fluid and nutritional services are aligned with recognised nutritional guidelines and appropriate to the scope of service. Residents confirm the food is tasty and they receive enough food during mealtimes, verified. The service use summer and winter menus with a four weekly rotating programme, sighted the menus. The menu is due for review in November 2013. The cook monitors food temperatures at each mealtime, sighted records.

Residents who have additional or modified nutritional needs have their needs met, sighted records to the kitchen to ensure special diets, preferences and other requirements are catered for. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislative requirements and guidelines.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facility and are accessible for staff. Hazard Register sighted and is current. Staff receive education to ensure safe and appropriate handling of waste and hazardous substances and chemical safety last provided 8 November 2012. Monthly visits by 'Diversey' occur who review kitchen, cleaning and laundry processes and cleaning. Copies of these reports reviewed during this audit.

A visual inspection of the facility provides evidence that protective clothing and equipment is appropriate to the risks associated with the waste or hazardous substance being handled and they are provided and used by staff. For example: goggles, gloves, aprons, and masks viewed in sluice rooms. Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. Two sluice rooms are available for the disposal of waste and hazardous substances. The sluices have an attachment to prevent unwanted material splashing on staff.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. Two maintenance persons are employed; one works four days per week and the other one day per week. One of the maintenance persons interviewed confirms there is a maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and reviewed during this audit along with current calibration / performance verified stickers in place on medical equipment. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 14 June 2014.

A visual inspection of the facility provides evidence of safe storage of medical equipment, and the building, plant and equipment is maintained to an adequate standard. Passageways are wide enough to allow residents to pass each other safely; safety rails are secure and are appropriately located; minimal changes in floor surface and levels occur; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; floor surfaces and coatings are maintained in good order. The external areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside, e.g.: safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes.

Staff receive education in the safe use of medical equipment by suitably qualified personnel, and there is a system in place to review staff competency for specific equipment. This was confirmed via interview of staff and review of staff education records. Care staff interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

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

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

Bedrooms provide single accommodation apart from two double bedrooms in the rest home area and six double bedrooms in the hospital area. All bedrooms have wash hand basins. Several bedrooms have ensuites and there is an adequate number of communal toilet and shower facilities.

Visual inspection provides evidence that toilet; shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored weekly 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).

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. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

Visual inspection evidences that adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. Bedrooms have double leaf doors that allow for easy access for mobility aids.

**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

Visual inspection evidences adequate access is provided to lounges, dining rooms, and other communal areas throughout the facility, including a large activities room. Residents observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

Cleaning policy and procedures, and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons.

All linen is washed on site in roomy laundry and there is adequate dirty / clean flow. The laundry person interviewed and describes management of laundry including transportation, sorting, storage, laundering, and return to residents.

Visual Inspection evidences the implementation of cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning reviewed, along with monthly 'Diversey' reports. Visual inspection of the facility evidences: 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 or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste - i.e. sluice room/facilities in all areas; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas. Residents and family interviewed state they are satisfied with the cleaning and laundry service.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

A letter from New Zealand Fire Service reviewed dated 12 November 2007 advising approval of fire evacuation scheme. The last trial evacuation was held on 5 September 2013.

All registered nurses, most carers, and diversional therapist have current first aid training and CPR, and includes competency assessment. There is at least one designated staff member on each shift with current first aid training.

Staff interviews and review of files provide evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals, last provided 26 June 2013. Staff records sampled evidences current training regarding fire, emergency and security education.

A visual inspection of the facility evidences: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations. A visual inspection of the facility evidences: emergency lighting via a generator, torches, and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.

An appropriate call bell system is in place that is easily used by the resident or service provider to summon assistance if required and is appropriate to the resident group and setting, e.g. call bell system. Call bells are accessible / within easy reach, and are available in resident areas, e.g. bedrooms, ablution areas, ensuite toilet/showers, dayrooms, dining rooms. Staff also carry pagers. Residents interviewed confirm they have a call bell system in place, which is accessible and staff generally respond to it in a timely manner.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual observation evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Heating is provided by water radiators and heat pumps provide cooling in summer. There is a designated external smoking area. Residents and family interviewed confirm the facilities are maintained at an appropriate temperature.

The ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The service is currently using bedrails and lap belts as enabler or as restraints. There are three residents using enablers. Enabler use is voluntary and the least restrictive option in order to promote safety and meet the needs of the resident, confirmed during resident, family and the nurse manager interviews, verified during the onsite audit and sighted the enabler assessment, consent, care plan, identified risks, monitoring records and the evaluation forms. The service has five restraints in the form of lap belts, bedrails and pelvic belts in place and three enablers in the form of bedrails.

The ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

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

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

The responsibility for the restraint process is clearly defined with lines of accountability for restraint use, sighted the restraint position description for the restraint coordinator who is also the nurse manager, confirmed during interviews with the general manager and the nurse manager.

**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 service ensure assessments of residents are completed in relation to restraint use. The assessments of residents who may need to use restraint includes risk assessments, considering the possible reasons for relevant behaviour that may lead to residents having to use restraint and reviewing restraints and the need for on-going restraint use. Assessments and review include cultural considerations and the service consider alternative intervention or strategies to restraint, sighted assessment, monitoring and review documentation, the restraint register and confirmed at the GP interview.

**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

Restraints are used as last resort, confirmed at the nurse manager and the GP interviews, sighted records for restraint approval. monitoring and review.

Each episode of restraint is documented and includes the date, the time, the type of restraint, the duration of the restraint, the outcome and observations made during the period of restraint, sighted the restraint monitoring records.

The service has a restraint register that includes the following; the date of when the restraint was first approved, the name of the resident, behaviour indicating restraint, alternative strategies for restraint, who approved the restraint, the type of restraint, consents for restraint signed, three monthly restraint review and comments, sighted the restraint / enabler register and confirmed at the nurse manager and the GP interviews. The ARC requirement is met.

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

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

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

(d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

Episodes of restraint is evaluated in collaboration with the resident and their family, confirmed at the resident, family and nurse manager interviews.

Where the restraint is on-going the time intervals between evaluations are based on the nature and the relating risks of the restraint, confirmed at the nurse manager and the RN interviews. The ARC requirement is met.

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

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

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

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

(d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

The service regularly review restraints and restraint practices, confirmed at the GP and nurse manager interviews, sighted the quality and risk meeting minutes that record restraint reviews. The multi-disciplinary team review occurs three monthly or when required, sighted review records for individual residents. The ARC requirement is met.

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The facility is managed to minimise the risk of infection to residents, staff members and visitors. There is a sign on the front entry to the facility reminding people who suffer from infections to please refrain from contact with residents due to their susceptibility, verified. Residents, visitors and staff members who suffer from or are exposed to infection are made aware of the importance of preventing others being exposed to infections, confirmed at the resident, family and staff interviews.

The responsibility for infection control is assigned to the infection control coordinator (ICC), a registered nurse, who has a specific position description guiding the role, sighted the ICC position description. Lines of accountability and reporting are clearly defined in the position description and the ICC is aware of the responsibilities to the governing body, confirmed during interview.

The facility has a clearly defined infection control programme which forms an integral part of the quality programme, sighted the quality meeting minutes and the minutes of the annual management review dated 23 September 2013.

The ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control committee comprises of the infection control coordinator and the nurse manager with the expectation that all staff will contribute to infection control and prevention. The infection control data is reported and discussed at the quality and infection control committee meetings every two months, sighted the two monthly quality improvement and infection control meeting minutes with monthly statistics on infections.

Infection surveillance includes completing a monthly infection control register with the name of the resident, the type of infection and the organism. The statistics also include a summary of the type of infections, the number of the infections, the organisms, the number of infections from a specific organism, whether the infection was resolved or if it is still on-going. The ICC completes an infection assessment on each resident and the monthly statistics are expressed in graphs showing the total infection rate per 1000 bed days in the hospital and rest home, and the types of infections per 1000 bed days plus a summary of the infection numbers per month, sighted.

**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

The service has written policies and procedures for the prevention and control of infection which comply with the relevant legislation and accepted good practice, sighted the policies and confirmed at the infection control coordinator and the nurse manager interviews.

**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 coordinator (ICC) is responsible for the annual education and training of staff regarding infection control prevention and management. The infection control coordinator completed a 50 hour course on infection control management for registered nurses at the Christchurch Polytechnic of Technology, confirmed at the ICC and the nurse manager interviews.

The course included lectures and tutorials, independent learning opportunities which covered infection control requirements related to the Health and Disability Sector Standards, issues for meeting certification, identification of micro-organisms in residential and acute hospital settings, the principles of infection control and analysis of infections, how to analyse and evaluate the effectiveness of the infection control programme, how to develop policies and procedures for infection prevention and control including good practice and how to assess educational requirements in order to ensure best practice for infection control, sighted. Infection control training for staff members occurs throughout the year, sighted training records.

Resident education is on-going throughout service delivery, residents and their families confirm they are aware of the need for hand washing and to segregate themselves when suffering from an infection.

The ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

The service participates in benchmarking internally, measuring outcomes of different years against one-another and externally through a national group called Healthcare Help, sighted the benchmarking reports that are entered online and confirmed at the nurse manager, the administrator and the infection control coordinator interviews.

The organisation determines the type of surveillance and the frequency with which it is undertaken on the size, appropriateness and the complexity of the service.

Surveillance results are expressed in graphs and trends in monthly reports that are submitted to the quality committee every two months, sighted reports.

**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:**