**Kowhai Resthome (2002) Limited**

**Current Status:** **16-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**

Kowhai Rest Home provides rest home level care for up to 28 residents with full occupancy.

The owner/ manager is an experienced aged care manager and registered nurse (RN). The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke positively about the care and support provided. The service is implementing a robust quality and risk management system and identify and improve shortfalls.

This audit identified improvements required by the service in the following areas; documentation of family communication, care plan documentation, medication management, and dietician review of menus.

**Audit Summary AS AT** **16-Sep-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
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|  | 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 Audit16-Sep-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Organisational Management** | Day of Audit16-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 Audit16-Sep-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit16-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 Audit16-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 Audit16-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** **16-Sep-13**

**Consumer Rights**

The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. An improvement is required around documenting family involvement. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

**Organisational Management**

The manager is actively involved in the management and resident care in the service. She is supported by a part time registered nurse and an enrolled nurse.

There is a quality and risk management system in place that is being implemented with improvements made to the programme in 2013.

The quality management system included review and management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections through the surveillance programme, review of risk and monitoring of health and safety including hazards and maintenance (planned and reactive) to the building and grounds.

A review of the audits documents that they have been undertaken according to the documented audit schedule. Audits have documented action plans that are signed of when out comes addressed.

There is a document control system in place and currently policies are going through review.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

**Continuum of Service Delivery**

There is a needs assessment completed prior to entry. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services and residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs. Sampling of residents' clinical files validates the service delivery to residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes with alteration to the long term care plan or noted on a short term care plan. Improvement is required to ensure reassessment of all possible care needs is documented.

Planned activities are appropriate to the resident group with a focus on individual activities for those that choose not to participate in group activities. Residents and family interviewed confirm satisfaction with the activities programme.

A medication management system is in place. Policies and procedures record service provider responsibilities. Staff responsible for medicine management have completed in-service education on medication management and have current medication competencies. An improvement is required to medication management.

A central kitchen and on site staff provide the food service for the home. All staff have completed food safety training. Residents' individual needs are identified on admission. Improvement is required to ensure a dietician approved menu is used and that changes to resident nutritional and dietary needs are documented to ensure all staff are aware of the change.

**Safe and Appropriate Environment**

All building and plant comply with legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. There are policies and procedures in place for the safe disposal of waste and hazardous substances. Chemicals are stored securely. Staff has access to personal protective clothing and equipment. The service has a van available for transporting residents. The building has a current warrant of fitness and there is an approved evacuation scheme. The physical environment and fixtures and fittings are maintained, appropriate and safe. The facility is spacious and provides sufficient space to enable the use of mobility equipment. There are appropriate numbers of toilets and bathrooms.

There are cleaning and laundry policies and procedures with residents and family reporting satisfaction with the cleanliness and laundering. General living areas and resident rooms are appropriately heated, ventilated and have good lighting.

Regular fire drills are completed. Emergencies and first aid are included in the training programme. There is a civil defence kit in place. Call bells are evident across the facility in resident's rooms, lounge areas, and toilets/bathrooms.

**Restraint Minimisation and Safe Practice**

The Restraint and Enabler Policy includes definitions, approved restraint, authorisation, assessment, emergency situations, de-escalation, training and review and evaluation. There is a definition for both restraint and for enablers. The service promotes a restraint free environment and this is maintained. There are no residents requiring the use of enablers and no residents requiring restraint. The registered nurse states that any emergency restraint is used only when absolutely necessary. Staff are trained in restraint minimisation and in management of enablers and behaviours.

**Infection Prevention and Control**

The service and the environment minimise the risk of infection to residents, staff and visitors. There are documented processes implemented. The service has yet to undertake an annual review as IC in this facility has only been implemented in this facility since October 2012 (due January).

Regular infection control audits, hazard documentation and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings.

Staff receive training in infection control at orientation and as part of the on-going education programme.

All surveillance activities are the responsibility of the infection control coordinator who is the enrolled nurse with support from the registered nurse. The infection control coordinator and registered nurse also receive support from Bug control, who also assist with training when required.

**Kowhai Rest Home**

Kowhai Rest Home 2002 Limited

Certification audit - Audit Report

Audit Date: 16-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

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| **Provider Name** | Kowhai Rest Home 2002 Limited |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
|  Kowhai Rest Home | 25 Aynsley Terrace | Hillsborough | Christchurch  |

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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:** 16-Sep-13 **End Date:** 16-Sep-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand 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 | XXXXXXX | RN, BSc. Mmgnt, lead auditor | 8.00 | 5.00 | 16-Sept-13 |
| Auditor 1 | XXXXXXX | RN auditor | 8.00 | 4.00 | 16-Sept-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 2 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 11.00 | **Total Audit Hours** | 27.00 |
| **Staff Records Reviewed** | 5 of 25 | **Client Records Reviewed** *(numeric)* | 7 of 28 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 7 |
| **Staff Interviewed** | 7 of 25 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 7 |
| **Consumers Interviewed** | 4 of 28 | **Number of Medication Records Reviewed** | 14 of 28 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 22 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  Kowhai Rest Home | 28 | 28 |       | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Kowhai Rest Home provides rest home level care for up to 28 residents with full occupancy. The owner/ manager is an experienced aged care manager and registered nurse (RN). The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke positively about the care and support provided. The service is implementing a robust quality and risk management system and identify and improve shortfalls.

This audit identified improvements required by the service in the following areas; documentation of family communication, care plan documentation, medication management, and dietitian review of menus.

1.1 Consumer Rights

The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents’ rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. An improvement is required around documenting family involvement. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

1.2 Organisational Management

The manager is actively involved in the management and resident care in the service. She is supported by a part time registered nurse and an enrolled nurse.

There is a quality and risk management system in place that is being implemented with improvements made to the programme in 2013.

The quality management system included review and management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections through the surveillance programme, review of risk and monitoring of health and safety including hazards and maintenance (planned and reactive) to the building and grounds.

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There is a needs assessment completed prior to entry. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services and residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs. Sampling of residents' clinical files validates the service delivery to residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes with alteration to the long term care plan or noted on a short term care plan. Improvement is required to ensure reassessment of all possible care needs is documented.

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1.4 Safe and Appropriate Environment

All building and plant comply to legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. There are policies and procedures in place for the safe disposal of waste and hazardous substances. Chemicals are stored securely. Staff has access to personal protective clothing and equipment. The service has a van available for transporting residents. The building has a current warrant of fitness and there is an approved evacuation scheme. The physical environment and fixtures and fittings are maintained, appropriate and safe. The facility is spacious and provides sufficient space to enable the use of mobility equipment. There are appropriate numbers of toilets and bathrooms.

There are cleaning and laundry policies and procedures with residents and family reporting satisfaction with the cleanliness and laundering. General living areas and resident rooms are appropriately heated, ventilated and have good lighting.

Regular fire drills are completed. Emergencies, and first aid are included in the training programme. There is a civil defence kit in place. Call bells are evident across the facility in resident’s rooms, lounge areas, and toilets/bathrooms.

2 Restraint Minimisation and Safe Practice

The Restraint and Enabler Policy includes definitions, approved restraint, authorisation, assessment, emergency situations, de-escalation, training and review and evaluation. There is a definition for both restraint and for enablers. The service promotes a restraint free environment and this is maintained. There are no residents requiring the use of enablers and no residents requiring restraint. The registered nurse states that any emergency restraint is used only when absolutely necessary. Staff are trained in restraint minimisation and in management of enablers and behaviours.

3. Infection Prevention and Control

The service and the environment minimise the risk of infection to residents, staff and visitors. There are documented processes implemented. The service has yet to undertake an annual review as IC in this facility has only been implemented in this facility since October 2012 ( due January).

Regular infection control audits, hazard documentation and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings.

Staff receive training in infection control at orientation and as part of the on-going education programme.

All surveillance activities are the responsibility of the infection control coordinator who is the enrolled nurse with support from the registered nurse. The infection control coordinator and registered nurse also receive support from Bug control, who also assist with training when required.

Summary of Attainment

* 1. Consumer Rights

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | PA Low | 0 | 1 | 1 | 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: 11 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA:22 PA:1 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: 0Criteria (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 | PA Low | 0 | 0 | 1 | 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 | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Low | 0 | 2 | 1 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 9 PA Neg: 0 PA Low: 2 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:18 PA:3 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: 0Criteria (of 36): CI:0 FA:17 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 5 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:1 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: 0Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 5 **CI:** 0 **FA:** 41 **PA Neg:** 0 **PA Low:** 3 **PA Mod:** 1 **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:** 89 **PA:** 4 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Kowhai Rest Home 2002 Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:16-Sep-13 End Date: 16-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.9 | 1.1.9.1 | PALow | **Finding:**Care plans reviewed ( seven) do not document family communication for all problems and involvement in care planning and incident forms do not always document if the family has been informed (six of eleven reviewed) and one had documented ' not informed' but no further information as to why, or if the family or resident requested this**Action:**The service should document communication with family | 6 months |
| 1.3.4 | 1.3.4.2 | PALow | **Finding:**Not all actual or possible care needs had a documented assessment tool completed during the evaluation or at least six monthly, including those already identified and included in the care plan. **Action:**Ensure reassessment of all possible care needs is documented. | 6 months |
| 1.3.12 | 1.3.12.1 | PAModerate | **Finding:**In the previous two months the weekly controlled drug check did not always include a RN. When PRN medication is used there is no entry in the resident progress notes of the reason for the use or the effectiveness. Two of four eye drops currently in use were not dated to indicate when the drops were opened or when they should be discarded. **Action:**Ensure all medication processes include good practice principles for controlled drug checks by a RN, PRN medication effectiveness is recorded, eye drops are dated to ensure discarded as per stated requirements.  | 1 month |
| 1.3.13 | 1.3.13.1 | PALow | **Finding:**The current menu has not been reviewed against recognised nutritional guidelines by a dietician in the last two years. Changes of resident nutritional and dietary requirements are not documented in a permanent manner to ensure all staff involved in food preparation and serving are aware of these changes. **Action:**Ensure a dietician approved menu is used and that changes to resident nutritional and dietary needs are documented to ensure all staff are aware of the change. | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Kowhai Rest Home 2002 Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:16-Sep-13 End Date: 16-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

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

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

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

The code of health and disability rights is incorporated into care. Discussions with two caregivers, the enrolled nurse, the nurse and manager identified their familiarity with the code of rights. A review of all resident files documents that the code of rights is incorporated into care. Training around the code of rights and complaints was last provided in May 2013 as part of abuse and neglect training

**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

D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information. Code of rights leaflets are available at the front entrance of the service. Code of rights posters are on the walls in the service. Client right to access advocacy services is identified for residents and advocacy service leaflets are available or residents and family.

All four residents and all seven family members interviewed indicated they were aware of the advocacy services particularly in relation to the complaints process.

Discussions with the clinical manager and manager identified they are aware of the right for advocacy and how to access and provide advocacy information to residents if needed.

**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

D3.1b, d, f, I The service involves residents in decisions about their care, consultation, encouraging wellness and facilitating mixing with others.

The two caregivers, the clinical manager and manager interviewed discussed how respect and empowerment is a focus of the service.

The 2012 resident/family survey (eight returned) all stated privacy is respected.

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Personal belongings are to be documented and included in resident files if the resident choses to complete this.

D4.1a Seven resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified and these are discussed as part of the six monthly care reviews .

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach.

The initial and on-going assessment includes gaining details of people’s beliefs . Interventions to support these are identified and evaluated. Residents are addressed by their preferred name and this is documented in all seven files reviewed.

A policy is available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality in an appropriate and discreet manner with strategies documented if required to manage any inappropriate behaviour.

D5.4q On admission residents are asked their religious preferences, this is noted on their care plan and in the activities profile. A monthly interdenominational service is held. Four residents and all seven family members interviewed are able to confirm that their privacy and dignity was respected and staff were observed to be respectful on the day of the audit.

There are a couple of shared ensuites between two rooms have no locks. Residents and management described how this is managed to ensure privacy. Residents described knocking. A shower in the communal bathroom area has only a curtain to ensure privacy. While, residents and staff described how this is managed and residents are always respectful, the service monitors this to ensure it maintains privacy. Residents stated there was no issues with this curtain.

**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

A3.2 Maori Health Plan & Cultural Awareness policy (includes several ethnic / cultures). This cultural information is for use by staff to assist in responding to cultural values and beliefs of Maori. Staff receive cultural awareness training.

There are currently three residents who identify as Maori at the time of audit. Two files reviewed specifically for cultural needs and these two files both documented the culture , IWI and specific care needed.

D20.1i A Maori Health Plan and Cultural Awareness policy is in place to guide staff with supporting Maori residents and whanau. The importance of whanau is identified in the policy. The service has a linkage to a local Maori Advisor/contact.

Policy process involves that staff read and sign all polices and this had included the Cultural awareness policy. Training with regard to mental health and the elderly this has included cultural considerations has been provided.

**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

Staff recognise and respond to individual cultural values and beliefs. The service identifies and records resident values and beliefs in the initial assessment and resident care plan and as part of the Resident Profile completed by the activities person

It was noted by the manager and clinical manager that many residents have little or no contact with their family, however when family are involved every effort is made to include them in decisions including information relating to values and beliefs.

.D3.1g The service provides a culturally appropriate service by asking residents and family members what their cultural needs are at each assessment, plan and review and through links with the community.

D4.1c Resident files reviewed (Seven) all include the residents social, spiritual, cultural and recreational needs.

Seven family members and four residents all agreed that values and believes are considered by the service,

**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 a number of policies that provide support for the resident to ensure that they are not subject to discrimination, harassment, and sexual or other exploitation. These include Residents Rights, Complaints, Advocacy, Abuse and Neglect, Sexual and Intimacy and Harassment.

The manager and clinical manager are able to describe the process for managing any allegations of abuse or neglect.

Education regarding the code of rights and abuse and neglect is provided during the orientation of new staff and is expected to be completed annually as part of the in-service training programme - last provided in May 2013.

Employment agreements include confidentiality and work rules. There is a staff conduct policy to maintain professionalism.

Discussions with the two caregivers, indicate that they are aware of professional boundaries including taking of gifts etc.

All four residents interviewed and seven of seven family members interviewed state that there is no indication that there is discrimination or abuse.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

A2.2 Services are provided at Kowhai that adhere to the health and disability services standards. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001.

There is an implemented quality improvement programme with an audit schedule implemented, review of complaints, management of incidents and accidents, documentation of any restraint or enabler use and documentation of infections with infection control surveillance completed.

The service has a specific quality and risk plan for the merge of service between Heathbrae and existing residents at the Kowhai site. This plan includes close monitoring of residents behaviour, an activities plan designed to familiarise residents to the new surroundings, staff reporting, monitoring of falls , skin tears, behaviour, wandering, and staffing with adjustment of rosters. This is very well monitored and reported. The reports are daily to begin with and gradually has decreased monitoring over eight months. The Outcome has documented that the merge of the two sites to one has had very little in the way of difficulties. The service is commended.

D1.3 All approved service standards are adhered to.

D17.7c.There are implemented competencies for care workers and other staff. There are clear ethical and professional standards and boundaries within job descriptions

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. A booklet is provided to residents on entry and this includes information around rights, complaints, abuse and neglect etc.

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

D16.4b Seven of Seven relatives state that they are always informed when their family members health status changes. The recent resident survey documents that eight of eight respondents feel they are l kept well informed.

However care plans reviewed ( seven) do not document family communication for all problems and incident forms do not document if the family has been informed (six of eleven reviewed) and one had documented ' not informed' but no further information as to why, or if the family or resident requested this

D11.3 The information pack is available in large print and advised that this can be read to residents. The service has policies and procedures available for access to interpreter services noting that there are no residents requiring interpreting services.

Four residents interviewed and seven of seven family members interviewed state they were welcomed on entry and were given time and explanation about services and procedures.

Resident meetings occur monthly and family are invited to this.

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

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

Seven of Seven relatives state that they are always informed when their family members health status changes. The recent resident survey documents that eight of eight respondents feel they are kept well informed.

**Finding Statement**

Care plans reviewed ( seven) do not document family communication for all problems and involvement in care planning and incident forms do not always document if the family has been informed (six of eleven reviewed) and one had documented ' not informed' but no further information as to why, or if the family or resident requested this

**Corrective Action Required:**

The service should document communication with family

**Timeframe:**

6 months

**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

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service and adhere to the Code. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with two caregivers identify that consents are sought in the delivery of personal cares and this is confirmed by five residents interviewed. Written consent includes the signed admission agreements, advanced directives, health information release form, outing and indemnity, and photograph. All seven resident files reviewed has signed consent forms. Advanced directives forms are reviewed.

D13.1 Admission agreements are held by the facility manager and were signed.

D3.1.d Discussion with seven family identified that the service actively involves them in decisions that affect their relatives lives and they are well informed of their residents care needs. Link 1.1.9.1.

**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

D4.1d; Discussion with seven family members family and four residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.

ARC D4.1e, The resident file includes information on resident’s family/whanau and chosen social networks.

Resident families are informed of their right to access advocacy services on admission and staff describe the principles of advocacy. There is an advocacy policy.

Staff are aware of the right for advocacy and how to access and provide advocacy information to residents if needed and training has been provided last in May 2013.

The two caregivers interviewed were aware of the advocacy services.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

D3.1h Discussion with seven family members confirm that they are encouraged to be involved with the service and care.

D3.1.e Discussion with the two caregivers, the clinical manager and manager notes that residents are supported and encouraged to remain involved in the community and external groups such as attendance at church and community programs.

The service has open visiting and relatives were sighted coming and going on the day of the audit. All seven family members state that they can visit any time.

**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

There is a complaint management policy that aligns with right 10 of the Code of Rights. The complaints policy and complaints forms are displayed on the notice board in the corridor. There is a complaints register and a folder where complaints forms are retained.

D13.3h. A complaints procedure is provided to residents and their family within the information pack at entry.

Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family.

All seven family members and four residents said they felt able to complain if needed at the manager would assist with the problem.

**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

Kowhai has been providing rest home level care at this site for 12 months. The residents are a mix of residents that were already resident at this site ( previously called Heathbrae) residents transferred over from the 'old' Kowhai and some new residents.

The service has completed an interim risk management developed to monitor potential risks with the merger of the two resident groups. The plan includes the monitoring of behaviour management plans and trending of incident/accidents. It was evidenced that this plan has enabled a smooth with few incidents and accidents/ behavioural issues as a result of the merge of two sites.

The service has a quality and risk management policy based on the ‘plan, do, act and check cycle. There are specific quality objectives that link directly to the audit schedule. An example includes the quality outcome of a happy, cheerful harmonious atmosphere and the homely- ness audit.

There is a documented mission statement and philosophy.

 The service philosophy and mission includes; ' The service provides care and support for residents with a mental health back ground who want a smaller personal environed to live'.

Performance is monitored through a quality and risk management programme that includes an implemented internal audit programme.

There are monthly staff / quality meetings.

The manager is the owner of the service she is an RN with many year management experience. There is a clinical manager (RN) and an enrolled nurse. The clinical manager's file includes a letter from the MOH (2002) approving her ability to manager such a facility. .

ARC,D17.3di (rest home): The manager has maintained professional development activities related to managing a rest home.

The two caregivers interviewed state that they receive good support from the manager who is able to provide advice at any time.

**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

When the manager is absent there is oversight by the clinical manager. The enrolled nurse can also provide support as required, The clinical manager indicated that she is very able to manage the role if the manager is away.

**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

Kowhai has a documented quality management system and policy. This includes an initial quality and risk plan for the initial merge of two facilities and an on-going quality plans and on-going risk plan. There is a documented internal audit programme including resident/ family surveys.

A review of the audits documents that they have been undertaken according to the documented audit schedule. Monthly meetings up until February 2013 do not document that audit outcomes are reported well at meetings. However. From April onwards the service has rectified this and monthly meetings from April2013 document that audits, and other quality data ( incidents and accidents and IC for example) are documented as reported well.

Staff meetings also document that polices are discussed at reviewed at meetings. The May 2013 meeting for example documents a review and discussion of the Pain policy and February the process for transferring residents.

Audits have documented action plans that are signed of when out comes addressed and this was in place for all audits reviewed.

There is a document control system, the service is currently reviewing and amalgamating polices from the two merged units.

Documents no longer relevant to the service are removed and archived.

 Staff interviewed were familiar with polices in use and how to access policies (two caregivers, the enrolled nurse, the registered nurse, and the manager)

There are implemented health and safety policies that include hazard identification. There is a preventative maintenance schedule implemented and other maintenance problems are managed promptly as these arise.

The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning.

D5.4 Kowhai have the following policies/ procedures to support service delivery;

1) Continence Policy.

2) Challenging behaviour policy.

3) Pain management policy and procedure.

4) Personal grooming and hygiene policy

5) Skin integrity management policy.

6) Wound care policy and procedures.

7) Transportation of subsidised residents policy and procedure includes costs, resident, and staff safety.

8) D10.1 A policy around death and dying.

9) Vehicle/transportation policy.

10) The service has a health and safety management system and this includes a health and safety programme ( dated Aug 2013) and an up to date hazard register that links to hazards identified through the incident and accident process.

Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There are infection control policies and procedure, a restraint policy and health and safety policies and procedures.

D19.2g: Falls prevention strategies are in place that include the analysis of falls incidents, sensor mats for relevant residents, increased supervision if required for a resident identified as a high falls risk and the identification of interventions on a case by case basis to minimise future falls.

There are six weekly resident meetings facilitated by the diversional therapist.

**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

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

Incidents/accidents and near misses are investigated and a log of incidents occurs monthly.

There is a discussion of incidents/accidents in monthly staff meetings and combined health and safety, and quality meetings.

D19.3c Discussions with the manager and clinical manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

There is an open disclosure policy and seven family members interviewed stated they are informed of changes in health status.

Incident/accident forms reviewed for August 2013 include' nine falls, three medication errors and two residents with behaviour . RN review of the incident forms is well documented, and outcomes link into care plans.

All incidents are collated monthly and presented on a bar chart for presentation at the staff meetings. The service also completes monthly summary of all incidents that includes the person, the incident type, injuries and action taken. Medication errors are similarly collated, reviewed and presented and also include an action plan for on-going management. As noted in 1.1.9 family information is not well documented (noting that seven relative state they are always informed)

The two caregivers, the enrolled nurse, the registered nurse and manager interviewed are all familiar with the incident/accident reporting process and describe discussion of these at the staff meeting.

**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

Kowhai employs two RNs, one EN, 18 care givers , an activities person , two cooks, plus house keepers, maintenance and gardener,. There are a job descriptions in place for all positions.

There are a range of appropriate human resources policies implemented. An orientation programme is in place Five staff files reviewed document that good employment practices are documented including police and reference checks. Orientations are in place for all five files and for the four staff who had been employed for over a year there is a documented appraisal.

Two caregivers state that they had received an orientation programme

An annual in-service education programme is in place. The annual training plan covers a range of subjects and attendance at these is recorded on staff records. Discussions with the two caregivers, the enrolled nurse, the registered nurse and manager and a review of documentation demonstrates a commitment to the education of staff that is implemented into practice.

D17.7d: There are implemented competencies for staff related to medication with all relevant caregivers, enrolled nurse and the registered nurse completing these annually.

The registered nurse and enrolled nurse have a current practicing certificate - sighted.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

The two care givers, EN and RN all agreed that staffing is sufficient to meet resident needs

The diversional therapist works Monday to Friday from 9am-3pm and an extra caregiver is rostered in the weekends to support residents.

Staff turnover is low. The service does not use agency staff and all leave is covered in the rosters reviewed.

The GP interviewed confirmed that staffing is appropriate to meet the needs of residents.

Seven family members interviewed state that there are sufficient staff on duty at all times.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service. There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.

D7.1 Entries are legible, dates and signed by the relevant caregiver, enrolled nurse, registered nurse or other staff member including designation.

Residents files are protected from unauthorised access by being locked away in an office.

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

Individual resident files demonstrate service integration. This includes medical care interventions. Medication charts are in a separate folder with medication and this is appropriate to the service.

**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

The service has an assessment process and resident’s needs are assessed prior to entry. The service has an admission policy, admission agreement, resident welcome pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and / or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process.

Of five residents and seven family members interviewed one resident and five family confirmed they received information prior to admission and understood rights. Remainder could not remember as long term resident or not clear on question (level of understanding compromised) .

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

There is an acceptance and declining entry to service policy. Consumers are advised of decline of entry when there are no beds available, the facility manager reports there have been no declined entry for any other reason. The service records the reason for declining service entry to residents and communicates this to residents/family/whanau. Anyone declined entry is referred back to the Needs Assessors or referring agency for appropriate placement and advice.

**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

There are policies and procedures that guide the admission of a resident and planning interventions with timeframes.

The Facility manager (who is an RN) and the clinical manager are responsible for development of the care plan, with input by the caregivers. Activity lifestyle assessments and activities care plans have been completed by the activity officer.

D16.2, 3, 4; An assessment is completed within 24 hours which is also developed as the initial care plan. Seven of seven resident files reviewed identified that the initial admission assessment/care plan was developed within 24 hours of admission and the long term care plans were completed by the registered nurses within a three week timeframe for the six long term residents (one was a respite resident).

Specific detailed assessment tools are completed on admission include a) pressure area risk, b) continence, c) falls risk, d) dietary needs, and e) pain. The care plan is reviewed by the completing registered nurse and amended when current health changes.

There is a care plan multi-disciplinary evaluation form that is completed by the RN as a comprehensive overview of care needs that is completed at least four monthly but usually three monthly. Link to 1.3.4.2.

Family are, where appropriate, involved from time of admission with communication documented.

D16.5e; Medical assessments were documented in six long term files within 48 hours of admission, the one respite resident was seen immediately prior to admission. It was noted in the six long term resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. More frequent medical assessment/ review noted occurring in residents with acute conditions.

Staff could describe use of a handover sheet to alert to resident needs and a verbal handover at the end of each duty that maintains a continuity of service delivery.

Progress notes are written at least daily but usually for each shift with any matters of note or untoward events.

The facility GP interviewed stated he has confidence in the ability of the registered nurses and staff to provide good care to their residents. No area for improvement was identified.

The one current wound file was reviewed which is a pressure area. There was an assessment tool, wound care, evaluation form in use which included type of wound and location with detailed wound care requirements. There was a short term care plan in place.

Tracer Methodology:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

Prior to admission, a needs assessor carries out a needs assessment. An initial assessment which also forms the initial care plan is completed by the admitting RN within 24 hours of admission which includes a comprehensive range of possible needs.

Further detailed assessment tools are completed within three weeks of admission including (but not limited to); continence, falls risk, pressure area and pain. There is a review document that includes all possible care needs completed by a RN at least four monthly but usually three monthly sighted on six of the seven files reviewed (one file was for a respite resident), however this does not include detailed assessment information. There is detailed re-assessment information completed for identified care needs of falls, pressure area and nutrition on six of seven files reviewed (one file respite resident).

The facility manager has completed InterRAI training and stated that the intent is to now implement the InterRAI as the assessment tool both on admission and for review over the next 12 months.

Improvement is required to ensure reassessment of all possible care needs is documented.

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

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

There is a suite of assessment tools used on admission to assess the care needs of residents. There is a review document that includes all possible care needs completed by a RN at least four monthly but usually three monthly sighted on six of the seven files reviewed (one file was for a respite resident), however this does not include detailed assessment information. There is detailed re-assessment information completed for identified care needs of falls, pressure area and nutrition on five of seven files reviewed (one file respite resident). One resident with care needs for incontinence, nutrition and challenging behaviour did not have documented re-assessment. On interview the facility manager, who is one of two RN's, described considering all areas of possible care needs as a part of the review document.

**Finding Statement**

Not all actual or possible care needs had a documented assessment tool completed during the evaluation or at least six monthly, including those already identified and included in the care plan.

**Corrective Action Required:**

Ensure reassessment of all possible care needs is documented.

**Timeframe:**

6 months

**STANDARD 1.3.5 Planning**

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

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

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

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

A review of seven resident files indicated the use of an initial, short term and comprehensive long term care plans that address all care needs. These reflect variances in resident health status. They are current and there is evidence of evaluation which is signed by the allocated registered nurse at least four monthly but usually three monthly. The care plan is completed within three weeks by a registered nurse. Six long term care plans reviewed included all needs identified in the assessment process. The facility and clinical managers stated at interview that discussion took place with family concerning the care planning of residents however this is not documented. On interview seven family members stated they were kept well informed of their resident care needs and what care was being provided. Link to 1.1.9.1.

All care needs were addressed in the care plans including specific strategies for those with mental health and other care requirements.

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

D16.3f; Seven resident files reviewed evidenced and seven family interviewed stated they were fully informed of their residents care needs and any changes. Link 1.1.9.1.

**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

Kowhai includes residents transferred from other facilities. A proportion of residents have a mental health diagnosis. Many of these residents have been transferred to the ARC contract.

Seven files were reviewed.

D18.3 and 4 Dressing supplies are available in the treatment room and well stocked.

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

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

Wound assessment and wound management plan was in place for one resident. Documentation for a wound now healed was also reviewed.

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

There is good specialist input into residents with mental health diagnosis with visits by assigned community psychiatric nurses, medication oversight by psychiatrist. Referral to psychiatric services for the elderly documentation for consultation and management advice was sighted on two files.

**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

The activities officer is currently completing ACE advanced modules with view to completing the diversional therapy papers next. She was previously a caregiver in one of the previous facilities and commenced the activity role on the move to Kowhai in November 2012. She works 40 hours per week Monday to Friday. The activity officer supports caregivers during lunch time by assisting residents one to one if required.

The programme is planned monthly and residents receive a personal copy of planned weekly activities including in large print as required. Activity plans are displayed on notice boards around the facility. Residents are also reminded each morning of activities that are occurring that day.

There is a new DT/activities plan being implemented which includes sections of individual, mental stimulation, comfort, well-being and behaviours with strategies for each. The Activities Officer on interview stated there is a focus on individual interaction and activities as many of the residents choose not to participate in many of the group activities.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed at least six monthly. There is a monthly evaluation.

ARHSS 16.5g.iii: A comprehensive lifestyle history is complete on or soon after admission and information gathered is included in the activity care plan. The activity officer at interview stated residents are quick to feedback likes and dislikes, each afternoon she discusses the next day programme and any preferences other than the programmed activity.

ARHSS 16.5g.iv: Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.

**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

D16.4a Long term care plans are evaluated at least four monthly but usually three monthly or as health care changes require, commencing with the completion of the care plan multi-disciplinary evaluation tool that considers all possible care needs by a registered nurse. Link to 1.3.4.2

It was stated at interview by the facility manager that the activity and caregiver staff are asked for verbal feedback for the care plan evaluation and then the RN completes the evaluation. Interview with the G.P stated fully involved in the decision of care for their residents and considers communication between him and RN's is very good.

Interview with seven family members stated they are kept fully informed of their residents care needs. Link with 1.1.9.1.

There is documented evidence of GP review at least every three months and on an as required basis for all seven files reviewed and three monthly medication reviews were documented for all 14 medication files reviewed.

There was evidence of alteration to the long term care plan as a part of the frequent, at least four monthly, and evaluation.

The facility manager has completed InterRAI and verbally state the intention to fully implement this assessment system over the next 12 months.

D16.3c: All initial care plans were evaluated as a part of the development of the long term care plan by the RN within three weeks of admission.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The service facilitates access to other medical and non-medical services, evidenced by GP documentation, involvement of mental health services and specialist services for the elderly. Referral forms and documentation are maintained on resident files.

There is information available pre-admission and in the admission documentation on the health and disability code of rights, advocacy, health practitioners code of conduct and informed consent.

D16.4c; the service provided examples of where residents condition had changed and the residents were reassessed by psychiatric services for the elderly.

D 20.1 discussions with registered nurses identified that the service has access to dietician, physiotherapist, podiatrist, specialist mental health and elderly services.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

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

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

The service has policies for transfer or exit of the service. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities with a transfer letter, with accompanying photocopied relevant documentation including medication charts. The facility manager or clinical manager are available for any follow up or queries

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by a RN. Medication charts record prescribed medications by residents’ general practitioner, including PRN and short course medications.

Medication administration was observed at lunchtime as administered to guideline requirements by the EN. Medications and associated documentation are kept on the medication trolley which is stored in the locked treatment room.

Controlled drugs are stored in a locked container which is adhered to the wall inside a locked cupboard in the locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Medication fridge is monitored weekly.

All senior caregivers complete medication training with an assessment for competency completed by a RN. An annual medication administration competency is completed of each staff member with RN’s peer evaluating each other. Medication training last occurred in June 2013.

The EN or senior caregivers deemed competent are responsible for administering medication with support from the RN when on duty.

No residents self-medicate at Kowhai, policies are in place should this need arise..

Kowhai has a number of residents with mental health diagnosis as a part of their care needs and have PRN antipsychotic medications charted by psychiatrist and GP. It was noted when reviewing that PRN use of such medications was very low.

Improvement is required to ensure all medication processes include good practice principles for controlled drug checks by a RN, PRN medication effectiveness is recorded, eye drops are dated to ensure discarded as per stated requirements.

D16.5.e.i.2; 14 medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

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

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

Controlled drugs are checked in when delivered weekly by the pharmacy manager and the most senior staff member available, while this is often the RN it is not always. RN weekly checks of controlled drugs were conducted weekly up until two months ago. In the period since only the check during deliver has been conducted which has not always included a RN.

Kowhai has a number of residents with mental health diagnosis as a part of their care needs and have PRN antipsychotic medications charted. It was noted when reviewing that PRN use of such medications was very low. PRN use of paracetamol is utilised and it was noted that one resident had received PRN paracetamol regularly until charted as regular.

Two of four eye drops currently in use were not dated to indicate when the drops were opened or when they should be discarded.

**Finding Statement**

In the previous two months the weekly controlled drug check did not always include a RN. When PRN medication is used there is no entry in the resident progress notes of the reason for the use or the effectiveness. Two of four eye drops currently in use were not dated to indicate when the drops were opened or when they should be discarded.

**Corrective Action Required:**

Ensure all medication processes include good practice principles for controlled drug checks by a RN, PRN medication effectiveness is recorded, eye drops are dated to ensure discarded as per stated requirements.

**Timeframe:**

1 month

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Food services policies and procedures are appropriate to the service setting. There are documented protocols for management of residents with unexplained weight loss or gain. Resident's individual dietary needs are identified, documented on the nutritional profile and a copy given to the kitchen. Nutritional needs are reviewed on a regular basis as part of the care plan review. The residents individual care plan includes any specific nutritional or dietary requirements. There is a summary sheet developed identifying those residents requiring a consistency of food that is not standard which is readily located on the kitchen wall. Additional snacks are available for residents when required and left-over food is named and dated in the fridge for use. Residents are offered fluids throughout the day. Residents' files sampled demonstrate regular monthly monitoring of individual resident's weight. Residents and family interviewed were satisfied with the food service provided and report their individual preferences are well catered for including individual meals when the main course is not of their liking and confirm adequate food and fluids are provided. Temperatures are recorded for the main meal of the day hot dishes, and daily for fridge and freezer temperatures. All records reviewed were within acceptable limits.

Kitchen and food audits include; Food monitoring Jan 2013 and food hygiene and storage May 2013. Cleaning tasks were sighted and the kitchen appeared to be clean and tidy on the day of audit with all food labelled and dated with either day of preparation or use by date.

D19.2 All staff have been trained in safe food handling at staff meeting conducted 24 July 2013.

Improvement is required to ensure a dietician approved menu is used and that changes to resident nutritional and dietary needs are documented to ensure all staff are aware of the change.

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

There is a four week menu in use however this menu was developed over two years previous and had not been checked by a dietician since development. A dietician is booked to complete a full menu review on the 30 October 2013.

There is a white board with listed resident food preferences and special dietary requirements. It was noted on the day of the audit that some of the information had rubbed off. Kitchen and caregiver staff are informed if resident's dietary requirement change verbally and in the communication book. It was confirmed at cook and caregiver staff interview that they are informed on the individual residents nutritional dietary requirements and know the residents preferences well.

**Finding Statement**

The current menu has not been reviewed against recognised nutritional guidelines by a dietician in the last two years. Changes of resident nutritional and dietary requirements are not documented in a permanent manner to ensure all staff involved in food preparation and serving are aware of these changes.

**Corrective Action Required:**

Ensure a dietician approved menu is used and that changes to resident nutritional and dietary needs are documented to ensure all staff are aware of the change.

**Timeframe:**

3 months

**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 implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemical safety training for staff provided April 2013. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. The service has an accident/incident system for investigating, recording and reporting incidents. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols.

**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

 Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The service displays a current warrant of fitness which expires on 1 April 2014. There are maintenance policies and procedures in place including bi-annual electrical checks and a preventative maintenance schedule being implemented for 2013.

Consideration is given to residents when purchasing new furniture and equipment. Relevant persons are consulted when selecting furniture, equipment, floor surface coverings. The external areas are maintained and enjoyed by residents. There are several seating areas in the garden and plenty of shade.

The facility is carpeted throughout with vinyl surfaces in bathrooms/toilets and kitchen areas. Hand rails are available around the hall ways. There is ample space for resident use including to safely mobilise using mobility aids.

 D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities.

There are a range of seating areas including a second small lounge.

There is a van that has a current warrant of fitness and registration.

Interviews with two caregivers and two registered nurses and one enrolled nurse confirmed there was adequate equipment.

Interview with five residents and seven family members stated satisfaction with the facilities and care provided.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

There are communal toilets close to each lounge and the dining room. There is a visitors' toilet. Hot water is monitored monthly and kept at an appropriate 45 degrees. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning.

There was alcohol based hand rub available throughout the facility with staff hand washing at each of the communal toilet areas.

**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

Resident rooms are of sufficient size to ensure care and support to rest home level residents and for the safe use of mobility aids. Transfers are undertaken on a trolley or by wheelchair. Residents and family interviewed are happy with their rooms and report adequate space. Residents were observed moving freely around the facility. Two caregivers interviewed report resident rooms have sufficient space to allow for the use of mobility equipment.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

There is a large separate dining room, large lounge and four smaller lounge / sitting areas that allow for quiet spaces and privacy with family. Residents and caregivers are able to move freely. The communal areas can accommodate the equipment required for the residents.

At interview the activity officer stated activities take place in a range of location depending on the type of activity including outside if weather permits.

D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety. Hallways are wide enough to facilitate staff assisting residents when mobilising.

**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

Policies reflect current practice. Policies include laundry policy, safe storage of chemicals and cleaning procedures. There is a small but functional designated laundry area and only resident’s personal laundry is done on site. Sheets, pillowcases, kylies and towels are laundered by a commercial laundry service. There is a clean linen storage area.

The service has a secure cupboard for the storage of cleaning and laundry chemicals. All chemicals were labelled and information sheets are available. The laundry and cleaning areas have hand-washing facilities.

Residents and family interviewed report being very happy with cleaning and laundry services. Services are audited for effectiveness monthly last completed Jan 2013.

**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

Emergency training is included as part of the orientation and annual in-service programme.

There is a NZFS approved fire evacuation scheme dated 10.4.95. Fire drill last conducted on 27 March 2013.

There is a least one staff member with a current first aid certificate on each shift. There is a functional call bell system for all bedrooms, communal rooms and bathroom facilities.

The service has a Security and Safety Policy that includes on call arrangements.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There is a gas cooker and barbecue for back up food preparation.

Water and food supplies are sufficient for at least three days with a stocked civil defence kit that is checked. There is extra blankets and emergency lighting.

**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 is under floor and ceiling with supporting night storage units, on the day of the audit the dining and large lounge rooms were of a comfortable temperature but it was noted that as it was a cold morning the hallway areas were of lower temperature. On interview the facility manager stated that air temperatures are monitored and efforts had been made to support an even temperature by having electrician checks. It was noted the older villa style section of the facility has high ceiling and that residents moved freely in and out of the buildings and a number of residents had their bedroom windows open. The recent annual survey question on environment identified residents and family members were satisfied. On interview with residents and family only one person commented on some areas being cooler.

Resident’s rooms have access to natural light with external windows and there is adequate external light in communal areas. Smoking is only permitted in designated area.

**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 Restraint and Enabler Policy includes definitions, approved restraint, authorisation, assessment, emergency situations, de-escalation, training and review and evaluation. There is a definition for both restraint and for enablers.

 The service promotes a restraint free environment and this is maintained.

Any assessment of use of enablers would be based on information in the care plan, discussions with residents and on staff observations of residents.

There are no residents requiring the use of enablers and no residents requiring restraint.

The registered nurse states that any restraint is used only when absolutely necessary.

Staff are trained in restraint minimisation and in management of enablers and behaviours. -

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The service and the environment minimise the risk of infection to residents, staff and visitors. The infection prevention and control programme is well known by staff as described by two caregivers and enrolled nurse. There are documented processes implemented. The service has yet to undertake an annual review as IC in this facility has only been implemented in this facility since October 2012 ( due January).

There are infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008 with policies reviewed in 2013.

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

The enrolled nurse (infection control coordinator) could describe how the service would manage an outbreak as could the registered nurse.

 Staff and visitors suffering from infectious diseases are advised not come to the facility. Residents suffering from infections will be isolated. An outbreak management policy is documented.

 There is a staff policy around what should happen if staff are sick.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

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

The enrolled nurse and clinical manager (an RN) are able to describe access to the DHB and Bug Control if advice and support is needed. The clinical manager and / or facility manager ( also an RN) would predominantly work with the GP if any issues were identified.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

Kowhai Resthome has a comprehensive infection control set of policies, The service also has the 'Bug Control" infection control set of polices as a resource for staff.

Infection control policies were reviewed and updated July 2013 and are in a user friendly format and freely available to staff

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

D 19.2a: Infection control policies include; infection control quality and risk management policy, PPE, antimicrobial policy, blood or body fluid management, communicable disease, hand washing, housekeeping and cleaning polices, clinical disinfection, role of the IC coordinator, MRSA, control of hazardous waste, surveillance, monthly monitoring , needles and sharps, notifications, outbreak management, staff infections, single use, renovation, standard precautions, plus a range of related polices that give assurance that the service has appropriate policies to guild and support staff with IC management.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

All staff receive infection prevention and control education at orientation and as part of the on-going education programme. All infection control education sessions are documented - sighted. Staff folders all document attendance at infection control training.

The most recent IC training was provided by Bug Control October 2012

Resident education is expected to occur as part of providing daily cares. Hand washing was seen to be encouraged and toilet facilities all have had washing reminders.

The infection control coordinator is an enrolled nurse with oversight from the registered nurse. The Bug Control nurse specialist is responsible for providing education and training to staff. The enrolled nurse has documented IC training through Bug Control on her staff file.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

Infection surveillance is an integral part of the infection control programme and is described in Kowhai's infection control policy.

The infection control nurse is responsible for ensuring monitoring of infection risk. Monthly infection surveillance occurs and is followed up at quality/staff meetings where outcomes and trends are discussed. Meetings minute reviewed document discussion of IC.

Each month a summary is developed for each resident with an infection. An infection control log is also developed, the log includes how the infection was identified, site of infection contributing factors and whether the treatment has been effective. The infection control log includes resident name, infection type, organism (if identified) treatment and evaluation.

**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:**