**The Ultimate Care Group Limited - Manurewa Lifecare**

**Current Status:** **07-Oct-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**

Manurewa Lifecare provides residential care for up to 51 residents who require hospital level care and rest home level care. Occupancy on the day of the audit is at 46, which includes three residents aged less than 65 years. The facility is operated by The Ultimate Care Group Limited. Staffing is stable with minimal turnover of staff. Residents and family interviewed provide positive feedback on the care provided.

Two areas requiring improvement have been identified during this audit relating to documentation of standing orders used for medication; and the appropriateness of the activities programme for all residents.

Three areas have been rated as continuous improvement relating to quality and risk management with various quality improvement projects undertaken including falls prevention, continuing education, and enhancing medication safety. Three areas of continuous improvement have been identified relating to quality improvements made concerning the transition of Maori residents from the community to residential care.

**Audit Summary AS AT** **07-Oct-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  07-Oct-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. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Organisational Management** | Day of Audit  07-Oct-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  07-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit  07-Oct-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  07-Oct-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  07-Oct-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** **07-Oct-13**

**Consumer Rights**

Residents and family interviewed report that services are provided in a manner that is respectful of residents rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs. A quality initiative was established to assist Maori residents and their whanau transition from the community to residential care and evaluation of this initiative, including feedback from the Counties-Manukau District Health Board (CMDHB), provides evidence that this has been successful.

Residents interviewed state they are happy with the service provided and report that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and of any significant change in the resident's condition. Visual inspection provides evidence the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms.

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

**Organisational Management**

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Manurewa Lifecare. A 'Manurewa Lifecare Business Plan 2013 - 2014', 'Quality Improvement Plan, Ultimate care Group', and 'Risk Management Plan January 2013 - January 2014' reviewed and include a vision statement, core values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Manurewa Lifecare including regular monthly reporting by the business manager and clinical services manager to The Ultimate Care Group Head Office. The clinical services manager is a registered nurse who has worked at Manurewa Lifecare for the last 18 months and was appointed to their current position in October 2012. The clinical services manager has a current annual practising certificate. The business manager has worked in the aged care sector for the last 16 years, the last two and a half years in their current role.

The Ultimate Care Group quality and risk management systems are fully imbedded at Manurewa Lifecare. Manurewa Lifecare has a well-established, documented, and maintained quality and risk management system that is maintained to a high standard, and reflects continuous quality improvement principles. There is comprehensive evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. As part of this process the service provider identifies any areas that needs improvement and undertakes quality improvement projects that includes monitoring and evaluation to ensure the improvements required have been made. There is comprehensive quality improvement project evidence available including evidence of monitoring and improvements to service as a result of the projects. As a result of the improvements to service noted as a consequence of these quality improvement projects, three criteria are rated continuous improvement.

There is an internal audit programme in place, risks are identified, and there is a hazard register. Adverse events are documented on accident/incident forms and an electronic database that is able to be reviewed by personnel from The Ultimate Care Group Head Office. Review of quality improvement data provides evidence the data is being collected, collated, analysed for trends, and is reported to The Ultimate Care Group Head Office via their intranet as well as to staff via various meetings. Combined quality improvement / staff meetings are held monthly, as are clinical/registered nurses meetings. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Copies of meeting minutes are available for staff to review in the nurses' station. Resident meetings are also held monthly.

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

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

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

**Continuum of Service Delivery**

There are clearly documented process for entry to the facility. Admissions are managed in an equitable and timely manner. Adequate information about the service is made available. Admission information includes eligibility criteria.

Care and support is provided by a range of health professionals. This includes the registered nurses, trained caregivers, general practitioner, mobility coordinator, activities coordinator and visiting allied health professionals. Clear time frames for service provision are defined and monitored and residents are involved in the care planning process as appropriate and able. Residents maintain access to additional health services as required. Referrals and transfers are managed in the timely and proficient manner.

Assessments and lifestyle plans are fully documented. Interventions are consistent with good practice and nursing outcomes are documented. Lifestyle care plans are reviewed every three months, or as required. Short term care plans are well utilised and reviewed as required. The nursing team is led by an experienced nurse who is responsible for implementing a number of quality projects and clinical trials resulting in some improved outcomes for residents.

An activities programme is provided and coordinated by an activities coordinator. A range of activities are provided, however there is insufficient evidence that residents are fully satisfied with the activities provided and an improvement is required. The service also implements a physiotherapy programme with is coordinated by the mobility coordinator. The combination of exercises provided and a falls prevention programme has resulted in improved mobility outcomes for some residents.

Manurewa Lifecare provides an appropriate medication management system. All medications are stored securely. Medications are monitored by the registered nurse and the authorised prescriber. Administration is conducted by staff who have completed a medication competency and one nurse is an approved vaccinator. One low risk improvement is required to the standing orders process.

Food and nutritional needs of residents are assessed and the menu is reviewed by a dietician. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements.

**Safe and Appropriate Environment**

Bedrooms provide single accommodation and have wash hand basins. Several of the bedrooms have shared toilet facilities and there is an adequate number of communal toilet and shower facilities throughout the facility. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as a carer. There are separate lounges for the hospital and rest home areas and a communal dining area, as well as a conservatory available. An external area is available for sitting and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

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

**Restraint Minimisation and Safe Practice**

There are adequately documented guidelines on the use of restraints, enablers and challenging behaviours. The use of restraints/enablers is comprehensively assessed and monitored. Recent quality initiatives have been successful in reducing overall restraint use. All staff receive adequate training in the safe use of restraint/enablers and the management of challenging behaviours.

**Infection Prevention and Control**

The infection control programme is clearly documented and is suitable for the facility and residents. Infection control responsibilities are clearly documented. Adequate information, resources and on-going training are provided. Annual review of all infection control activities ensures that prevention and control processes are up to date. The infection surveillance program is appropriate for the facility and the level of care provided. Use of antibiotics is monitored and overall infection rates are analysed for comparisons.

**Manurewa Lifecare**

The Ultimate Care Group Limited

Certification audit - Audit Report

Audit Date: 07-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | The Ultimate Care Group Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Manurewa Lifecare | 39 Great South Road | Manurewa | Auckland 2013 |

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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:** 07-Oct-13 **End Date:** 08-Oct-13 |
| **Designated Auditing Agency** | Health Audit (NZ) Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | Lead Auditor, RN, RM, ADipN, BN | 12.75 | 9.50 | 07-Oct-13 to 08-Sep-13 |
| Auditor 1 | XXXXXXXX | RN, LA, 8086 | 12.75 | 5.00 | 07-Oct-13 to 08-Oct-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX |  |  | 2.50 | 12-Oct-13 |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 25.50 | **Total Audit Hours off site** *(system generated)* | 17.00 | **Total Audit Hours** | 42.50 |
| **Staff Records Reviewed** | 7 of 41 | **Client Records Reviewed** *(numeric)* | 7 of 46 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 7 |
| **Staff Interviewed** | 15 of 41 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 1 |
| **Consumers Interviewed** | 6 of 46 | **Number of Medication Records Reviewed** | 14 of 46 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 11 day of October 2013

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

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

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

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

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

# Services and Capacity

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Manurewa Lifecare | 51 | 46 | 37 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Manurewa Lifecare provides residential care for up to 51 residents who require hospital level care and rest home level care. Occupancy on the day of the audit is at 46, which includes three residents aged less than 65 years. The facility is operated by The Ultimate Care Group Limited. Staffing is stable with minimal turnover of staff. Residents and family interviewed provide positive feedback on the care provided.

Two areas requiring improvement have been identified during this audit relating to documentation of standing orders used for medication; and the appropriateness of the activities programme for all residents.

Three areas have been rated as continuous improvement relating to quality and risk management with various quality improvement projects undertaken including falls prevention, continuing education, and enhancing medication safety. Three areas of continuous improvement have been identified relating to quality improvements made concerning the transition of Maori residents from the community to residential care.

1.1 Consumer Rights

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

1.3 Continuum of Service Delivery

There are clearly documented process for entry to the facility. Admissions are managed in an equitable and timely manner. Adequate information about the service is made available. Admission information includes eligibility criteria.

Care and support is provided by a range of health professionals. This includes the registered nurses, trained caregivers, general practitioner, mobility coordinator, activities coordinator and visiting allied health professionals. Clear time frames for service provision are defined and monitored and residents are involved in the care planning process as appropriate and able. Residents maintain access to additional health services as required. Referrals and transfers are managed in the timely and proficient manner.

Assessments and lifestyle plans are fully documented. Interventions are consistent with good practice and nursing outcomes are documented. Lifestyle care plans are reviewed every three months, or as required. Short term care plans are well utilised and reviewed as required. The nursing team is led by an experienced nurse who is responsible for implementing a number of quality projects and clinical trials resulting in some improved outcomes for residents.

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Manurewa Lifecare provides an appropriate medication management system. All medications are stored securely. Medications are monitored by the registered nurse and the authorised prescriber. Administration is conducted by staff who have completed a medication competency and one nurse is an approved vaccinator. One low risk improvement is required to the standing orders process.

Food and nutritional needs of residents are assessed and the menu is reviewed by a dietician. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements.

1.4 Safe and Appropriate Environment

Bedrooms provide single accommodation and have wash hand basins. Several of the bedrooms have shared toilet facilities and there is an adequate number of communal toilet and shower facilities throughout the facility. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as a carer. There are separate lounges for the hospital and rest home areas and a communal dining area, as well as a conservatory available. An external area is available for sitting and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

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

2 Restraint Minimisation and Safe Practice

There are adequately documented guidelines on the use of restraints, enablers and challenging behaviours. The use of restraints/enablers is comprehensively assessed and monitored. Recent quality initiatives have been successful in reducing overall restraint use. All staff receive adequate training in the safe use of restraint/enablers and the management of challenging behaviours.

3. Infection Prevention and Control

The infection control programme is clearly documented and is suitable for the facility and residents. Infection control responsibilities are clearly documented. Adequate information, resources and on-going training are provided. Annual review of all infection control activities ensures that prevention and control processes are up to date. The infection surveillance program is appropriate for the facility and the level of care provided. Use of antibiotics is monitored and overall infection rates are analysed for comparisons.

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 | CI | 3 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:0 CI:1 FA: 11 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:3 FA:20 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:3 FA:19 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 10 PA Neg: 0 PA Low: 2 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:19 PA:2 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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

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

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 0 **CI:** 1 **FA:** 47 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 6 **FA:** 93 **PA:** 2 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: The Ultimate Care Group Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:07-Oct-13 End Date: 08-Oct-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXX

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| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.7 | 1.3.7.1 | PA  Low | **Finding:**  There is insufficient evidence that the activities programme is implemented in a manner which is meaningful to the resident. This is evident in resident/family satisfaction surveys and in two resident interviews.  **Action:**  Provide evidence of improved satisfaction with the activities programme. | 6 months |
| 1.3.12 | 1.3.12.1 | PA  Low | **Finding:**  The provision of standing orders does not fully comply with standing orders guidelines (2012). For example the length of time, or number of doses which can be administered has not been defined.  **Action:**  Provide evidence that standing orders include the length of time and number of doses which can be administered. | 1 month |

# Continuous Improvement (CI) Report

Provider Name: The Ultimate Care Group Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:07-Oct-13 End Date: 08-Oct-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXX

|  |  |  |
| --- | --- | --- |
| **Std** | **Criteria** | **Evidence** |
| 1.1.4 | 1.1.4.2 | **Finding:**  Following consultation with Counties-Manukau District Health Board (CMDHB), a quality initiative was established to assist Māori residents and their whanau transition from the community to residential care. Documentation concerning this initiative, including evaluation and feedback from whanau and CMDHB, provides evidence that this initiative has been successful. There were two residents who identified as Māori prior to this initiative being implemented and since April 2013 there have been three Powhiri held for new residents and their whanau. |
| 1.1.4 | 1.1.4.3 | **Finding:**  A quality improvement project reviewed that was established in April 2013 to assist Māori residents and their whanau transition from the community to residential care. This project came about because of the perception that many Māori are fearful of moving in to residential care because many Māori perceive that the existing services provided are not culturally safe and appropriate for Māori. Following discussion between CMDHB and the business manager it was decided that a Powhiri to the facility for Māori residents and their whanau was appropriate to assist with the transition from community to the facility. Prior to this project there were two Māori residents and three Powhiri have been held to welcome new Māori residents and their whanau since implementing this project. Tikanga Māori education has also been provided by CMDHB personnel to assist staff. Evaluation for this project reviewed and feedback from residents and their whanau indicates the residents 'feel like they belong and are not a visitor.' |
| 1.1.4 | 1.1.4.5 | **Finding:**  Three Powhiri have been held since April 2013 to assist Māori residents and their whanau transition from the community to residential care. Evaluation for this project reviewed and feedback from residents and their whanau indicates the residents 'feel like they belong and are not a visitor.' Feedback from resident includes 'the Powhiri done by the staff of the facility, all non-Māori, ka pai!'. Tikanga Māori education has also been provided by CMDHB personnel to give staff the tools to care for Māori residents. |

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| 1.2.3 | 1.2.3.6 | **Finding:**  There is an established, documented, and maintained quality and risk management system in place at Manurewa Lifecare that is maintained to a high standard, and reflects continuous quality improvement principles. There is comprehensive evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. There is evidence available indicating the service provider identifies any areas that needs improvement and undertakes quality improvement projects that includes monitoring and evaluation to ensure the improvements required have been made. For example, a quality improvement initiative relating to falls prevention implemented as a result of analysis of falls data. Review of this project including the project overview, problem statement, project scope, expected outcome, measures, interventions, PDSA worksheets, various tools used, contributing factors, data, and project evaluation indicates an improvement to resident safety and a raised awareness/vigilance of hazards by staff. |
| 1.2.3 | 1.2.3.7 | Finding:  2013 internal audits reviewed and provide robust evidence of clear tracking of audit outcomes from month to month. The clinical services manager provides month by month 'Manurewa Lifecare Action Plan' for audits completed that month. These reports reviewed and include issues identified, action plan, evidence required to demonstrate correction of identified variance; by when, by whom, evidence to show completion of the corrective action plan. Along with meeting minutes, these are used to document and monitor areas that have been identified as requiring improvement and review of these action plans and minutes indicate monitoring to ensure achievement has been met. Various quality improvement projects have been implemented as a result of analysis of clinical indicators and other areas identified as requiring improvement. Documentation reviewed during this audit indicates continuing improvement to service provision. |
| 1.2.3 | 1.2.3.8 | **Finding:**  There is extensive evidence of documented corrective actions having been developed, implemented, reviewed and signed off as having been completed throughout all of the quality and risk management documentation, including meeting minutes, reviewed during this audit. Continued improvements to service are evident in the documentation reviewed and interviews conducted. |

**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

Ten of 10 care staff (seven care givers - five hospital and two rest home covering morning and afternoon shifts; three registered nurses - working morning and afternoon shifts), the business manager, and the clinical services manager/registered nurse demonstrate a knowledge of the Code of Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. All care staff interviewed confirm they have received recent education on the Code, as part of their inservice education programme. Review of education records and staff files (seven) evidence education provided 27 February 2013.

Visual observations during the audit indicates staff are respectful of residents and incorporate the principals of the Code in their practice. Staff observed knocking before entering residents' bedrooms.

Residents interviewed (four rest home and two hospital) confirm that staff respect their rights and most are aware of the Code. Family member interviewed (one hospital) confirm staff respect their family members rights. Documentation reviewed indicates education on the Code was provided for residents 03 July 2012.

Resident and family satisfaction surveys completed August 2013 and collated results reviewed indicates residents and their family are satisfied with the amount of involvement in decisions affecting their care, their privacy is respected and staff treat them with dignity and respect.

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

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

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

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

Resident meetings are held monthly and minutes reviewed indicate feedback from residents on various aspects of service delivery including the residents making suggestions concerning meals, laundry and activities programme. Residents and family interviewed report they are informed of their rights by both pre-admission and admission information being provided. Documentation reviewed indicates education on the Code was provided for residents 03 July 2012. All residents are provided with an information pack on admission and this includes information on the Code and complaints processes. The Code - including large print posters, and advocacy details are displayed throughout the facility, and copies are available and accessible and residents are given opportunity for discussion regarding these. Admission Agreement reviewed and includes information on the Code of Residents’ Rights. Signed Admission Agreements on residents files held in the administration office.

The ARC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

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

Visual inspection of the facility provides evidence that all bedrooms are single and residents have dedicated areas to keep their personal property and possessions and the rooms are as personalised as resident's want them to be. A conservatory is available for residents to meet with family members if required. There is a suitable environment available for caring for a dying resident and their family. Communal hygiene facilities display appropriate signage and a safe locking system.

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

Two chaplains rotate weekly visits to the facility so that church services are held weekly. The chaplains also undertake one-on-one visits with residents during these visits.

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

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

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

This standard and the three criteria it contains have been rated as Continuous Improvement as a result of a quality initiative that was established to assist Māori residents and their whanau transition from the community to residential care. Documentation concerning this initiative, including evaluation and feedback from whanau and the Counties-Manukau District Health Board (CMDHB), provides evidence that this initiative has been successful. There were two residents who identified as Māori prior to this initiative being implemented and since April 2013 there have been three Powhiri held for new residents and their whanau.

Documentation reviewed includes appropriate Māori protocols, a Māori health plan, and a 'Māori Health Activities Record' that is used to record any specific Māori focused activities e.g. Powhiri, blessings, marae visits. There are currently four residents, three caregivers, and business manager, who identify as Māori.

Access to Māori support and advocacy services is available via the Manurewa marae, Kaumatua, and via the Māori health unit from the local DHB if required. Cultural support and advice is also available from the four staff members who identify as Māori.

Systems are in place to allow for review processes including input from whanau/family, where appropriate, for any resident who identifies as Māori. Cultural assessments are part of all residents' care plans and was reviewed on resident's files. The file of one resident who identifies as Māori reviewed and indicates their family is involved in resident's care. A resident who identifies as Māori interviewed and confirms their spiritual and cultural needs are being met.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Māori tikanga education provided 03 October 2013 for staff by CMDHB personnel and attended by 28 members of staff.

The ARC requirements are met.

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

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

Access to Māori support and advocacy services is available via the Manurewa marae, Kaumatua, and via the Māori health unit from the local DHB if required. Cultural support and advice is also available from the four staff members who identify as Māori.

**Finding Statement**

Following consultation with Counties-Manukau District Health Board (CMDHB), a quality initiative was established to assist Māori residents and their whanau transition from the community to residential care. Documentation concerning this initiative, including evaluation and feedback from whanau and CMDHB, provides evidence that this initiative has been successful. There were two residents who identified as Māori prior to this initiative being implemented and since April 2013 there have been three Powhiri held for new residents and their whanau.

**Corrective Action Required:**

**Timeframe:**

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

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

A resident who identifies as Māori interviewed and confirms their spiritual and cultural needs are being met.

**Finding Statement**

A quality improvement project reviewed that was established in April 2013 to assist Māori residents and their whanau transition from the community to residential care. This project came about because of the perception that many Māori are fearful of moving in to residential care because many Māori perceive that the existing services provided are not culturally safe and appropriate for Māori. Following discussion between CMDHB and the business manager it was decided that a Powhiri to the facility for Māori residents and their whanau was appropriate to assist with the transition from community to the facility. Prior to this project there were two Māori residents and three Powhiri have been held to welcome new Māori residents and their whanau since implementing this project. Tikanga Māori education has also been provided by CMDHB personnel to assist staff. Evaluation for this project reviewed and feedback from residents and their whanau indicates the residents 'feel like they belong and are not a visitor.'

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

Systems are in place to allow for review processes including input from whanau/family, where appropriate, for any resident who identifies as Māori. Care plan for one resident who identifies as Māori reviewed and indicates their family is involved in resident's care.

**Finding Statement**

Three Powhiri have been held since April 2013 to assist Māori residents and their whanau transition from the community to residential care. Evaluation for this project reviewed and feedback from residents and their whanau indicates the residents 'feel like they belong and are not a visitor.' Feedback from resident includes 'the Powhiri done by the staff of the facility, all non-Māori, ka pai!'. Tikanga Māori education has also been provided by CMDHB personnel to give staff the tools to care for Māori residents.

**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

There are several different ethnic groups within the facility and observations during this audit indicate the individual's cultural values and beliefs are being met. Service provider's documentation provides evidence appropriate culturally safe practices are implemented and are being maintained. Policies list access details to appropriate expertise (e.g. cultural specialists, and interpreters). Currently one resident has no English and key words have been translated by family and are displayed on the resident's bedroom wall.

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

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met (see link 1.1.4). These findings supported during review of resident satisfaction survey completed in August 2013. Church services are held on site as part of the activities programme.

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

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

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

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

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

Systems are in place to ensure service providers receive a range of opportunities which promote good practice within the facility. Service provider’s documentation evidences that policies and procedures are based on evidence-based rationales. Education by specialist educators is provided as part of the in-service education programme and this was confirmed during review of education records and interview of the BM and clinical services manager (CSM) who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. CSM, who has a background in nursing education, has recently implemented a continuing education quality improvement project (see 1.2.3) and one of the stated aims of this project is to incorporate more evidence-based literature in to the education programme.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

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

Residents and family interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff who are responsible for their care. Family member interviewed (hospital resident) advises staff advise them of any change in their family members condition.

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

The ARC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The BM, CSM, and RN's advise informed consent is discussed and recorded on the resident's admission to the facility.

Residents/family are provided with various consent forms on admission for completion as appropriate. Resident files reviewed have copies of EPOAs where EPOAs are recorded. A 'Checklist For Enduring Power of Attorney' sighted on resident's files and includes information on whether or not there is a named EPOA and if a copy of this documentation has been sighted.

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

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

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

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

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

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

The service has appropriate policies regarding advocacy/support services that specify advocacy processes and how to access independent advocates. The BM advises a family member who visits the facility on a daily basis, and attends the monthly residents meetings, acts as an advocate for residents if required. The BM also advises a representative from Age Concern visits six monthly and two chaplains visit weekly and also act as advocates, if required.

Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care givers interviewed confirm they have had education on the Code of Right, advocacy, complaint management as part of their education programme. This was confirmed during review of staff education records.

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

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

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

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

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has appropriate systems in place to manage the complaints processes. A complaints register is maintained at the facility and there are eight complaints recorded for 2013 (three from one resident and four of the eight relating to one event from four different residents). A complaints register is also maintained at The Ultimate Care Group (UCG) Head Office for complaints that are escalated up to them (not reviewed during this audit). Reporting of complaints occurs via monthly meetings and via the managers reports to the UCG Head Office. The BM reports there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. The BM advises the HDC complaint received December 2011 and referred to in the last audit report (June 2012) remains open. The BM advises the last action on this complaint by the HDC was interviews of two staff members who were on duty during the incident, on 25 February 2013.

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

A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of quality/staff meeting minutes and manger's monthly reports evidences reporting of complaints.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Manurewa Lifecare. A 'Manurewa Lifecare Business Plan 2013 - 2014', 'Quality Improvement Plan, Ultimate care Group', and 'Risk Management Plan January 2013 - January 2014' reviewed and includes a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed documented values, mission statement and philosophy, which are displayed.

UCG has established systems in place which define the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems. Interview of Manager Audit and Compliance from UCG Head Office confirms reporting processes and monitoring of quality and risk management goals.

There is an ' Ultimate Care Group Clinical Advisory Group' (CAG) in place that has four CSM's and is responsible for reviewing clinical issues and policies and procedures following feedback from each of the 16 UCG sites. Each of the four CSM's is responsible for liaising with four or five UCG sites to ensure their participation in the process. 'Ultimate Care Group Clinical Governance Group Terms of Reference' reviewed.

The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service. Meeting schedules and minutes reviewed and monthly quality/staff and resident meetings are held as are three monthly RN meetings. Meeting minutes are available for review by staff along with clinical indicator reports, graphs, and various service reports. The managers provide weekly and monthly reports to the governing body and these reviewed. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.

Manurewa Lifecare has a business manager (BM) and a clinical services manager (CSM). The clinical services manager is a registered nurse who has worked at Manurewa Lifecare for the last 18 months and was appointed to their current position in October 2012. The clinical services manager has a current annual practising certificate. The business manager has worked in the aged care sector for the last 16 years, the last two and a half years in their current role.

Review of the managers' personal files and interview of the BM and CSM indicates the managers undertake training in relevant areas. Twenty four hour RN cover is provided and the CSM, and a senior RN in the absence of the CSM, is responsible for oversight of clinical care provided to residents. Support for the BM and CSM is provided by a Regional Operations Managers for UCG.

Manurewa Lifecare is certified to provide hospital level care and rest home level care and there are 51 beds provided (14 rest home and 37 hospital). On day one of this audit there are 28 hospital residents (including one aged less than 65 years) and 18 rest home residents (including two aged less than 65 years).

Ultimate Care Group Limited have contracts with the DHB to provide aged related residential care (rest home and hospital services), and long term support - chronic health conditions - residential. UCH also has a contract with Ministry of Health for residential - non aged services..

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

There are appropriate systems in place to ensure the day-to-day operations of the service continues should the clinical services manager and/or the business manager be absent. The clinical services manager and administrator relieve the business manager if they are absent. A senior RN relieves the clinical services manager if they are absent. Twenty four hour RN cover is provided.

An UCG Regional Operations Manager, and other personnel from UCG Head Office are also available for assistance and support as required. Services provided meet the specific needs of the residents groups within the facility. Job descriptions and interviews of the BM and CSM confirms their responsibility and authority for their roles.

The requirements of the ARC are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The Ultimate Care Group (UCG) quality and risk management systems are fully imbedded at Manurewa Lifecare, are maintained to a high standard, and reflect continuous quality improvement principles. There is comprehensive evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. As part of this process the service provider identifies any areas that need improvement and undertakes quality improvement projects that includes monitoring and evaluation to ensure the improvements required have been made. There is comprehensive evidence of quality improvement projects available including evidence of monitoring and improvements to service as a result of these projects. As a result of the improvements to service noted as a consequence of these quality improvement projects, three criteria (1.2.3.6, 1.2.3.7, and 1.2.3.8) are rated continuous improvement.

UCG launched 'Releasing Time to Care' (RTTC) modules at some trial sites in January 2012 and rolled it out to all UCG sites in August 2012. Manurewa Lifecare have integrated the RTTC modules in to their service.

There is an internal audit programme in place and completed internal audits for 2013 reviewed. Review of quality improvement data provides evidence the data is being reported to The Ultimate Care Group Head Office via their intranet, as well as to staff via various meetings. Combined quality improvement / staff meetings are held monthly, as are clinical/registered nurses meetings. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Copies of meeting minutes are available for staff to review in the nurses’ station. Resident meetings are also held monthly.

Family/whanau and residents survey was completed in August 2013 via UCG head office and collated results reviewed and indicate the majority of responders are either satisfied or very satisfied with the various aspects of service provided.

The Ultimate Care Group (UCG) 'Quality and Risk Management Plan - 2012 - 2014' is used to guide the quality programme and includes quality goals and objectives.

UCG implemented an electronic database (Inscribe database) in December 2012, which is used to input clinical indicators on a daily basis. This information is available for review by staff at UCG head office. Information on this database, including benchmarking graphs, reviewed.

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

Clinical indicators are recorded on various registers and forms and reviewed during this audit. There is documented evidence of collection, collation, and reporting of quality improvement data including reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in the monthly quality/staff meetings. A quality improvement initiative relating to falls prevention implemented as a result of analysis of falls data.

Staff interviewed report they are kept well informed of quality and risk management issues including clinical indicators. Copies of these meeting minutes are available in nurses' stations along with graphs of clinical indicators which are attached to the meeting minutes. The managers are responsible for providing 'Weekly and Monthly Report' to the UCG Head Office and these provide evidence of reporting of clinical indicators and quality improvements - including education and internal audits. Other areas reported on include occupancy, staffing and HR, Resident Ins and Outs, Property/Environmental Issues, Financial, General Comments, Compliance/Indicator Summary.

Quarterly internal audits are being undertaken by the Manager Audit, from the Ultimate Care Group to ensure compliance with the quality and risk management programme, certification requirements, and funding contract requirements. Corrective action plans are developed following these internal audits to address any improvements required and the facility is re-audited if required to achieve compliance with the standards set by the organisation. The outcome of these audits are reported to the Board.

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

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

The requirements of the ARC are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

There are policies and procedures in place relating to key components of service delivery, including quality and risk management.

There is evidence of analysis, evaluation, and reporting of clinical indicators in meeting minutes, various reports, and in the clinical indicators component of the manager’s reports to UCG.

Appropriate data collection forms and registers for documenting events related to key components of service delivery reviewed.

Accident/incident register and completed forms reviewed.

Monthly reports to governing body via the UCG intranet includes reporting of quality improvement data.

Seven of seven caregivers and three of three RN's interviewed report quality improvement data is discussed during their handovers, and at monthly quality/staff meetings. They also confirm meeting minutes and graphs are available for them to review (sighted displayed).

**Finding Statement**

There is an established, documented, and maintained quality and risk management system in place at Manurewa Lifecare that is maintained to a high standard, and reflects continuous quality improvement principles. There is comprehensive evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. There is evidence available indicating the service provider identifies any areas that needs improvement and undertakes quality improvement projects that includes monitoring and evaluation to ensure the improvements required have been made. For example, a quality improvement initiative relating to falls prevention implemented as a result of analysis of falls data. Review of this project including the project overview, problem statement, project scope, expected outcome, measures, interventions, PDSA worksheets, various tools used, contributing factors, data, and project evaluation indicates an improvement to resident safety and a raised awareness/vigilance of hazards by staff.

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

'Quality Improvement Plan, Ultimate Care Group' reviewed and outlines audits to be completed for each month. Audits completed for 2013 reviewed.

Processes are in place for the collection of key performance and risk data, such as: Accident / incident data - reported by area, by type, and time of event; Infections; Complaints data. This data reviewed.

Documentation reviewed such as reports, registers and forms evidences appropriate data collection for accident / incidents and complaints.

Monthly quality / staff meetings and health, as well as RN meetings and meeting minutes reviewed demonstrate that quality and risk issues, including numbers of events, are being discussed at these meetings e.g. accident/incident/event reporting outcomes, complaints, audit outcomes, infection control, health & safety, restraint usage. This finding confirmed during interviews of staff.

**Finding Statement**

2013 internal audits reviewed and provide robust evidence of clear tracking of audit outcomes from month to month. The clinical services manager provides month by month 'Manurewa Lifecare Action Plan' for audits completed that month. These reports reviewed and include issues identified, action plan, evidence required to demonstrate correction of identified variance; by when, by whom, evidence to show completion of the corrective action plan. Along with meeting minutes, these are used to document and monitor areas that have been identified as requiring improvement and review of these action plans and minutes indicate monitoring to ensure achievement has been met. Various quality improvement projects have been implemented as a result of analysis of clinical indicators and other areas identified as requiring improvement. Documentation reviewed during this audit indicates continuing improvement to service provision.

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

'Manurewa Lifecare Action Plan' and Manurewa Lifecare PDSA Worksheets are used to record and track areas identified as requiring improvement.

Internal audit tools also include corrective action plans - including timeframe and person responsible for ensuring the action is implemented. Review of internal audits indicates these are being completed and signed off by the BM (non-clinical) or CSM (clinical).

Quality / staff meetings and RN meeting minutes include actions to be taken, by whom, and by when, and provide evidence of tracking/monitoring and completion.

Completed adverse event forms reviewed in resident files and corrective action plans documented to address areas requiring improvement as appropriate.

**Finding Statement**

There is extensive evidence of documented corrective actions having been developed, implemented, reviewed and signed off as having been completed throughout all of the quality and risk management documentation, including meeting minutes, reviewed during this audit. Continued improvements to service are evident in the documentation reviewed and interviews conducted.

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

The adverse event reporting system evidences a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG Inscribe electronic database, and filed in resident files. 2013 data reviewed includes summaries and registers of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff indicate appropriate management of adverse events. See link 1.2.3.6 re falls prevention quality project.

An 'Incident Management Form' is used to document all incidents that are referred to The Ultimate Care Group.

There is an open disclosure policy. Resident files reviewed (three hospital and four rest home) provide evidence of communication with families following adverse events involving the resident, or any change in the residents condition. This finding confirmed during family interview.

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

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Written policies and procedures in relation to human resource management are available and reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (seven of seven) along with employment agreements, criminal vetting, completed orientations and competency assessments.

The CSM is responsible for management of the inservice education programme and there is evidence available indicating inservice education is provided for staff at least twice a month. Individual records of education are maintained for each staff member and copies reviewed on staff files. Also viewed competency assessment and education spread sheets as well as education records for each session, and inservice education programmes.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff advise they are 'buddied' for one week at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided i.e.: The quality improvement plan; Policies and procedures; Health and safety requirements; The physical layout of the facility; The authority and responsibility of their individual positions; The organisation’s vision, values & philosophy.

The CSM has a background in nursing education and has implemented a quality improvement project (see 1.2.3) relating to continuing education that aims to increase the staff attendance in non-compulsory education sessions, as well as considering different models for delivering education. As part of this project they have subscribed to online education, have developed a structure for the implementation of small group discussions and subscribed to the Health Education Trust ACE Programme. All care givers and RNs are currently working their way through the ACE dementia modules. It is UCG policy that all RNs are required to complete the ACE Dementia education modules. The CSM advises that once staff have completed the dementia modules they will complete the ACE core and advanced programmes.

An appraisal schedule is in place and current staff appraisals sighted on all staff files reviewed. Annual practising certificates are current for all staff who require them to practice.

Care staff interviewed (seven care givers, three RNs) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is a clearly documented rationale ('Policy For Service Management') for determining service provider levels and skill mixes in order to provide safe service delivery in place at Manurewa Lifecare. The staffing rationale is based on 'SNZ:HB 8163:2005 Indicators for Safe aged-care and dementia-care for Consumers' - 'Table 4 Recommended hours per consumer' and is reported on weekly to the Ultimate Care Group Head Office by the manager. Registered nurse cover is provided 24 hours a day. The minimum amount of staff is provided during the night shift and consists of one registered nurse and three care givers. The business manager and the clinical service manager are on call after hours.

Caregivers interviewed report that there is enough staff on duty and they are able to get through the work allocated to them. Residents and family interviewed report there is generally enough staff on duty to provide them with adequate care.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

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

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

Ten of 10 clinical staff interviewed (three RNs and seven caregivers) and the CSM confirm they know how to maintain confidentiality of resident information. Historical records are held on site for 12 months and are then transferred to Recall for storage (since September/October 2012).

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

The Manurewa Lifecare facility operates twenty four (24) hours per day, seven days per week. Information about the service is readily available on the Ministry of Health and Eldernet web sites. The Clinical Services Manager states that referring agencies are kept fully informed of bed availability and the eldernet web site is kept current.

The Clinical Services Manager is responsible for ensuring the entry process is delivered in a timely and equitable manner. Guidelines on entry criteria, assessment and screening processes are clearly documented. An admission checklist is utilised to ensure all entry processes are occurring as required.

All residents are assessed as requiring rest home or hospital level care prior to entry. The required referrals/assessments are evident in seven out of seven resident records sampled. Evidence of the completed admission documents is also sighted. For example consents, resident admission agreements and initial care plans.

Full details regarding the resident's right to receive additional services is included in the resident agreement and the Work and Income brochure on how to apply for a subsidy is provided in the welcome information folder.

The related ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARHSS D4.2

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

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

There is an adequately documented process for the management of any declines to entry and waiting lists. Records of enquiries are maintained and, it is reported that in the event of decline, information is given regarding alternative services. The service currently has some bed availability and there are no potential residents on the waiting list. The Clinical Services Manager is interviewed and states there has had no refusals since their employ in October 2012.

**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

Residents' and staff files sampled confirm that each stage of service provision is completed by a suitably qualified person. All assessments and care plans are developed and reviewed by a registered nurse and/or the multidisciplinary team. Daily interventions and support with activities of daily living are implemented with the support of trained caregivers.

Timeframes for service delivery are defined and met as evident in seven out of seven residents' files sampled. An initial assessment is completed on admission by the registered nurse and a medical assessment conducted by the general practitioner (GP) within forty eight hours. A lifestyle care plan is developed within 21 days. Short term care plans are also developed as and when required and care plan reviews are completed (at a minimum) every three months. GP reviews are also completed every three months. The GP interviewed confirms their involvement in specialist referrals and medication reviews and states they are always contacted regarding any concerns in a timely and proficient manner.

Continuity of care is maintained. For example, GP entries and visits from allied health providers are sighted. Daily handovers between shifts also ensures continuity. During the audit a handover is observed and confirms accurate and comprehensive information is communicated. Residents' files are integrated and contain a section for allied health reporting.

The remaining relevant ARC requirements are met. Lifestyle care plans are comprehensive and include physical, spiritual and cultural abilities, deficits and expected nursing outcomes.

Tracer methodology - hospital resident:

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

Tracer methodology - rest home resident.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

The registered nurses complete a number of assessments on admission inclusive of Coombes, Norton, pain, incontinence, oral health, nutrition, and risk. Challenging behaviour assessments are completed as required and are sighted in records sampled. A physiotherapy assessment, medical assessment and activity profile is also completed. Base line observations, including weight, are also recorded on admission, and there after monthly (or more frequently if required).

Seven resident files are sampled. The sample is stratified and includes both hospital and rest home residents. The required (and appropriate) assessments are sighted in all files samples. The results of the assessment process are then transferred onto the lifestyle care plan with nursing outcomes and goals documented. Assessments are reviewed by the nurse and updated, as required, to reflect the current status of the resident. Residents interviewed report involvement in the assessment process and there are adequate areas within the facility to ensure assessments are conducted in private.

The relevant ARC requirements are met. Lifestyle care plans sighted have been completed within three weeks of entry. Assessments sighted are commensurate with the current needs of the resident.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

An initial care plan is developed on admission and a lifestyle care plan developed within three weeks. The nursing process is used and lifestyle care plans include a nursing diagnosis, nursing objective/goal and related interventions. The lifestyle care plan is comprehensive and includes nutrition/hydration, personal care/hygiene, skin integrity, elimination/bowels/bladder, respiratory, cardiovascular, communication/sensory, pain/comfort, maintaining safety, sexuality/intimacy, spirituality, social, cultural, grief/loss/end of life care, sleep/rest and medical conditions. Resident’s ability and level of dependence is noted and the required interventions for each heading are documented.

Short term care plans are also developed when required. A number of short term care plans are sighted within the sample. For example, wound care plans, challenging behaviour charts and infection data care plans (also refer criterion # 1.3.3). Short term care plans are reviewed regularly and closed out when discontinued. In addition, physiotherapy plans and activity plans are documented and related interventions implemented.

Residents' files sampled evidence integration. Sections exist for care, progress, correspondence, medical notes, adverse events, consents, family contacts, laboratory results, needs assessment correspondence, referral agencies, District Health Board letters and medical specialists records. Staff interviewed confirm they have access to residents' records/plans and are sighted completing their progress notes on the day of the audit.

The remaining relevant ARC requirements are met. Initial assessments are completed on admission and residents/ family confirm input in the development of their lifestyle care plans.

**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

Interventions are documented for each nursing objective/goal. Interventions sighted are commensurate with the residents' current needs and the nursing goals. Interventions are detailed and documented clearly to guide staff.

The GP interviewed is satisfied that clinical interventions are based on good practice and implemented in a timely and competent manner. It is noted that the Clinical Services Manager is implementing a number of quality initiatives in order to ascertain the effectiveness of specific interventions. Evidence and results of clinical trials are sampled by the auditors, resulting in the allocation of continuous improvement ratings (refer standard 1.2.3). Clinical trials and innovative interventions are fully supported by the GP and the multi-disciplinary team.

Interventions from allied health providers are also given due consideration and implemented. For example the interventions suggested by a dietician following weight loss for a resident. The allied health section in the residents' file also includes the suggested/requested interventions as developed by other providers. For example the podiatrist and physiotherapist.

All changes to interventions are recorded and updated as required. For example the blood sugar levels of one resident was inconsistent and peaking in the morning. The medication dose and timeframe for administration was changed resulting in improved and more stable blood sugar levels. The lifestyle care plan is was updated accordingly.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The activities programme is developed by the designated activities coordinator. The activities coordinator is interviewed and states that monthly plan is developed, with the residents' input. The activities plan is approved by the Clinical Services Manager and Business Manager. The programme is displayed and reflects a variety of activities and games. Some external outings are provided and the facility has a people mover, which seats up to six residents.

The activities coordinator is on-site 17 hours per week. In their absence, the programme is implemented by the staff. The activities coordinator completes a social profile with the resident on admission and monitors individual participation in activities. Reviews of participation and response to the programme are completed every three months. The related records are sighted in resident files sampled.

In addition, the provider contracts the services of a physiotherapist. Physiotherapy plans are documented and these are implemented by the designated mobility coordinator. The mobility coordinator is interviewed and confirms their knowledge and understanding of the exercise programme and physio goals for each resident.

Although residents are supported to access the community and continue with meaningful activities and personal interests, residents and family members interviewed during the audit report a level of dissatisfaction with the current activity programme and an improvement is required.

The relevant ARC requirements are met.

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

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

A range of activities are provided. These include, for example, flower arranging, indoor bowls, quoits, newspaper reading etc. Holidays, birthdays and festivals are observed. A church service is offered and some residents go to another rest home for 'chit chat' mornings. Individual resident profile forms are completed by the activities coordinator and hobbies/interests are documented. Family are encouraged to provide feedback regarding the previous interests and hobbies of the resident.

Two residents interviewed reported a level of dissatisfaction with the provision of activities and range of activities provided. This is also evident in resident/family satisfaction surveys.

**Finding Statement**

There is insufficient evidence that the activities programme is implemented in a manner which is meaningful to the resident. This is evident in resident/family satisfaction surveys and in two resident interviews.

**Corrective Action Required:**

Provide evidence of improved satisfaction with the activities programme.

**Timeframe:**

6 months

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Support and the provision of interventions are reviewed in a regular manner. Three monthly reviews of lifestyle care plans are conducted. Reviews are documented in the evaluation section of the lifestyle care plan and a three monthly resident report is completed. The lifestyle care plan is then updated if required. Daily progress notes are also completed by the staff on duty which assess daily response to interventions. Any changes to support interventions are documented.

In addition and multi-disciplinary (MDT) review is conducted annually. These are attended by the Business Manager, caregivers, cook, Clinical Services Manager, physiotherapist, GP, mobility coordinator, activities coordinator and family (if available). Short term care plans are also evaluated as required. Additional reviews include the three monthly medication review by the GP.

The results of clinical trials and related interventions are evaluated in a comprehensive manner. Full analysis of clinical data is reviewed against pre-set objectives and early results are showing some improved outcomes (refer standard 1.2.3).

The required reviews/evaluations are sighted in all resident records sampled and residents/family members state they are involved in the care planning and review process (as appropriate and able).

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The GP interviewed states that resident support for access or referral to another health and disability provider is facilitated in a timely and proficient manner. The GP confirms involvement in the referral process.

The Clinical Services Manager states that a formal referral process exists which includes the identification of risk and involvement of family (if available). Discussion regarding choice of health professional are sighted in the family contract sheets and evidence of recent referrals are sighted in the resident files sampled.

The ARC requirements are met. Residents interviewed state they have access to the community and allied health services of their choice.

**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

Planned discharges or transfers are preferable and conducted in collaboration with the resident and family (if available) to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner and that the needs of residents are paramount. There is also a defined, and well implemented process, for the management of emergency transfers to inpatient services (refer criterion # 1.3.3).

In the event of a discharge/transfer the resident's records are copied and necessary data transferred with the resident. The GP interviewed confirms involvement in the discharge/transfer process.

The Clinical Services Manager provides the auditor with two examples of discharges. One was a rest home resident and the other a hospital resident. Both residents responded so well to the support and interventions they received that they were discharged. Both residents went to live with family members and discharge planning was completed in in conjunction with the GP and district nursing services.

The ARC requirement is met. The resident admission agreement includes the reasons for termination.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

There are adequately documented policies and procedures for all stages of medicine management. Policies reflect current legislative requirements and safe practice guidelines.

A blister pack medication system is implemented. All medicines are prescribed by the GP using the pharmacy generated medication chart. The service has one prescribing GP for medical needs. All medication charts include identification and allergies. Three monthly medication reviews are evident in all fourteen medication records sampled.

Medications are checked on entry to the facility by the registered nurse. This includes blister packs, non-packaged medication, injections and controlled drugs. Records are maintained.

Non-packaged medication is safely stored in the medication trolley or the medication cupboard. A small medication fridge is provided and the temperature maintained in line with cold chain storage requirements. Daily medications are administered from a secure medication trolley (one for the rest home and two for the hospital). There is a small locked and secure box in the medication cupboard which is used to store controlled drugs. There are currently seven residents on controlled drugs. The required drug checks of controlled drugs are evident, including the six monthly check conducted by the pharmacist.

A small supply of stock medication for hospital residents is stored in the medication and supplies room. These include antibiotics, a range a cream and lotions, sachets and liquids. Verbal orders are not allowed and there is a current list of medications which have been approved as standing orders. The organisation has a standing orders process with is fully compliant with the 2012 Standing Orders Guidelines, however this has not been implemented at Manurewa Lifecare facility and an improvement is required. All medications for rest home residents are labelled per person.

Medications are administered by care givers in the rest home and registered nurses in the hospital. Competencies for medicine management and administration are monitored by the Clinical Services Manager. Records are sighted to verify the competency process and a lunch time medication round is observed. Administration records are complete and signed as required. Signatures are checked against the current specimen signature list. Records of response to medication are also maintained. Crushed medications are approved by the pharmacy.

There is a process for the safe self-administration of medication, however there are currently no residents who self-administer.

Medication errors are reported and investigated. Records of past medication errors are sampled and confirm appropriate follow up and remedial action. The Clinical Services Manager has implemented a quality improvement project called 'Enhancing Medication Safety'. The key objectives of the project is to be medication error free and achieve 100% compliance to the internal medication audits. Early results demonstrate improved processes (refer standard 1.2.3).

The remaining ARC requirements are met. Policies comply with the Medicines Act 1981 and residents' medication is reviewed on entry to the facility. This includes a medication reconciliation on entry.

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

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

The organisation's documented medicine management system includes the requirements of the standing orders guidelines (2012). This clearly defines the length of time (48 hours) and number of doses which can be given under a standing order. This process has not been fully implemented at the Manurewa Lifecare facility.

**Finding Statement**

The provision of standing orders does not fully comply with standing orders guidelines (2012). For example the length of time, or number of doses which can be administered has not been defined.

**Corrective Action Required:**

Provide evidence that standing orders include the length of time and number of doses which can be administered.

**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:** FA

Residents are provided with a well-balanced diet which meets their cultural and nutritional needs. The menus have been reviewed by a registered dietician and confirm they are appropriate for the needs of the older person. Deviations from the menu, occurring as a result of the availability of fresh produce, are recorded.

Nutritional assessments are completed on entry. Special dietary needs are identified and the cook confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident.

Residents are weighed monthly and confirm nutritional needs are being sufficiently addressed. Where required, any additional nutritional support is clearly documented in lifestyle plans and appropriate interventions implemented. This includes referrals to a dietician as required. There are currently no residents requiring subsidised nutritional supplements and the GP monitors health needs at each review.

Residents interviewed are (generally) satisfied with the food. The meal service is observed on both days of the audit. Meals appear well presented and sufficient in quantity.

The cook is interviewed and has the required food safety qualifications. Nutrition and safe food management policies define the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers and records of temperature monitoring are maintained and this includes temperature monitoring of food taken to the hospital wing in the bain maree. Guidance is provided for staff on defrosting, environmental cleaning, storage, minimising risk of contamination and food hygiene principals.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

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

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

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

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

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

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facility and are accessible for staff. Hazard Register sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and chemical safety last provided March 2012 and scheduled for 11 November 2013. Monthly visits by Ecolab who reviews kitchen, cleaning and laundry processes and cleaning. Copies of these reports reviewed during this audit.

A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example: goggles/visors, gloves, aprons, footwear, and masks viewed in sluice rooms. Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. One sluice room in an area between the rest home and hospital is available for the disposal of waste and hazardous substances.

ARC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

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

A maintenance person is employed for 40 hours a week and is interviewed during this audit. Maintenance person interviewed confirms there is a maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and reviewed during this audit along with current calibration / performance verified stickers in place on medical equipment. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 16 March 2014.

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

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

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

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.3d ARHSS D15.3c

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

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

Bedrooms provide single accommodation and have wash hand basins. Several of the bedrooms have shared toilet facilities and there are an adequate number of communal toilet and shower facilities.

Visual inspection provides evidence that toilet; shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at three monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).

All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and washbasin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

Visual inspection evidences that adequate personal space is provided in bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. The 28 hospital bedrooms have double leaf doors and are large enough to allow for easy access for mobility aids.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC E3.4b ARHSS D15.3d

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

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

Visual inspection evidences adequate access is provided to lounges (two), the communal dining room, and the conservatory. Residents observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

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

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

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

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

All linen is washed on site in the laundry and although the laundry is on the small side, there is adequate dirty / clean flow. The previous laundry person has left and care staff are currently responsible for laundry management. The business manager advises they are proposing to employ another dedicated laundry person. Staff interviewed describes management of laundry including transportation, sorting, storage, laundering, and return to residents.

Visual Inspection evidences the implementation of cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning reviewed, along with monthly Ecolab reports.

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

Residents and family interviewed state they are generally satisfied with the cleaning and laundry service and this finding confirmed during review of satisfaction surveys completed August 2013.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

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

Email from New Zealand Fire Service dated 28 June 2012 advising 'Manurewa has an evacuation scheme approved on 15 February 2000. Unfortunately we don't have a copy of the approval letter on file.' The last trial evacuation was held on 02 October 2013.

All registered nurses, activities co-ordinator, and maintenance person are required to complete first aid training. All staff are required to complete CPR training. There is at least one designated staff members trained on each shift with appropriate first aid training.

Staff interviews and review of files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled evidence current training regarding fire, emergency and security education. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.

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

There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas, e.g. bedrooms, ablution areas, ensuite toilet/showers. Residents interviewed confirm they have a call bell system in place which is accessible and staffs generally respond to it in a timely manner. Finding confirmed during review of satisfaction survey completed August 2013.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D15.2f ARHSS D15.2g

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

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

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.

Residents interviewed confirm the facilities are maintained at an appropriate temperature.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The staff at Manurewa Lifecare actively work to minimise the use of restraint. There are currently five restraints and two enablers in place; however one restraint and two enablers are used by one resident. The three monthly review of all restraint/enabler use ensures alternatives are explored and restraint use minimised where appropriate and safe. This is evident in the recent reduction of restraint hours.

There are adequately documented guidelines on the use of restraints and enablers. Definitions are congruent with the requirements of the Health and Disability Sector Standards and staff interviewed are well versed with the correct definitions and their application in practice. There are also guidelines on the management of challenging behaviours.

The ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

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

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

There are clear lines of accountability for staff involved in the assessment, approval and monitoring of restraints/enablers. There is a designated restraint coordinator (registered nurse) who chairs the restraint committee. The committee includes the Clinical Services Manager, the Business Manager, the physiotherapist and mobility coordinator, the GP and family (if appropriate).

The restraint approval process is also clearly defined. The approval process includes a comprehensive assessment followed by an application to the restraint committee. If the use of restraint is approved and applied, the first review occurs after 24 hours in order to assess the immediate impact and result.

The ARC requirement is met. There are adequately documented processes for the minimisation of restraint use.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

Assessments for restraint use are completed by a registered nurse and include risk, underlying cause, alternatives tried, previous episodes of restraint, maintaining cultural safety and the desired outcome. Completed assessments are sighted in the records of residents who have a restraint in use.

Current restraints in use include bed rails (for safety) and wrist restraints (for one resident). The use of the wrist restraint has full approval by the multi-disciplinary team and the family. The assessment and approval process is comprehensively documented. The service is working hard at reducing the number of hours the wrist restraints are in use by successfully implemented an alternative strategy.

The ARC requirement is met. There are adequately documented processes for the minimisation of restraint use.

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

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

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

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

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

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

(f) Maintaining culturally safe practice;

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

(h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

Approval for the use of restraint is gained through application to the restraint committee. Alternative strategies are trialled and the staff have been achieving success in the reduction of restraint hours.

Each episode of restraint is fully monitored and documented. Restraint reports are collated monthly using a standard report template. This provides an auditable record of all restraint/enabler use. The restraint coordinator provides a full analysis of each restraint use and reports the results to the committee. This data is effectively used to ensure each episode of restraint is reported in adequate detail to assess the impact and safety of all restraint use.

Bed rails are padded to provide safety and the use of the wrist restraints are loosely applied and closely monitored.

The ARC requirement is met. There are adequately documented processes for the minimisation of restraint use.

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

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

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

(d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

The first restraint review occurs after 24 hours. On-going restraint evaluations are then completed by the restraint coordinator monthly, with a three monthly evaluation. This includes future options, review, desired outcome, duration/hours, impact and whether or not the restraint was the least restrictive option. The reviews are comprehensively documented and communicated to the restraint committee and displayed on the staff notice board.

Additional reviews are sighted where a trial in the reduction of restraint use is being conducted. In this example, daily progress notes are being recorded to report daily responses to alternatives. This on-going assessment and collection of daily data has enabled the resident with wrist restraints to have them is use for shorter periods of time.

The ARC requirement is met. There are adequately documented processes for the minimisation of restraint use.

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

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

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

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

(d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

A comprehensive review of the restraint programme/process is conducted by the restraint coordinator and includes trends, adverse outcomes, education requirements and compliance with policies and procedures. The analysis of restraint use is reviewed by the restraint committee.

Adequate restraint training is provided at orientation and then in an on-going manner. Restraint training includes a competency assessment. The most recent training was conducted in May 2013 and the competency register is sighted. Restraint training includes the management of challenging behaviour.

The ARC requirement is met. There are adequately documented processes for the minimisation of restraint use.

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

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

ARC D5.4e ARHSS D5.4e

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

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

The responsibilities for infection prevention and control are clearly defined in the organisational Infection Control Governance policy. This defines the role of the infection control coordinator, accountabilities, key responsibilities, measurement criteria, aims and objectives of the programme.

Adequate information, resources and on-going training are provided. The annual review of the programme ensures that infection prevention and control activities and processes are up to date. Following annual review the infection control programme plan for the year is developed. This includes annual goals such as reporting of infection occurrences, immunisation and cold chain management, outbreak management, internal risk and mitigation and education and competencies.

Infection control data is communicated to senior management. Residents, visitors and staff are protected from the spread of infection by use of signage, available protection equipment and alcohol based hand sanitizer, adequate outbreak management and pandemic planning and communicating relevant information and education at staff and resident meetings. In addition, flu vaccinations are offered to all residents and staff and the infection control coordinator is an approved vaccinator.

ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control programme defines appropriate responsibilities and activities for the infection control coordinator (and staff) that are appropriate for rest home and hospital services. Interview with the infection control coordinator and review of resident records indicate that an infection record is maintained for each resident documenting type, treatment and duration.

The infection control coordinator confirms that designated space and time are provided for infection control management activities and resources. The infection control coordinator has the relevant skills and expertise to implement the programme. She reports to the Clinical Services Manager and has access to current information relevant to the size and complexity of the facility including infection control manuals, internet and expert advice (as required). Examples include accessing the support of the local practice nurse regarding recalls for immunisations, Ministry of Health resources and District Health Board updates and on line training.

Regular internal audits are conducted to ensure full implementation of the infection prevention and control programme. These include, for example, hand washing, cleaning, microbial compliance and annual review. Completed audits are sighted.

ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

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

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

Documented policies and procedures are in place for the prevention and control of infection. The policies are appropriate for the facility and reflect current accepted good practice and legislative requirements. Policies and procedures are written in a user friendly format, contain appropriate level of information and are developed and reviewed annually. Policies are readily accessible to staff in service areas and identify links to other documentation in the organisation e.g. health and safety and quality and risk. A bug control manual is also available as a resource.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

Infection control education and training is provided during orientation and again in an ongoing manner. The orientation and in-service training is provided by the infection control coordinator. There is also a competency programme which includes hand washing. In service training was last provided in June 2013. Resources, attendance and training evaluations are sighted.

Adequate and appropriate information on hand washing and standard precautions is displayed in resident toilets and bathrooms. Alcohol hand gel is sighted throughout the facility.

ARC requirement is met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

The infection surveillance programme is defined and appropriate for the facility and the level of care provided. The use of antibiotics is monitored and infection rates are graphed to enable useful analysis. Additional data includes the identification and classification of infection events, indicators and outcomes. Standard definitions are used to report infections.

Surveillance data is collated monthly and an analysis of the last three months is made in order to determine trends. Where a preventative response or corrective action is required, it is recorded and implemented. Reports are comprehensively documented and provide a full analysis. Data is displayed and communicated the staff (and residents) as appropriate. The Doctor is also informed if the resident has an infection.

**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:**