

## Oceania Care Company Limited - Franklin Village

**CURRENT STATUS: 23-Sep-13**

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

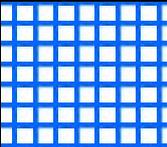
### GENERAL OVERVIEW

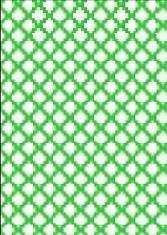
Franklin Village is part of Oceania Care Group and situated within the Counties Manukau District Health Board area. The service renders geriatric hospital, rest home and dementia care services with a capacity for 22 hospital and 4 beds suitable for either rest home or hospital level and 18 dementia residents. Occupancy on the day of the audit was 23 hospital, 1 rest home and 18 dementia residents. There is one requirement for improvement relating to medicines management.

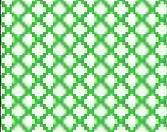
### AUDIT SUMMARY AS AT 23-SEP-13

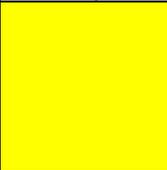
Standards have been assessed and summarised below:

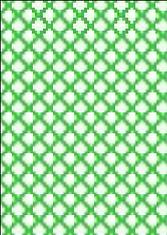
#### Key

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

<b>Consumer Rights</b>	Day of Audit 23-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		<b>Standards applicable to this service fully attained</b>

<b>Organisational Management</b>	Day of Audit 23-Sep-13	Assessment
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		<b>Standards applicable to this service fully attained</b>

<b>Continuum of Service Delivery</b>	Day of Audit 23-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		<b>Some standards applicable to this service partially attained and of low risk</b>

<b>Safe and Appropriate Environment</b>	Day of Audit 23-Sep-13	Assessment
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		<b>Standards applicable to this service fully attained</b>

<b>Restraint Minimisation and Safe Practice</b>	Day of Audit 23-Sep-13	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		<b>Standards applicable to this service fully attained</b>

Infection Prevention and Control	Day of Audit 23-Sep-13	Assessment
Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		<b>Standards applicable to this service fully attained</b>

## AUDIT RESULTS AS AT 23-SEP-13

### Consumer Rights

The staff members receive training regarding the Code of Health and Disability Services Consumer's Rights (the Code). The admission pack given to new residents and their family includes a copy of the Code, the Nationwide Health and Disability Advocacy pamphlet, and a copy of the Health and Disability Commissioners pamphlet relating to complaints.

Staff members respect the physical, visual, auditory and the personal privacy of residents and they confirm they are not subjected to abuse or neglect.

Residents who identify as Maori have their health and disability needs met in a manner that respects and acknowledge their individual and cultural values and beliefs. The service has documented policies and procedures to ensure culturally safe services.

The service ensures good practice and evidence based practice through current and up-to-date training and access to community based education and training opportunities.

The facility ensures effective communication with the residents through implementation of six week post admission family meetings, resident feedback opportunities and multidisciplinary meetings.

Residents and their family of choice are provided with information in order to make informed decisions and give informed consent. Residents are informed of their rights to an independent advocate, given information on how to access an advocate and they have the right to have support persons of their choice present.

Residents have the right and freedom to maintain links with their families, whanau and friends in the community.

The service has an easily accessed, responsive and fair complaints process.

### Organisational Management

The purpose, values, scope, direction and goals of the organisation are clearly defined in policy. The service has a business and quality improvement plan for 2013 to 2014. Policies and procedures are reviewed.

During the temporary absence of the facility manager, the regional clinical and quality manager, who is also, a registered nurse or the clinical leader stands in for the facility manager.

The service has a quality and risk management system that includes monthly internal audits, incident and accident reporting, education and training, health and safety, infection control, restraint and complaints management. There is an internal audit programme for monitoring processes. Education and training is aligned with the training program of Oceania. Adverse event management feeds into the quality and risk programme.

Health and safety team consists of representatives from different disciplines in the service.

The facility manager compiles three monthly graphs on all the clinical quality indicators that are presented at all the meetings in order to ensure staff members are informed regarding the quality progress and performance. The facility manager understands what is expected regarding statutory and or regulatory obligations.

The facility manager validates professional qualifications including registration with professional bodies and scope of practice for new staff members. The service ensures that newly appointed staff members have the skills and qualifications to safely meet the needs of the residents. New staff members receive induction and orientation to their individual roles. The service has clearly documented and implemented processes for determining staff levels and skill mix.

### **Continuum of Service Delivery**

Resident's entry into services is facilitated in a competent, equitable, timely, and respectful manner. Admission agreements are in place for all residents. A resident admission checklist is used in order to orientate the resident to the facility.

Resident's receive timely, competent, and appropriate services in order to meet their assessed needs and goals. All the registered nurses have a current annual practising certificate.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach.

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

Person centered care plans are resident focussed, integrated, and promote continuity of service delivery. Care plans are created and evaluated in a timely manner, including a multi-disciplinary review every six months. Appropriate interventions are in place to meet the desired outcomes.

Activity requirements are appropriate to the resident's needs, age, culture, and the setting of the service. The activities coordinator creates a weekly plan for activities and posts these on the bulletin boards. Each resident has a recreation assessment which is updated every six months.

Residents are given the choice and advised of their options to access other health and disability services where indicated or requested.

Residents receive medicines in a timely manner, however not all administration processes comply with current legislative requirements and safe practice guidelines.

Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines. Residents who have additional or modified nutritional requirements or special diets have these needs met.

### **Safe and Appropriate Environment**

The service follows documented processes for safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislative requirements.

Residents are provided with an appropriate, accessible physical environment and facilities that are fit for the purpose of the service.

The residents are provided with adequate toilet, showering and bathing facilities and their privacy is protected during personal cares. The personal space and bed areas of residents are spacious allowing residents with mobility aids to freely move around in their bedrooms. The service provides adequate, age appropriate and accessible communal areas for relaxation, activities and dining needs of residents.

Cleaning and laundry are monitored for effectiveness through the internal audit programme.

Residents receive appropriate and timely response during emergency and security situations.

Resident areas are provided with adequate natural light, safe ventilation and the environment is maintained at a safe and comfortable temperature.

### **Restraint Minimisation and Safe Practice**

The service provider demonstrates that the use of restraint is actively minimised. There are currently five residents using bedrails as restraint and one resident using a bedrail as an enabler.

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

Approved restraint is only applied as a last resort, after alternative interventions have been considered or attempted and determined inadequate.

The services ensure rigorous assessment of residents is undertaken, where indicated, in relation to the use of restraint. A restraint assessment is completed before commencing any resident on restraint.

## **Infection Prevention and Control**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The facility has a clearly defined infection prevention and control program that is reviewed annually. Infection control is part of health and safety meeting every month.

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. The organisation utilises external specialist advice on infection control.

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements are readily available and are implemented in the organisation.

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

The organisation has an internal benchmarking system and surveillance results are reported to the staff during staff meetings.

Results of the surveillance and specific recommendations to assist in achieving infection control reduction and prevention outcomes are acted upon, evaluated, and reported to the relevant personnel and management in a timely manner.

# **Franklin Village**

Oceania Care Company

Certification audit - Audit Report

Audit Date: 23-Sep-13



## Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RN,LA, RABQSA	12.00	8.00	23-Sept-13 to 24-Sept-13
Auditor 1	XXXXXXXX	RN, Auditor 8086	12.00	4.00	23-Sept-13 to 24-Sept-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX	RN, LA, 8086		2.00	03-October-13

<b>Total Audit Hours on site</b>	24.00	<b>Total Audit Hours off site</b> <i>(system generated)</i>	14.00	<b>Total Audit Hours</b>	38.00
<b>Staff Records Reviewed</b>	7 of 42	<b>Client Records Reviewed</b> <i>(numeric)</i>	10 of 42	<b>Number of Client Records Reviewed using Tracer Methodology</b>	3 of 10

<b>Staff Interviewed</b>	12 of 42	<b>Management Interviewed</b> <i>(numeric)</i>	2 of 2	<b>Relatives Interviewed</b> <i>(numeric)</i>	4
<b>Consumers Interviewed</b>	5 of 42	<b>Number of Medication Records Reviewed</b>	20 of 42	<b>GP's Interviewed</b> <b>(aged residential care and residential disability)</b> <i>(numeric)</i>	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 of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

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

Dated this 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

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Franklin Village	44	42	4	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Executive Summary of Audit

## *General Overview*

Franklin Village is part of Oceania Care Group and situated within the Counties Manukau District Health Board area. The service renders geriatric hospital, rest home and dementia care services with a capacity for 22 hospital and 4 swing beds (either rest home or hospital level) and 18 dementia residents. Occupancy on the day of the audit was 23 hospital, 1 rest home and 18 dementia residents. There is one requirement for improvement relating to medicines management.

## *1.1 Consumer Rights*

The staff members receive training regarding the Code of Health and Disability Services Consumer's Rights 1996 (the Code). The admission pack given to new residents and their family includes a copy of the Code, the Nationwide Health and Disability Advocacy pamphlet, and a copy of the Health and Disability Commissioners pamphlet relating to complaints.

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## *1.2 Organisational Management*

The purpose, values, scope, direction and goals of the organisation are clearly defined in policy. The service has a business and quality improvement plan for 2013 to 2014. Policies and procedures are reviewed.

During the temporary absence of the facility manager, the regional clinical and quality manager, who is also a registered nurse, or the clinical leader stands in for the facility manager.

The service has a quality and risk management system that includes monthly internal audits, incident and accident reporting, education and training, health and safety, infection control, restraint and complaints management. There is an internal audit programme for monitoring processes. Education and training is aligned with the training program of Oceania. Adverse event management feeds into the quality and risk programme.

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### *1.3 Continuum of Service Delivery*

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Resident areas are provided with adequate natural light, safe ventilation and the environment is maintained at a safe and comfortable temperature.

## *2 Restraint Minimisation and Safe Practice*

The service provider demonstrates that the use of restraint is actively minimised. There are currently five residents using bedrails as restraint and one resident using a bedrail as an enabler. The responsibility for restraint processes and approval is clearly defined and there are clear lines of accountability for restraint use. Approved restraint is only applied as a last resort, after alternative interventions have been considered or attempted and determined inadequate. The services ensure rigorous assessment of residents is undertaken, where indicated, in relation to the use of restraint. A restraint assessment is completed before commencing any resident on restraint.

## *3. Infection Prevention and Control*

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The facility has a clearly defined infection prevention and control program that is reviewed annually. Infection control is part of health and safety meeting every month. There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. The organisation utilises external specialist advise on infection control. Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements, are readily available and are implemented in the organisation.

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Results of the surveillance, and specific recommendations to assist in achieving infection control reduction and prevention outcomes are acted upon, evaluated, and reported to the relevant personnel and management in a timely manner.

## Summary of Attainment

### 1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	FA	0	1	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	FA	0	2	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect	FA	0	4	0	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs	FA	0	3	0	0	0	7
Standard 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	FA	0	1	0	0	0	2
Standard 1.1.7	Discrimination	FA	0	1	0	0	0	5
Standard 1.1.8	Good practice	FA	0	1	0	0	0	1
Standard 1.1.9	Communication	FA	0	2	0	0	0	4
Standard 1.1.10	Informed consent	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

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

## 1.2 Organisational Management

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

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

### 1.3 Continuum of Service Delivery

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

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 11	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:20	PA:1	UA:0	NA: 0		

#### 1.4 Safe and Appropriate Environment

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.4.1	Management of waste and hazardous substances	FA	0	2	0	0	0	6
Standard 1.4.2	Facility specifications	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	0	0	0	0	3
Standard 1.4.7	Essential, emergency, and security systems	FA	0	5	0	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating	FA	0	2	0	0	0	3

Safe and Appropriate Environment Standards (of 8):	N/A:0	CI:0	FA: 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:15	PA:0	UA:0	NA: 0		

## 2 Restraint Minimisation and Safe Practice

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

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

### 3 Infection Prevention and Control

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

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

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

**Total Standards (of 50)** N/A: 0 CI: 0 FA: 49 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA  
 Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  
**Total Criteria (of 219)** CI: 0 FA: 98 PA: 1 UA: 0 N/A: 0

## Corrective Action Requests (CAR) Report

Provider Name: Oceania Care Company  
Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:23-Sep-13 End Date: 24-Sep-13  
DAA: Health Audit (NZ) Limited  
Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.3.12	1.3.12.1	PA Moderate	<b>Finding:</b> Crushed medications are observed being administered to residents in the dementia unit. The documented medication management system does not clearly define which medications can be crushed and/or the consequence of doing so (for example the possible increase in side effects).  <b>Action:</b> Amend the related medication policy to include guidelines regarding crushing of medication and include same in the medication competency programme.	30 days

## Continuous Improvement (CI) Report

Provider Name: Oceania Care Company

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:23-Sep-13 End Date: 24-Sep-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXX

# 1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

## OUTCOME 1.1 CONSUMER RIGHTS

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

### STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

#### How is achievement of this standard met or not met?

**Attainment: FA**

Staff members receive training regarding the Code of Health and Disability Services Consumer's Rights 1996 (the Code). Training last occurred in January 2013, sighted training records. Staff members confirm during interview that they understand the application of the Code to their practice. The Code is displayed in English and Te Reo throughout the facility, sighted posters and pamphlets available for residents and visitors.

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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
<p>The admission pack given to new residents and their family / whanau includes a copy of the Code, the Nationwide Health and Disability Advocacy pamphlet, and a copy of the Health and Disability Commissioners' pamphlets relating to complaints with a complaints form, sighted. The pack also includes information regarding informed consent and a copy of the responsibilities and rights of the residents, confirmed during the facility manager interview.</p> <p>The Code and the Nationwide Health and Disability Advocacy Service posters are clearly displayed and pamphlets are easily accessible, verified and confirmed at the facility manager interview. Staff members confirm during interview that they understand how the Code applies to their practice, sighted training records and the training programme for the facility relating to the Code. ARC requirements are met.</p>	

**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.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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  Ma  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Staff members respect the physical, visual, auditory and the personal privacy of residents, confirmed during staff, resident and family / whanau interviews. Staff training on privacy and dignity is conducted and last occurred in April 2013.

Residents receive services that are responsive to their needs, beliefs, cultural, religious, social and ethnic orientation, confirmed at the resident and family / whanau interviews. Staff receive training on cultural safety which was also conducted in January and in August 2013 and training records are sighted.

The service promotes independence and focuses on the needs and wants of the resident, confirmed at the resident interviews.

Resident, family and whanau confirm they are not subjected to abuse and neglect, also confirmed during the interview with the general practitioner (GP). Training on prevention of abuse and neglect occurred in January and August 2013, sighted training records and confirmed at the facility manager interview. ARC requirements are met.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

Residents who identify as Maori have their health and disability needs met in a manner that respects and acknowledge their individual and cultural values and beliefs, confirmed at the resident, family and whanau interviews. Staff members receive cultural training in February and August 2013 which included the Maori health plan, sighted the training records and confirmed at the facility manager interview. Family and whanau involvement is encouraged through encouragement to bring Maori specific foods into the service and embracing Maori practices within the service.

ARC requirements are met.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

The service has documented policies and procedures to ensure culturally safe services, sighted the policies and confirmed at the facility manager interview. The facility ensures access for residents to local Iwi through consultation, sighted the consultation documents and other communication. The service has contact details for the Maori Cultural Advisor / Kaumatua for Pukekohe and the Maori Cultural Advisor at the Huakina Trust, sighted the information and confirmed at the Maori representative staff member interview.

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  Mal  V  CQ  SQ  STQ  Ma  L

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
Resident and their family / whanau interviews confirm the service is free of discrimination, coercion, harassment, sexual financial or other exploitation. The staff members received training on prevention of discrimination, coercion and abuse and neglect which occurred in January and July 2013. The facility manager confirms professional boundaries are maintained and training occurred in January 2013.	

**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.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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  Mal  V  CQ  SQ  STQ  Ma  L

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
The service ensures good practice and evidence based practice through current and up-to-date training, access to community based education and training opportunities, access to conferences, access to internet and current journals e.g. Medscape, and medical and nursing journals and other publications, sighted publications and confirmed at the RN and the facility manager interviews. ARC requirements are met.	

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

The facility ensures effective communication with the residents through implementation of six week post admission family / whanau meetings, resident feedback opportunities e.g. surveys and multidisciplinary meetings. The facility manager has an open door policy for residents and or their families to discuss any concerns, verified during the onsite audit and confirmed at the resident and family / whanau interviews.

The facility has contact details for interpreter services at the Counties Manukau District Health Board (CMDHB). This information is made available as part of the admission pack, and can also be accessed on request.

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

Resident and their family / whanau of choice are provided with information in order to make informed decisions and give informed consent, sighted ten resident files with consents signed and confirmed during the registered nurse, resident and family / whanau interviews.

The service provided training on informed consent which occurred in July and August 2013, sighted. Consents for the residents in the dementia unit include appointment of an enduring power of attorney (EPOA), sighted the legal documentation for EPOA's.

Advanced directives are made available to residents and staff act upon the wishes of residents were valid.

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**

Residents are informed of their rights to an independent advocate, given information on how to access an advocate and they have the right to have support persons of their choice present, verified information packs and confirmed at resident and the facility manager interviews. 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**

Residents have the right and freedom to maintain links with their families, whanau and friends in the community, sighted visitors to the facility and confirmed at resident and family / whanau interviews. Residents attend activities in the community They go shopping, go to the returned serviceman association (RSA) for lunch, and attend plays and shows, confirmed at resident and the facility manager interviews. Residents confirm they have access to community resources e.g. recreational facilities and other services. 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**

Residents, family and whanau have the right to complain. The service has an easily accessible, responsive and fair complaints process which includes; recording the date of the complaint, the complaint category, the summary, resolution review date and the sign off date / closing date. The service acknowledges receipt of complaints in writing. The complainant is also informed of the outcome in writing, sighted records, confirmed at staff and family interviews.

There are three complaints recorded for 2013 and two recorded for 2012, confirmed at the facility manager interview.

Information relating to the complaints process and the resident's rights to complain is given to new residents and their family at admission, sighted the information pack, confirmed at the family / whanau and the facility manager interviews. 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 purpose, values, scope, direction and goals of the organisation are clearly defined in policy. Sighted the business and quality improvement plan for 2013 to 2014. The policies and procedures were last reviewed in April 2013, sighted documentation. Part of the service's vision is to implement the standards that create an environment where there is a hospitality approach included to the service. The purpose and mission statement of the organisation is displayed in the foyer of the building and information was confirmed during the interview with the facility manager.

The facility manager was appointed into the position in at the end of 2010 after working clinical leader for more than two years. The facility manager has been a registered nurse for 14 years working various roles. The facility manager completed a diploma of business management in 2009 and is continuously completing training courses in order to stay current in the role.

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**

During the temporary absence of the business and care manager, the regional clinical and quality manager, who is also a registered nurse or the clinical leader, will stand in for the facility manager, confirmed at the regional clinical and quality manager and the facility manager interviews, sighted the job description for the regional clinical and quality manager. ARC requirements 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  Ma  V  CQ  SQ  STQ  Ma  L

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

The service has a quality and risk management system that includes monthly internal audits, incident and accident reporting, education and training, health and safety, infection control, restraint and complaints management.

There is an internal audit programme to guide the process, sighted. The internal audit programme is a 'live document' and is managed according to the needs and relevance to the service, sighted changes to the programme. The manager records the different internal audits, the level of achievement and opportunities for improvement. Internal audits where deficits are identified, the facility manager identifies corrective actions. Implementation of changes are signed off and the facility manager re-audits that specific area of service to ensure implementation of change was successful.

Internal audits sighted; continence management audit 13 August 2013, practice certificates audit 16 September 2013, medication management audit 17 September 2013, health information privacy 13 August 2013 and GP services audit 23 July 2013.

Incidents and accidents records include; general information about the people involved, the nature of the event, detailed description of the event, whether the incident / accident caused injury, identification of witnesses, whether family and or the GP have been informed, corrective and preventative actions identified and there are follow up actions required, sighted records for falls, bruising, skin tears and missing property.

The education and training is aligned with the training programme of the support office. The facility manager has spread sheets for monitoring training of staff members. The service requires competencies for safe handling, hand washing and infection control, medicines management, fire evacuation and training, restraint, management of challenging behaviour for all staff members. Registered nurses have additional competencies including; nebulisers, oxygen therapy, wound management, blood sugar monitoring and administration of insulin. Medicines management competencies include seven registered nurses (RN's), one enrolled nurse (EN) and nine health care assistants (HCA), all competencies are current, sighted. Registered nurses all have current annual practicing certificates (APC's), sighted.

Health and safety team consists of representatives from maintenance, cleaning, kitchen, the clinical leader, administrator and the facility manager who is also the health and safety representative. The role of the health and safety representative is defined and the position description for the role is signed and dated. The health and safety and infection control meeting is a combined meeting and the committee meets monthly, sighted meeting minutes for 9 August 2013. The service keeps a hazard register which is discussed at the monthly meetings.

The clinical leader is the infection control coordinator and presents infection control data at the monthly health and safety meetings, sighted infection control reports, data and graphs.

The clinical leader is the restraint coordinator and presents restraint data at the restraint bi-monthly meeting with the facility manger, sighted minutes for the restraint meetings and sighted the restraint coordinator's positions description.

The service has a complaints process with a complaints register which records; the date of the complaint, the complaint category referring to the type of complaint, a short summary of the complaint, actions taken to resolve the complaint and the closing date of the complaint.

The facility manager compiles three monthly graphs on all the clinical quality indicators that is presented at all the meetings in order to ensure staff members are informed regarding the quality progress and performance and quality plans for the facility are reviewed six monthly.

The service is guided by policies and procedures that are aligned with current good practice. Policies are reviewed bi-annually and it is part of a document control system where support office informs the facility of new policies, the policy manuals are updated by the facility manager and obsolete policies are removed from the system.

ARC requirements 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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
Corrective Action Required:		
Timeframe:		

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

This shall include, but is not limited to:

- (a) Event reporting;
- (b) Complaints management;
- (c) Infection control;
- (d) Health and safety;
- (e) Restraint minimisation.

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

#### **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 service has an evacuation folder with essential notification reporting information recorded. The facility manager understands what is expected regarding statutory and or regulatory obligations, sighted the contact information for different adverse event reporting and confirmed during the facility manager interview. The essential reporting includes; general information about the service with contact details for the facility manager, the clinical leader, administrator and the maintenance person, the support office contact, civil defence contacts and the service's safe arrival facility contacts. The facility manager understands the reporting requirements to the counties Manukau district health board (CMDHB) and the ministry of health (MoH). The service document, investigate and report on adverse events as part of the quality and risk management programme, family interviews confirm being informed of adverse events. ARC requirements are met.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

The facility manager validates professional qualifications including registration with professional bodies and scope of practice for new staff members. The service ensures that newly appointed staff members have the skills and qualifications to safely meet the needs of the residents. New staff members receive induction and orientation to their individual roles, sighted orientation and induction records for all seven of the reviewed staff files which includes the facility manager, the clinical leader, the activities coordinator, two registered nurses and two health care assistants.

The service has a system to identify, plan, facilitate and record on-going education for staff, sighted the education and training programme, education and training records, attendance records and competencies for staff.

All seven reviewed staff files have curriculum vitae (CV's), position descriptions, reference checks, signed employment contracts, evidence of qualifications, performance appraisals, evidence of professional registration where applicable, induction and orientation and current competencies on file, sighted all records.

The education and training programme includes the following training sessions in January 2013; Infection control training relating to hand washing competencies, standing precautions and dealing with hazardous waste, complaints management, cultural safety and Code of Rights training, prevention of abuse and neglect, February 2013; complaints management, Maori health, challenging behaviour and de-escalation training, March 2013; cultural safety and Code of Rights training, falls management training, privacy and dignity training, April 2013; Medication management training, May 2013; Pain management training, July 2013; challenging behaviour and de-escalation training, August 2013; prevention of abuse and neglect, September 2013; complaints management training. Staff members who work in the dementia unit are in the process or have completed the applicable unit standards.

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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The service has clearly documented and implemented processes for determining staff levels and skill mix. The interim staffing policy covering: staffing levels, union representation, facility manager employment responsibilities, rosters, safe staffing indicators, staff competencies and skill mix for safe service provision, sighted policy, rosters and confirmed at the facility manager and the regional clinical and quality manager interviews. Staff interviews confirm workloads are fair and manageable. 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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Information is entered into the resident information management system in an accurate, timely and appropriate manner, sighted information and confirmed at the administrator interview. Information of a private and personal nature is maintained in a secure manner, the information system is password protected and kept in the administration office, which is kept secure by having a pin pad lock on the door, verified. Records are legible and the name and designation of staff members are clearly documented.

All resident records are integrated to enhance service delivery, confirmed at the facility manager interview and sighted during review.

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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
Corrective Action Required:		
Timeframe:		

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
Corrective Action Required:		
Timeframe:		

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

### **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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
Resident's entry into services is facilitated in a competent, equitable, timely, and respectful manner. Admission agreements are in place for all residents, sighted. A resident admission checklist is sighted in order to orientate the resident to the facility. The residents have completed needs assessments on record. The service provides all new residents with an information pack. Entry criteria, assessment, and entry screening processes are documented and clearly communicated to residents, their family/whanau of choice where appropriate, local communities and referral agencies, confirmed during resident and family interviews. Admission agreements are in place for all residents, sighted. 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.**

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

Where referral and entry to the service is declined, the immediate risk to the resident is managed by the organisation, sighted referral records. The clinical leader completes a pre-admission enquiry form which is kept in the enquiry book. The clinical leader mentions that when they have no bed available prospective residents are referred to other appropriate facilities. ARC requirements are met.

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

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

Corrective Action Required:

Timeframe:

**STANDARD 1.3.3 Service Provision Requirements**

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

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

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Resident's receive timely, competent, and appropriate services in order to meet their assessed needs and goals. All the registered nurses have a current annual practising certificates (APC's), sighted. The clinical leader creates and evaluates the person centred care plan (PCCP) for each resident in a timely manner. Activity plans are created and evaluated within the required timeframes.

On admission, the clinical leader creates an initial plan of care and then creates the PCCP within three weeks. The PCCP's are reviewed every six months through a multi-disciplinary assessment process. The activities coordinator ensures that the activity plan is in place within three weeks and reviews this plan every six month, sighted. When a new resident is admitted to the facility, the clinical leader ensures that the general practitioner (GP) assesses the resident within 48 hours as per policy.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach. The clinical leader notifies the GP in a timely manner in the event that a resident presents with medical problems that require immediate attention. The GP confirms that treatment orders are implemented in a timely manner.

The registered nurses use a hand-over sheet to inform the next shift for any concern about the residents. The hand-over is comprehensive covering a wide range of aspects of care, attended the afternoon handover. The service use the progress notes as well as a communication book as part of ensuring continuity of service, sighted.

Tracer methodology in the hospital:

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

Tracer methodology in the rest home:

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

Tracer methodology in the dementia unit:

*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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Resident's needs, support requirements, and preferences are gathered and recorded in a timely manner. Risk assessments are completed for falls, balance, dietary needs, continence, cultural orientation, pain, activities and oral care and then used as the basis of creating the resident's PCCP. The clinical leader creates the PCCP for each resident within three weeks of admission and evaluates the PCCP every six months through a multi-disciplinary review, sighted and confirmed at the RN and the CL interviews. The Needs Assessment Coordination Service (NASC) assessment for each resident is taken into consideration when compiling the care plan. Short term care plans are created as required. ARC requirement met.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Person centred care plans are resident focussed, integrated, and promote continuity of service delivery. PCCP's are created and evaluated in a timely manner. Appropriate interventions are in place to meet the desired outcomes. Documents are integrated in resident folders with allocated sections for the GP, nurse progress notes and allied services. Ten of ten care plans reviewed reflect goals and interventions in order to achieve the desired outcomes. Any required changes to resident's care are clearly written in the progress notes or in the short term care plan. The GP interviewed reports excellent communication with the clinical leader to ensure continuity of care. ARC requirement is met.

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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  Mal  V  CQ  SQ  STQ  Ma  L

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
Resident's receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. Appropriate interventions are sighted in the resident's PCCP. New residents are welcome and orientated to the facility. The service utilise a resident orientation checklist, sighted. Ten of ten resident's PCCP clearly defines appropriate interventions in order to meet desired goal, monitored by all nurses on duty.	

ARC requirement is met.

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### **STANDARD 1.3.7 Planned Activities**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment:** FA

Activity requirements are appropriate to the resident's needs, age, culture, and the setting of the service. The activities coordinator creates a weekly plan for activities and posts these on the bulletin boards. Each resident has a recreation assessment which is updated every six months. Attendance sheets are kept for each resident is sighted.

The resident's in the dementia unit have a different activities appropriate for dementia level of care. The activities coordinator uses both group and one-on-one approach in facilitating activities for the residents.

Activities are planned and provided to develop and maintain strengths that are meaningful to the residents. The activities coordinator creates a weekly plan of activities and posts these in the bulletin boards. The activities programme include physical, intellectual, sensory, social, and fun activities. ARC requirement is met.

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

Resident's service delivery plans are evaluated in a comprehensive and timely manner. Each resident's PCCP is reviewed every six months through a multi-disciplinary review, evidence sighted. Evaluations are documented, resident-focused, indicate the degree of achievement or response to the support and / or intervention, and progress towards meeting the desired outcome, confirmed at the staff and RN interviews. 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**

Resident's support for access or referral to other health and/or disability service providers are appropriately facilitated. The clinical leader refers the residents according to their needs to the GP or to the public hospital. The clinical leader refers residents to the company dietitian when there is weight loss or swallowing problems. Referral form is sighted and are kept in the resident's folder.

Residents are given the choice and advised of their options to access other health and disability services where indicated or requested, confirmed during the nurse and clinical leader interviews. ARC requirements are met.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

ARC D21 ARHSS D21

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

#### How is achievement of this standard met or not met?

**Attainment:** FA

Resident's experience a planned and coordinated transition, exit, discharge, or transfer from services. The facility utilises a Resident Transfer Form which is included in a yellow envelope when the resident needs to be admitted to public hospital, or when transferred to another facility. The resident's PCCP is attached to the resident transfer form.

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

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

#### Audit Evidence

**Attainment:** FA

**Risk level for PA/UA:**

#### Finding Statement

**Corrective Action Required:**

**Timeframe:**

### STANDARD 1.3.12 Medicine Management

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

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

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

#### How is achievement of this standard met or not met?

**Attainment:** PA Low

The provider has a documented medicine management system which includes scope and all processes from prescribing to administration.

All medications are prescribed by the general practitioner and dispensed by the preferred pharmacy. The general practitioner signs the drug chart on admission and the pharmacy generates a medication administration sheet. Verbal and telephone medication order forms are sighted and standing orders comply with requirements.

The facility uses the robotics system and medications are checked by the registered nurse on entry to the facility. The service has a medication returns register in place which is signed by the registered nurse and pharmacy staff. Returns are collected every week by the pharmacy staff.

Medications are stored in the treatment room. The treatment room can be opened by the registered nurses on duty. Fridge monitoring is completed every week by the registered nurse. The medication cupboard is kept in a tidy manner and there are no expired medications sighted on inspection. A medication reconciliation process is in place.

The controlled drug safe is locked inside a cupboard kept inside the treatment room. The controlled drugs register is sighted and confirms the required checks and balances are in place.

A medication folder is designed for each resident with the resident name in bold, suite number, special instructions and allergies. Twenty medication charts are sampled and confirm the required prescription, identification and administration records are maintained.

Three monthly general practitioner reviews are sighted in all files sampled. Discontinued medications are identified as such.

The provider has a medication competency programme which ensures all staff who administer medication have been observed and assessed as competent. Competency records are sighted.

A medication round is observed on the second day of audit. A staff member is observed crushing an enteric-coated medication prior to administration. The said medication has not been identified or approved for crushing within the organisations medication policies and an improvement is required. There are currently no residents who self-administer their medication, however in the event, there are adequately documented procedures to ensure self-administration of medication is safe and monitored.

There is a sufficiently documented process for the management of medication errors and adverse events.

ARC requirements are not fully met.

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

<b>Audit Evidence</b>	<b>Attainment:</b> PA	<b>Risk level for PA/UA:</b> Moderate
Residents in the dementia unit who have difficulty with swallowing are having their medicines crushed and this is observed during a medication round. The staff member reports that there are eight residents in the dementia unit whose medications are crushed. This includes some 'as required' (prn) medications. The medication policy regarding the preparation of medicines is viewed and does not clearly define the requirements and consequences of crushing certain medications (for example the possible increase in side effects).		
<b>Finding Statement</b>		
Crushed medications are observed being administered to residents in the dementia unit. The documented medication management system does not clearly define which medications can be crushed and/or the consequence of doing so (for example the possible increase in side effects).		
<b>Corrective Action Required:</b>		
Amend the related medication policy to include guidelines regarding crushing of medication and include same in the medication competency programme.		
<b>Timeframe:</b> 30 days		

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

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
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**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  Mal  V  CQ  SQ  STQ  Ma  L

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
<p>Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines. The registered nurse completes the dietary assessment on admission and the cook signs this form with another copy kept in the kitchen file. The original dietary assessment form is kept in the resident's file. The cook updates the list of residents in the kitchen bulletin board. List of residents on special diets is sighted. In the event that a resident loses weight, the registered nurse commences a short term care plan, food and fluid monitoring charts and refers the resident to the GP for possible food supplement. Weights are recorded monthly and evaluated by the registered nurses. The clinical leader refers the resident to the dietician when residents continue losing weight despite their management. Fluid restrictions and consistencies are noted in their care plans. Residents who have additional or modified nutritional requirements or special diets have their needs met. The registered nurse and the cook coordinate if diet modification happens.</p> <p>The dietician provides guidelines to the registered nurse and cook. Change in the resident's diet is coordinated by the clinical leader to the cook in a timely manner.</p> <p>The cook and all kitchen staff hold current food safety certificates as sighted. Food is labelled and dated. Food production temperature sheet, food service sheet are sighted. Fridge and freezer temperature monitoring is completed once per day. A kitchen cleaning schedule is sighted. An emergency menu plan is in place as well as emergency stock.</p> <p>Kitchen and other staff wear disposable hats when preparing and serving meals. The menu is reviewed by the dietitian in March 2013. The cook verbalises that there is enough equipment for preparing the meals. ARC requirements are met.</p>	

**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.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
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**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  Mal  V  CQ  SQ  STQ  Ma  L **How is achievement of this standard met or not met?****Attainment: FA**

The service follows documented processes for safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation, sighted the infection control and waste management policies. Staff members confirm they are familiar with the infection control and waste management policies. Interview with

the senior cleaner and health care assistants (HCA) confirm they use personal protective equipment (PPE) when handling waste or hazardous substances, sighted the cleaning trolleys with PPE readily available for use and verified the use of PPE during the onsite visit. 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.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
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The service uses a contractor to perform biomedical equipment performance verification checks for Oceania. The latest annual report was completed on 12 June 2013. Equipment checks at the service include; air mattress pumps, aspirations, blood glucose meters, electric beds, hoists, hoist batteries, nebulisers, optical / aural, oxygen concentrators and regulators, pulse oximeters, scales, sphygmomanometers, stethoscopes, syringe driver pumps (Niki), thermometers and vital signs monitors.

The service use a contractor for monthly alarm and smoke detective checks, confirmed during the maintenance man and the regional clinical and quality manger interviews.

Sighted the Auckland City Council, Franklin Ward compliance schedule which includes the sprinkler systems, emergency warning systems, automatic doors, emergency lighting checks, automatic backflow preventer checks, mechanical ventilation and air conditioning checks, the emergency power, signs and systems checks, exit door checks, fire separation and fire escape checks and evacuation information. The fire hose reels and fire extinguishers were last inspected on 1 June 2013.

The fire evacuation scheme approval letter from the NZ Fire Service in Auckland City dated 2 September 2005. The last fire evacuation drill was conducted on 27 August 2013, sighted the records.

A contractor is responsible for electrical and plumbing services. The electrical checks were last conducted on 18 September 2013.

The building warrant of fitness expires on 1 June 2014, verified.

The physical environment promotes safety of residents, corridors are wide and allows for residents to safely mobilise with aids. Corridors have hand rails for residents to hold on to. The maintenance man is responsible for proactive maintenance programme which includes emergency lights, checking of fire doors, handrails, carpets, call bells and implementation of maintenance as required in the maintenance book.

There are no stairs throughout the building and therefore no need for ramps. Communal areas are spacious and provide opportunity for residents to pass one-another in a safe manner. The hospital and rest home residents have access to a courtyard with chairs and tables with umbrellas in summer time. In the dementia unit residents have access to a secure courtyard with tables and chair and a sunshade over porch.

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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The facility does not have ensuite rooms. The hospital and rest home part of the service has four showers and nine toilets servicing 26 residents. The dementia unit has two showers and four toilets servicing 18 residents. The service has two visitors toilets and a staff toilet, verified during the tour of the facility and confirmed at the regional clinical and quality manager interview, and sighted the floor plan. ARC requirement is met.

**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**

The personal space and bed areas of residents are spacious allowing residents with mobility aids to freely move around in their bedrooms, verified during the facility tour, confirmed at the facility manager and regional clinical and quality manager interviews.

**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  Ma  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The service provides adequate, age appropriate and accessible communal areas for relaxation, activities and dining needs of residents. There is a large open plan lounge and dining room area in the rest home and hospital side of the facility. The dementia unit also has an open-plan lounge and dining area for the residents. There are areas for residents where they can meet in private with family and friends, confirmed at the facility manager, residents and family interviews. The lounge areas are used for activities and entertainment verified during the facility tour and sighted the floor plan for the facility. ARC requirement is met.

**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 1.4.7 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  Ma  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Fist Fire completes monthly alarm and smoke detective checks, confirmed during the maintenance man and the regional clinical and quality manger interviews.

Sighted the Auckland City Council, Franklin Ward compliance schedule which includes the sprinkler systems, emergency warning systems, automatic doors, emergency lighting checks, automatic backflow preventer checks, mechanical ventilation and air conditioning checks, the emergency power, signs and systems checks, exit door checks, fire separation and fire escape checks and evacuation information. The fire hose reels and fire extinguishers were last inspected on 1 June 2013.

The fire evacuation scheme approval letter from the NZ Fire Service in Auckland City dated 2 September 2005. Staff members receive appropriate information, training and equipment to respond to identified emergency and security situations. The last fire evacuation drill was conducted on 27 August 2013, sighted the records.

The service have alternative energy sources in the event of the main supply failing.

The service has an appropriate call system throughout the different areas of the facility to summon assistance when required.

The security system for the facility includes designated staff members completing rounds at set times to check all external doors and windows for security purposes. Security services/ surveillance cameras/ intercom access/ bells for afterhours visits.

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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
Residents are provided with adequate natural light and ventilation. There are large windows throughout the services and the environment is maintained at a safe and comfortable temperature through the use of heat pumps, and air conditioners, verified and confirmed during the interviews with residents, family and the facility manager.	

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

## **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**

Service provider demonstrates that the use of restraint is actively minimised. There are currently five residents using bedrails as restraint and one resident using a bedrail as an enabler. Enabler use is voluntarily, confirmed at the resident interview. A current restraint register is sighted. Assessment and consent forms are completed in a timely manner. Risks are identified and minimised using the PCCP. Restraint monitoring form is sighted for residents on restraint. Evaluations are documented and sighted. De-escalation training occurred in February and August 2013 and challenging behaviour training occurred in July 2013.

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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The service provider maintains a process for determining approval of restraint use, restraint processes, duration of restraint, and on-going education on restraint use and this processes is made known to service providers and others. Restraint policies and procedure are sighted and implemented. The clinical leader completes an assessment before commencing any restraint and evaluates the restraint every six months through a multi-disciplinary meeting. The family is invited to attend the meeting. Restraint is included in the PCCP which identifies the risks of using the restraint, the duration of which the restraint will be used and the type of restraint to be used. Evaluations are documented and sighted.

The responsibility for restraint processes and approval is clearly defined and there are clear lines of accountability for restraint use. The clinical leader is the restraint coordinator with an appropriate job description as sighted. The ARC requirement is met.

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The services ensure rigorous assessment of residents is undertaken, where indicated, in relation to the use of restraint. The clinical leader completes a restraint assessment before commencing any resident on restraint. The reasons for restraint are identified and documented, sighted.

The clinical leader is the restraint Co-ordinator.

The ARC requirement is met.

**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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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  Mal  V  CQ  SQ  STQ  Ma  L

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
<p>The service provider use restraints in a safe and appropriate manner. The bedrails are covered with padded bedrail covers. Restraint monitoring form is completed in a timely manner. The restraint register, sighted.</p> <p>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 clinical leader determines the need of restraint and completes a restraint assessment.</p>	

Each episode of restraint is documented in sufficient detail to provide an accurate account the indication for use, intervention, duration and its outcome. The PCCP on Restraint is in place and sighted. It defines the type of restraint, duration of use and expected outcome. A restraint monitoring form is in place and sighted. The approval process is clearly outlined for restraint use to guide staff if and when required.

A restraint register is established to record sufficient information to provide an auditable record of restraint use. The ARC requirement is met.

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

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;

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

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

#### **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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
The service provider evaluates all episodes of restraint. The clinical leader evaluates the restraint every six months through the multi-disciplinary meeting, confirmed at the family interviews. Evaluations are documented and sighted.	
Each episode of restraint is evaluated in collaboration with the resident, family / whanau and staff. The restraint is evaluated every six months as documented and sighted.	

ARC requirement is met.

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

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The restraints are monitored through six-monthly reviews, sighted records and confirmed at the resident, family and the GP interviews.

**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 responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The clinical leader is the infection control co-ordinator. The facility has a clearly defined infection prevention and control program that is reviewed annually. The clinical leader is the infection control co-ordinator and the job description is sighted. The lines of accountability for infection control matters in the organisation to the governing body and / or senior management is clearly defines.

Infectious diseases prevention policy is in place to prevent visitors suffering from, or exposed to and susceptible to, from exposing others while infectious. Staff interviewed are aware that they have to stay off work when sick especially after having diarrhoea.

The ARC requirement is met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

ARC D5.4e ARHSS D5.4e

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. The organisation utilises Bug Control for external specialist advise on infection control and is accessible as reported by the clinical leader. Hand washing signs are sighted around the facility to remind staff the importance of having proper hand washing.

The infection control committee is comprised of staff from nursing, caregiving, kitchen and laundry. Infection control is part of health and safety meeting every month

When a resident is suspected having urinary tract infection (UTI), the registered nurse on duty conducts an assessment, obtains mid-stream urine sample, performs dipstick and sends the urine sample to the laboratory for sensitivity. The registered nurse on duty reports the laboratory result to the GP who then

prescribes the appropriate antibiotic. The registered nurse completes an Incident Report and gives this Incident Report to the clinical leader who will then enters the data to the Intranet for benchmarking and pre-populates an infection control demographics.

The 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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
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. Policies and procedures sighted. The service evidences implementation of the policies and procedures. 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.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
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**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The organisation provides infection control training to all service providers, support staff, and residents as sighted in the planner and education records. The infection control education is provide by either the clinical manager or the facility manager who are both suitably qualified and maintain a knowledge of current practice. All staff complete an annual quiz as part of the annual update. Training records are sighted. Staff are able to discuss the importance of proper hand washing and how to break the chain of infection.

The organisation maintains a regular in-service training for infection control and hand washing.

Infection control program is provided by either the facility manager or CL who are both suitably qualified and maintains their knowledge of current practice. They utilise Bug Control for external trainings for infection control updates. Infection control education record is in place and sighted. This record is kept in their database through the Intranet. Infection control questionnaire is also sighted.

The ARC requirement is met.

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

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment:</b> FA
<p>Results of the surveillance, and specific recommendations to assist in achieving infection control reduction and prevention outcomes are acted upon, evaluated, and reported to the relevant personnel and management in a timely manner. The surveillance result is reported during monthly staff meeting. Meeting minutes for August 2013, sighted</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Monthly infection log and antibiotics use, sighted. The organisation has an internal benchmarking system through Intranet. The surveillance result is reported to the staff during staff meetings, sighted meeting minutes.</p> <p>The organisation determines the type of surveillance required and the frequency with which it is undertaken. Surveillance is appropriate to the size and complexity of the organisation.</p>	

**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.

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		

**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:**