**Logan Samuel Limited - Anne Maree Court**

**Current Status:** **24-Oct-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance 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**

Anne Maree Court, located in Northcote, Auckland, is a 56 bed facility offering rest home and hospital level care. The residents, family and staff report that the service focuses on providing a non-clinical home like environment for the residents. Since the last audit the service has reconfigured five existing rest home level of care beds to be able to take residents at either rest home or hospital level of care. All but one smaller room in the facility are of an appropriate size to accommodate rest home or hospital level of care.

 There were three areas requiring improvement identified at the previous audit that are now addressed. The improvements include ensuring there is no private resident information in the newsletter, a copy of the written consent form is maintained in the residents' files and that the initial assessment is completed on admission.

There are no areas for improvement identified at this unannounced surveillance audit.

**Audit Summary AS AT** **24-Oct-13**

Standards have been assessed and summarised below:

**Key**

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

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| --- | --- | --- |
| **Consumer Rights** | Day of Audit24-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit24-Oct-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit24-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Standards applicable to this service fully attained** |

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| **Safe and Appropriate Environment** | Day of Audit24-Oct-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit24-Oct-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| --- | --- | --- |
| **Infection Prevention and Control** | Day of Audit24-Oct-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Anne Maree Court**

Logan Samuel Limited

Surveillance audit - Audit Report

Audit Date: 24-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Logan Samuel Limited |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Anne Maree Court | 17-27 Fraser Avenue | Northcote | Auckland |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 24-Oct-13 **End Date:** 24-Oct-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | RN, B.Nursing, RABQSA | 8.00 | 4.00 | 24-Oct-13 |
| Auditor 1 | XXXXXXXX | NZRN BHSc NZQA 8086 | 8.00 | 4.00 | 24-Oct-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXXX | RN,MBA,NZQA US 8086 |       | 2.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 10.00 | **Total Audit Hours** | 26.00 |
| **Staff Records Reviewed** | 5 of 35 | **Client Records Reviewed** *(numeric)* | 5 of 50 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 5 |
| **Staff Interviewed** | 4 of 35 | **Management Interviewed** *(numeric)* | 2 of 3 | **Relatives Interviewed** *(numeric)* | 1 |
| **Consumers Interviewed** | 4 of 50 | **Number of Medication Records Reviewed** | 10 of 50 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

# Declaration

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

I confirm that The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 7 day of November 2013

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

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

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

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

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

# Services and Capacity

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Anne Maree Court | 56 | 50 | 40 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Anne Maree Court, located in Northcote, Auckland, is a 56 bed facility offering rest home and hospital level care. The residents, family and staff report that the service focuses on providing a non clinical home like environment for the residents. Since the last audit the service has reconfigured five existing rest home level of care beds to be able to take residents at either rest home or hospital level of care. All but one smaller room in the facility are of an appropriate size to accommodate rest home or hospital level of care.

There were three areas requiring improvement identified at the previous audit that are now addressed. The improvements include ensuring there is no private resident information in the newsletter, a copy of the written consent form is maintained in the residents' files and that the initial assessment is completed on admission. There are no areas for improvement identified at this unannounced surveillance audit.

1.1 Consumer Rights

The residents and family report that they are kept well informed in a manner that reflects the organisation's open disclosure policy. Complaints are managed to meet policy requirements. At the time of audit the service has no outstanding complaints. The previous area for improvement to ensure a copy of the consent form is kept in the residents file is now addressed and an improvement implemented since the last audit.

1.2 Organisational Management

The service is owned and operated by two owners/managing directors, one of these being a registered nurse. The management ensures that services are planned and coordinated to meet residents' needs. The organisation's strategic and business plans identify their purpose, values, priorities and goals. The planning process is reviewed annually and evaluated quarterly to measure achievement.

The day to day operation of the facility is undertaken by staff who are appropriately experienced and qualified to undertake the role in a manner that ensures residents' needs are being met in a safe and efficient manner.

All quality and risk management processes are implemented to meet policy requirements. Policies and procedures reflect current accepted good practice. Incidents, accidents and untoward events are recorded, evaluated and discussed with family/whanau in a manner that is reflective of open disclosure principles. All quality actions are recorded and reported at staff and management levels. Key components of service are explicitly linked to the quality management system. Quality data collection and findings are used as opportunities for improvements which are well documented. Quality improvements are evaluated to ensure the desired outcomes are reached.

Staffing levels and skill mix are maintained to meet recommendations and exceed contractual requirements. All shifts are covered by at least one registered nurse. Staffing is planned to meet the needs of the resident at rest home and hospital level of care.

The previous area for improvement required to ensure private resident information is not documented in the newsletter is now addressed and an improvement implemented since the last audit.

1.3 Continuum of Service Delivery

Anne Maree Court employs a facility manager who is a registered nurse. The Manager oversees registered nurses to ensure that all assessments, planning and evaluations of service delivery is completed. All initial nursing assessments, long term care plans and care plan evaluations are being completed and reviewed within the required time frames, which addresses the required improvement from the previous audit.

There is a qualified diversional therapist who is employed Monday to Friday and an activities co-ordinator, who is training to qualify as a diversional therapist, works the weekend. This ensures activities are provided for residents over seven days. The activity plans for each of the residents are completed and evidence is seen of resident and family consultation. Resident and family interviewed report they are involved and enjoy the activities provided.

Medication management systems comply with current legislation and registered nurses administer medication. The controlled drug processes meet legislative requirements and the pharmacy is actively involved in medication reconciliation.

Anne Maree Court uses a four weekly seasonal menu cycle approved by a dietician. Initial dietary assessments identify special dietary requirements and the kitchen is notified as required. There is food and snacks available 24 hours a day for all residents. All food and safety standards are met .

1.4 Safe and Appropriate Environment

The facility has a current warrant of fitness. There are no alterations to the layout of the building since the last audit. The service has an ongoing maintenance and refurbishment plan to ensure the up-keep of the building and grounds. Since the last audit the service has reconfigured five existing rest home level of care beds to be able to take residents at either rest home or hospital level of care. All but one smaller room in the facility are of an appropriate size to accommodate rest home or hospital level of care.

2 Restraint Minimisation and Safe Practice

The service have no residents requiring enabler use at the time of audit. Where enablers are used, these are voluntary and the least restrictive option for the resident. Staff are able to demonstrate their understanding of the restraint minimisation policy and procedures and the definition of an enabler.

3. Infection Prevention and Control

Anne Maree Court has identified processes for surveillance of infections. Documentation is sighted of completed forms by clinical staff of infections which are collated and graphed by the facility manager monthly. The facility infection control data is benchmarked against the other facility in the group.

Summary of Attainment

* 1. Consumer Rights

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 1 | 0 | 0 | 2 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:9 CI:0 FA: 3 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA:5 PA:0 UA:0 NA: 2 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 1 | 0 | 0 | 3 | 10 |

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| Organisational Management Standards (of 7): N/A:1 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: 0Criteria (of 34): CI:0 FA:18 PA:0 UA:0 NA: 3 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 1 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 2 | 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) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 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: 0Criteria (of 51): CI:0 FA:14 PA:0 UA:0 NA: 3 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:7 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:0 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 0 | 0 | 3 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 1 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 1 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 2 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 7 |

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| **Total Standards (of 50) N/A:** 32 **CI:** 0 **FA:** 18 **PA Neg:** 0 **PA Low:** 0 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 40 **PA:** 0 **UA:** 0 **N/A:** 15 |

# Corrective Action Requests (CAR) Report

Provider Name: Logan Samuel Limited

Type of Audit: Surveillance audit

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

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

# Continuous Improvement (CI) Report

Provider Name: Logan Samuel Limited

Type of Audit: Surveillance audit

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

DAA: The DAA Group 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 1.1.9 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 one family member interview confirms they are kept informed of the resident's status, including any events adversely affecting the resident. The family communication is recorded in each resident's electronic file and the incident form follow up. Evidence of open disclosure is documented in the family contact sheets, on the accident/incident form and in the residents' progress notes (evidenced in five of five residents' files). The manager reports open disclosure is a strength of the service. Family are contacted after any event with the electronic system utilized that alerts the staff member regarding follow up and closure of the incident, this includes the open disclosure processes. Interviews with the one family member and five residents confirms they are kept well-informed by the staff.

The interpreter policy's purpose is to ensure residents who have English as a second language can be effectively communicated with. The facility manager reports family members most commonly assist with translation (as appropriate) and that the service has staff that can speak the different languages of the residents.

The Aged Related Residential Care (ARRC) service agreement 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

The previous CAR at 1.1.10.4 identified that the consent form is attached to the resident information booklet and that a copy of the consent form is not evidenced in the residents' files. This is now addressed and an area of improvement since the last audit. The consent form is evidenced in the five of five residents' files reviewed. The one family and four residents confirm that they have provided consent to care.

The ARRC requirements are met.

**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:**

**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

Complaints management is explained as part of the admission process. It is fully described in policy and shown in the resident welcome book. The facility manager includes the right to complain as part of the admission discussion and the service respects the resident's right to make a complaint. The sighted complaints procedure is easily accessible, responsive and complies with Right 10 to the Code.

The complaints register identifies that in 2013 there have been three complaints. The complaints register records email/feedback received from the DHB in regards to a resident admitted to the acute care hospital in February 2013. All complaints show in detail all dates, with the actions recorded on the complaint report form. The facility also maintains a compliments register and folder which contains numerous cards, letters and complement forms regarding satisfaction with the care and services provided at Anne Maree Court.

Interviews with the one family/whanau and four of four residents confirms their understanding of the right to make a complaint. Monthly resident meetings are used as a forum for residents to voice any concerns. The family member interviewed confirms they have access to the facility manager at any time including after hours, and reports that communication with all staff is excellent.

The relevant ARRC 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 Business Plan 2013-2104 is sighted for Anne Maree Court. The business plan includes the mission statement, goals, objectives, statement of purpose, philosophy of the service, summary of the long term goals that have been met over the past year. The business plan also includes a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis and executive summary. The organisation has two owners/managing directors, with the services planned and documented to provide quality services that are appropriate the needs of the residents. The organisations main focus is to provide a non clinical home like environment. The four of four residents and one family/whanau report high satisfaction with the quality of care, the home like environment and all report that the needs of the residents are met.

The facility manager has over 18 years of experience in the aged care sector. The facility manager is also a registered nurse (RN) with a current annual practising certificate (APC). The manager has been employed by the owner since September 2011. The job description sighted identifies the managers authority, accountability and responsibility. Previous to this, the manager worked with a DHB as a RN. The facility manager has post graduation qualifications in management and has completed their Masters in Health Science in 2009. The facility manager participates in the Waitemata District Health Board (DHB) professional development recognition programme (PDRP) for registered nurses. Evidence is sighted of their attendance at education seminars presented by DHB. The facility manager has attended in excess of 8 hours education related to management of aged care services in the past 12 months (sighted in training records and interview with the facility manager).

One of the owners is a RN with a current annual practising certificate. In addition to Anne Maree Court, the owners operate one other aged care facility in Auckland.

ARRC 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 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The five staff interviewed (one RN, two caregivers, one diversional therapist and one cook) and two members of the management team (facility manager and one managing director) demonstrate an understanding of the quality and risk processes that are identified in policy.

Policies and procedures sighted are aligned with accepted good practice and service delivery and legislative requirements, evidenced by the links documented in policy. Policies are reviewed annually, as confirmed at interview with the facility manager. A system is in place for documentation reviews as part of the annual business review, which is conducted January to February each year. Obsolete documents are archived, with the service moving towards electronic records, the service has both an electronic and hard copy back up of records and documents.

An audit schedule provides the manager with a list of internal audits that are due each month. There is a monthly quality review that covers clinical safety, clinical practice, human resources management, mandatory updates, health and safety, education and quality monitoring of incident forms and complaints. The internal audits cover the range of services provided. Examples of internal audits reviewed include, cleaning (January 2013) medicine management (April 2013), informed consent (June 2013), resident satisfaction (April 2013) infection control (August 2013) and diversional therapy (July 2015). Key components of the service are incorporated into the audit system and discussed at the integrated staff meetings as confirmed in meeting minutes sighted.

The quality improvement data collected is analysed and evaluated and trended by the facility manager. If a trend is noted to be increasing (negatively) then corrective action planning is put in place as required, using the audit evaluation form and corrective action request/report forms. Corrective actions are put in place for any deficit that is noted during internal or external audits and in response to complaints, resident requests and satisfaction survey result findings as appropriate. The resident/family satisfaction survey, last conducted in April 2013, with overall positive response to all questions asked. The corrective action request forms sighted include a non-conformance report, root causes, proposed corrective actions and quality improvement recommendations, referral to the integrated staff meeting and approval of the implementation of the corrective actions.

Data is collected each month as per the audit schedule. Data is analysed and evaluated by the facility manager. Results are discussed at the integrated staff meetings and are communicated to staff through the weekly newsletters that are included with staff payslips.

Actual and potential risks are identified, documented and communicated to staff and residents as appropriate. Examples sighted include residents being informed of the fire safety and evacuation procedures and staff being informed of new processes put in place to report medication errors. The system used by the service identifies all hazards and if they cannot be eliminated they are added to the significant hazard register. Hazards are reviewed and evaluated quarterly at the management level (which is often attended by one owner/manager) and reported against at the annual service review meeting which both owner/directors attend. A review of five staff files shows that as part of orientation staff must read and make themselves familiar with emergency procedures and health and safety.

ARRC 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.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

The facility manager understands their obligations in relation to essential notifications and the correct authority is notified where required. The facility manager reports that in 2013 there have been two fractures from falls that have been reported to the DHB portfolio manager.

The staff are required to complete incident and accident reports for any actual or near miss accident/incident. The hard copy form is completed and the incident/accident is also recorded on the electronic resident information management system (Lee Care). The five of five staff interviewed understand their responsibilities on how and when to complete the incident/accident forms. Five incident and accident forms from July and August 2013 are sighted as part of this surveillance audit. The August analysis records that there are 32 falls recorded, with one of these falls resulting in an injury to the resident. The analysis of the August incident/accident summary records that 15 of these falls are related to one resident. The interventions that are implemented for this resident, with a degenerative medical condition, include the use of sensor mat, low bed, at least hour rounds by the staff and medical review. The resident did not respond to the interventions and the resident was referred to specialist review, with an admission to the acute care hospital for further review by the gerontologist. The resident has subsequently been re-assessed and admitted to a specialist dementia level of care facility. (Also refer to the review of residents with fall management in 1.3.3).

The ARRC 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

There is a system in place to record annual practising certificates for staff who require them (sighted). The service has due dates recorded for staff practising certificates noted for all staff who require them.

A review of five of five staff files (two RNs, two caregivers and one cook) and interviews with five staff (one RN, two caregivers, one diversional therapist and one cook) confirm that the orientation process prepares staff for the roles they undertake. The orientation includes 'buddy shifts' an orientation checklist and a self-directed learning package. The training package and skills checklist cover the essential components of services delivery (such as, infection control, emergency management, health and safety, restraint minimisation), with skill and competencies relevant to each role (eg, caregiver, RN, cook).

Staff file reviews and the training schedule sighted for 2013 identifies that the service plan facilitates and records all education. Education is undertaken onsite and offsite and is presented by specialist providers as is appropriate. Examples of ongoing education for 2013 include the Code of rights (July), communication (August), infection control (March) and incident reporting (July). The clinical education includes topics on the aging process, management of challenging behaviours, palliative care, pain management, falls management, wound care, continence management, skin care and specific medical conditions. Staff are encouraged to attend education both in-house and off site related to the roles they perform.

The service also has a programme for volunteer student placements from the local high school, tertiary placements for nursing students and links with the DHB with entry to nursing practice for new graduates.

The relevant ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is a documented staffing levels policy that ensures staffing levels meet the residents' needs. All staff undertake appropriate education and training to undertake their roles. If staff are off work for any reason the person is replaced. All clinical care is well planned and identified in the five of five residents' files reviewed (three hospital and two rest home).

The rosters sighted for the previous four weeks confirm that all shifts are covered by at least one staff member who holds a current first aid certificate. Management and staff interviews confirm additional staff are rostered as required to meet residents' needs. The facility manager (RN) is on duty Monday to Fridays. The minimum staff levels are:

Morning shift: one RN, four caregivers on duty from 7am to 3pm, one caregiver from 7am to 1pm and the one additional caregiver from the night shift that assists with the morning till 9am.

Afternoon shift: one RN, four caregivers 3pm to 11pm and an additional caregiver from 3.30pm to 9.30pm

Night shift: one RN, two caregivers 11pm to 7am and one caregiver from 11pm to 9am

The service has at least one diversional therapist on duty seven days a week, some days have two diversional therapists on duty. There are adequate kitchen, cleaning and laundry staff to meet the needs of the service.

The four of four residents and one family/whānau interviewed identify that services are delivered in an appropriate and safe manner to meet all required needs.

The relevant ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

There is a previous CAR at 1.2.9.7 that identified that the weekly newsletters for staff are attached to staff payslips. Newsletters contain residents' names and personal information relating to the resident. A corrective action was made to ensure resident information of a private or personal nature must be maintained in a secure manner that is not publicly accessible or observable. The newsletters sighted do not contain any confidential information regarding the residents. The four of four residents an one family/whanau interviewed report that they feel their privacy is respected. The previous corrective action request is now addressed and an improvement implemented since the last audit.

The relevant ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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 1.3.3 Service Provision Requirements**

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

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

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

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

Service delivery is overseen by the facility manager and the registered nurses.

In all five files reviewed (two rest home and three hospital) there is evidence of initial assessments, care plans being completed, and clinical risk tools being reviewed, within the required timeframes. The previous area for improvement has been addressed.

Anne Maree Court uses the Leecare computer programme for clinical documentation. This includes seven clinical risk assessments and follow up times for documentation reviews or completed is part of the alert process on the computer. The hard copy of the resident's chart includes a covering sheet, a yellow alert sheet with any relevant data for that resident, and the 'traffic light' system for falls system, as a result of the risk assessment. The general practitioner and the pharmacy have direct access to the system.

The facility manager and the RN report there is a process for six monthly multidisciplinary resident reviews. There is evidence in the five files reviewed that the family/whanau are given a copy of all clinical notes from the computer prior to the multidisciplinary meeting. Handover at the beginning of each shift is undertaken in the nurses’ station for privacy. The GP visits weekly, or at other times, if required. He was not available for interview on the day of the audit. The three clinical staff interviewed (one RN and two caregivers) report that they are given information concerning service delivery at handover and any other times, if there is a change in service delivery requirements. Evidence is seen of visits from the Mental Health Service for the Older Person (MHSOP) and the dietitian from the Waitemata District Health Board.

The four residents and one relative interviewed are very positive about the staff, GP and all aspects of care. The three clinical staff interviewed (one RN and two caregivers) report that they all use the Leecare computer system and have been given training and follow-up opportunities. Two RNs have received training in InterRAI and are starting to use the system particularly in connection with the DHB. The staff interviewed (one RN, two caregivers, one cook, one diversional therapist) report that they aware of any changes in residents' requirements relating to all aspects of care or nutritional requirements. All areas of the ARC requirements are met.

Tracer Methodology Rest Home -

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

Tracer Methodology Hospital -

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

The ARRC requirements are met.

**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 1.3.6 Service Delivery/Interventions**

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

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

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

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

In five of five files reviewed (three hospital and two rest home) there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are assessed at required timeframes to ensure residents desired outcomes are being met. The five clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education if required.

Assessments relating to falls and the use of the traffic light system are reviewed by the physiotherapist to ensure residents' desired outcomes are being met. There is also evidence of continence interventions and wound plans. Alerts are part of the Leecare computer system and to ensure staff are made aware of any changes. The three clinical staff interviewed (one RN and two caregivers) report that the computer is used as well as verbal notification at handover.

The four residents and one relative report that they aware of any changes in their care and are involved in planning all aspects.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

There is one qualified diversional therapist (full time) and one activities coordinator (part time, and who is training towards her diversional therapy qualification) employed at Anne Maree Court to provide activities for all residents. The diversional therapist has worked at the facility for nine years and the activities coordinator for three years. The programme is available for all residents over seven days. The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of hospital and rest home residents. There is an annual plan with monthly overview for the year. This includes the theme for each month and process of weaving the activities for the month around this focus. An example is St Patrick's day in March and over the month activities relating to Irish music, dancing, diet and history are organised.

 Evidence of minutes from the two monthly residents meetings were sighted where activities are discussed. There is focus on both bringing the community to the facility and external visits. The four residents and one relative interviewed report the activities are positive and include walking, music and puzzles.

All ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

In five of the five files reviewed evidence is seen of documentation if an event occurs that is different from expected and requires changes to service. This includes use of the alert system on the computer. Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in five of the five files reviewed. Progress notes are signed once every duty by the RN on Leecare. The three clinical staff interviewed have knowledge of the care plan documentation requirements.

Evidence is seen of the family/whanau involvement in the care reviews. The one relative interviewed reports that she receives a copy of the printed clinical notes and is consulted regarding care reviews. The four residents interviewed report they are involved in their care planning and one resident recalls the meeting regarding her falls and that now she uses hip protectors.

All ARRC contracts 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 1.3.12 Medicine Management**

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

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

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

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

Anne Maree Court uses the blister medicine system whereby medicines are delivered monthly. These are checked individually on arrival and before being given to the resident and evidence is seen of signing by the RN. There are controlled drugs on the premises and all processes comply with the legislative requirements.

There is evidence in all ten medication charts reviewed of three monthly reviews by the GP. Evidence is seen of this process overseen by the RN and alerts are part of the Leecare system.

There are no individual standing orders in place at this facility.

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required.

The RN reported that the GP works with the pharmacy but he is responsible for all medicines administered to his residents. The RNs are responsible for all medicine management and administering medicines. The RN observed during the lunchtime medicines round followed correct procedures. Medicine sheets are signed in ink as required following administration. The gerontology nurse specialist for the WDHB also gives in service education relating to safe medication procedures in aged care.

A self-administration of medicines policy, including a form to be signed by the GP is available. There is no one self-administering medications on the day of audit. All four rest home residents spoken with report the GP discusses their medicine requirements with them.

The ARRC requirements are 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.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The seasonal menu is appropriate and varied. Evidence is seen of the summer and winter menu being reviewed two yearly by an approved dietitian. An individual dietary assessment is completed on admission which identifies individual needs and preferences. This is carried out in consultation with the family/whanau as required. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours.

Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.

All aspects of food requirements are within legislative requirements. Evidence is seen of completed cleaning schedules and there is adequate supplies for emergency requirements. Evidence is seen of temperature checking of fridges, freezers and meals. There are two cooks who cover the kitchen over seven days. One of the cooks is a qualified nutritionist in her own country and worked as a cook in Australia prior to her employment at Anne Maree Court. Evidence is seen of kitchen staff enrolled to attend the Food Safety Certificates in November 2013.

Resident survey support the meals are satisfactory and individual needs are recognised.

All ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

Policy identifies that the facility has a no-restraint environment. At the time of audit there are no residents requiring restraint of enabler use. All documentation, including assessment, approval processes and actions to be taken, are clearly set out should restraint be required. Policy shows that enablers are voluntary and that the least restrictive option would be used with the intention of promoting or maintaining resident independence and safety, such as a chair lap belt to prevent falls, or bedside rails to help the resident feel safe. The facility manager reports that they have had one respite resident who has requested the use of bed rails in 2013. The manager reports that with this respite resident's recent admission, a wider bed was used and the resident felt safe in this bed, and then did not require the use of bed rails. Observation and staff interviews confirm that no restraint or enablers are in use at the time of audit. The RN and two caregivers interviewed demonstrate knowledge that enablers use is voluntary and the least restrictive option for the resident.

The ARCC requirements are 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:**

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

**STANDARD 3.5 Surveillance**

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

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

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

There is a surveillance programme which includes surveillance for the following infections:

- urinary tract infections

- respiratory tract infections

- skin and wound infections (cellulitis, soft tissue and wound infections)

- scabies

- conjunctivitis

- gastroenteritis.

An annual summary of the number and type of infections per month is maintained and sighted for 2012 and 2013. A register is kept of all residents who develop infections, the type of infections, results of cultures (where obtained) and details of treatment provided. The register notes whether further follow-up is required.

At present there is a number of residents who are having outbreaks of rashes on their arms and chest. The facility manager has spoken to the WDHB infection control officer and they are treating this as an outbreak. This has included carpets shampooed, scrapings sent to the laboratory, washing machine on hot cycle, and prophylactic treatment for scabies. They are awaiting reports from the laboratory. Evidence is seen of numbers and this is kept in the surveillance folder.

An initiative started this year at the facility is the use of hand wipes on all residents before all meals. The facility manager reports that there has been no outbreak of gastro-intestinal infections this year.

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**