

The Ultimate Care Group Limited - Bishop Selwyn Lifecare

CURRENT STATUS: 26-Sep-13

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

GENERAL OVERVIEW

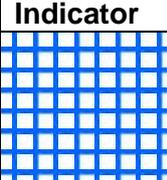
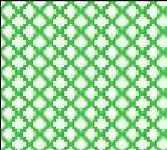
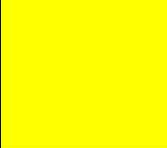
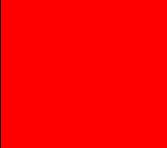
Bishop Selwyn Lifecare provides residential care for up to 78 residents who require hospital level care and rest home level care. Occupancy on the day of the audit is at 67. The facility is operated by The Ultimate Care Group Limited. Staffing is stable with minimal turnover of staff. Residents and family interviewed provide positive feedback on the care provided.

Two areas requiring improvement have been identified during this audit relating to completion of resident documentation within required timeframes for one resident file reviewed, and monitoring of residents who self-administer their own medications.

AUDIT SUMMARY AS AT 26-SEP-13

Standards have been assessed and summarised below:

Key

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

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

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

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

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

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

| Infection Prevention and Control | Day of Audit 26-Sep-13 | Assessment |
|---|---------------------------|--|
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained |

AUDIT RESULTS AS AT 26-SEP-13

Consumer Rights

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

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

Organisational Management

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Bishop Selwyn Lifecare. The Ultimate Care Group quality and risk management systems have been implemented at Bishop Selwyn Lifecare over the last 12 months.

Systems are in place for monitoring the service provided at Bishop Selwyn Lifecare including regular monthly reporting by the facility manager and clinical services manager to The Ultimate Care Group Head Office. The facility manager is an experienced registered nurse who has worked in the aged-care sector for just over three years and was appointed to their current position in November 2011. The facility manager is supported by a clinical services manager who is an experienced registered nurse who was appointed to their current position in July 2007. The facility manager and clinical services manager have current annual practising certificates.

A 'Quality and Risk Management Plan for Bishop Selwyn Lifecare Hospital and Rest' reviewed and includes a vision statement, core values, quality objectives, quality indicators and quality projects. The quality and risk management plan and associated quality and risk management systems are used to guide the quality programme in place at Bishop Selwyn Lifecare.

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

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RN), enrolled nurses (EN), pharmacist, dietician, and general practitioners (GPs) is occurring. There is evidence available indicating an in-service education programme is provided for staff including the provision of regional study days that staff attend annually as well as monthly in-service education sessions which are often provided prior to the monthly staff meetings. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Aged Care Education (ACE) modules. Review of staff records evidences human resource processes are followed e.g. reference checking, criminal vetting, and interview questionnaires are completed, and individual education records are maintained.

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

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

Continuum of Service Delivery

Bishop Selwyn Lifecare has a documented entry criteria, which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input and is coordinated to promote continuity of service delivery.

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. Residents

interviewed confirm that interventions noted in their care plans are consistent with meeting their needs.

There is one area requiring improvement around documenting long term care plans within three weeks of resident's admission to the facility.

A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Residents and family interviewed confirm their participation in these evaluations. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan.

A planned activities programme is provided at the facility. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management have attended in-service education for medication management and have current medication competencies.

There are three residents' who self-administer medicines. There is one area requiring improvement around monitoring of medication administration for residents that self-administer medicines.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Kitchen staff have completed food safety training. The menu has been reviewed by a dietitian.

Safe and Appropriate Environment

All bedrooms are single and have wash hand basins. Several of the bedrooms have their own ensuite and there is an adequate number of communal toilet and shower facilities. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as a carer. There are three lounges, three dining areas, an activities area, a conservatory, and a whanau room available. External areas are available for sitting and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

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

training in chemical safety. Visual inspection provides evidence of compliance regarding safe and hygienic storage areas of cleaning equipment, soiled linen and chemicals.

Restraint Minimisation and Safe Practice

The service has an overarching risk and quality management system, that demonstrates compliance with the Standard. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive.

The facility was not using any restraints and using one enabler, on audit days.

Infection Prevention and Control

The Infection Prevention and Control (IC) Programme includes policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice.

New employees are provided with training in infection control practices and there is on-going education available for all staff. Staff interviews confirm staff are familiar with infection control measures at the facility.

Surveillance for infections is carried out at the facility and results of surveillance are evaluated and reported on monthly.

Bishop Selwyn Lifecare

The Ultimate Care Group Limited

Certification audit - Audit Report

Audit Date: 26-Sep-13

Audit Team

| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
|---------------------|----------|---------------------------------|-----------------------|------------------------|--------------------------|
| Lead Auditor | XXXXXXXX | Lead Auditor, RN, RM, ADipN, BN | 12.75 | 8.50 | 26-Sep-13 to 27-Sep-13 |
| Auditor 1 | XXXXXXXX | RN, Lead Auditor, BHSc | 12.75 | 4.00 | 26-Sept-13 to 27-Sept-13 |
| Auditor 2 | | | | | |
| Auditor 3 | | | | | |
| Auditor 4 | | | | | |
| Auditor 5 | | | | | |
| Auditor 6 | | | | | |
| Clinical Expert | | | | | |
| Technical Expert | | | | | |
| Consumer Auditor | | | | | |
| Peer Review Auditor | XXXXXXXX | LA, RCpN, 8086 | | 2.00 | 09-Oct-13 |

| | | | | | |
|----------------------------------|---------|--|----------|---|---------|
| Total Audit Hours on site | 25.50 | Total Audit Hours off site <i>(system generated)</i> | 14.50 | Total Audit Hours | 40.00 |
| Staff Records Reviewed | 9 of 67 | Client Records Reviewed <i>(numeric)</i> | 11 of 67 | Number of Client Records Reviewed using Tracer Methodology | 2 of 11 |

| | | | | | |
|------------------------------|----------|---|----------|---|---|
| Staff Interviewed | 15 of 67 | Management Interviewed <i>(numeric)</i> | 4 of 4 | Relatives Interviewed <i>(numeric)</i> | 4 |
| Consumers Interviewed | 9 of 67 | Number of Medication Records Reviewed | 20 of 67 | GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i> | 1 |

Declaration

I, (full name of agent or employee of the company) XXXXXXXXXX (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 03 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*):

Executive Summary of Audit

General Overview

Bishop Selwyn Lifecare provides residential care for up to 78 residents who require hospital level care and rest home level care. Occupancy on the day of the audit is at 67. The facility is operated by The Ultimate Care Group Limited. Staffing is stable with minimal turnover of staff. Residents and family interviewed provide positive feedback on the care provided.

Two areas requiring improvement have been identified during this audit relating to completion of resident documentation within required timeframes for one resident file reviewed, and monitoring of residents who self-administer their own medications.

1.1 Consumer Rights

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

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1.4 Safe and Appropriate Environment

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2 Restraint Minimisation and Safe Practice

The service has an overarching risk and quality management system, that demonstrates compliance with the Standard. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive.

The facility was not using any restraints and using one enabler, on audit days.

3. Infection Prevention and Control

The Infection Prevention and Control (IC) Programme includes policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice.

New employees are provided with training in infection control practices and there is on-going education available for all staff. Staff interviews confirm staff are familiar with infection control measures at the facility.

Surveillance for infections is carried out at the facility and results of surveillance are evaluated and reported on monthly.

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 | PA Low | 0 | 2 | 1 | 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: 10 | PA Neg: 0 | PA Low: 2 | PA Mod: 0 | PA High: 0 |
| | PA Crit: 0 | UA Neg: 0 | UA Low: 0 | UA Mod: 0 | UA High: 0 | UA Crit: 0 | |
| Criteria (of 51): | CI:0 | FA:19 | PA:2 | UA:0 | NA: 0 | | |

1.4 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 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 5 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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

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 | Not Applicable | 0 | 0 | 0 | 0 | 1 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 1 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 3 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 2 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 1 | 1 |
| | | | | | | | | |
| | | | | | | | | |

| | | | | | | | |
|--|------------|-----------|-----------|-----------|------------|------------|------------|
| 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: 0 | |
| Criteria (of 21): | CI:0 | FA:1 | PA:0 | UA:0 | NA: 8 | | |

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

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

Total Standards (of 50) N/A: 5 CI: 0 FA: 43 PA Neg: 0 PA Low: 2 PA Mod: 0 PA High: 0 PA Crit: 0 UA
 Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0
Total Criteria (of 219) CI: 0 FA: 91 PA: 2 UA: 0 N/A: 8

Corrective Action Requests (CAR) Report

Provider Name: The Ultimate Care Group Limited
 Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:26-Sep-13 End Date: 27-Sep-13
 DAA: Health Audit (NZ) Limited
 Lead Auditor: XXXXXXXX

| Std | Criteria | Rating | Evidence | Timeframe |
|--------|----------|-----------|---|------------|
| 1.3.3 | 1.3.3.3 | PA Low | <p>Finding: One long term care plan has not been recorded within three weeks of admission to the facility. This care plan was recorded two months post admission to the facility.</p> <p>Action: Provide evidence resident's long term care plan is developed within three weeks of resident's admission to the facility.</p> | Six months |
| 1.3.12 | 1.3.12.5 | PA Low | <p>Finding: There are no recorded medicine administration data for the residents who self-administer medicines. The Ultimate Care Group (UCG) have developed a system of monitoring residents who self-administer medicines. As per direction from UCG head office, this is to be conducted on each shift, however this is not implemented for the three of four residents' who self-administer medicines. One of four residents who self-administer medicine conducts this when on leave from the facility and this has not occurred in the last three months.</p> <p>Action: Provide evidence the medication monitoring review system has been fully implemented for residents who self-administer medicines.</p> | Six Months |

Continuous Improvement (CI) Report

Provider Name: The Ultimate Care Group Limited

Type of Audit: Certification audit

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

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

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

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| How is achievement of this standard met or not met? | Attainment: FA |
| <p>Ten of 10 care staff (seven care givers - five hospital and two rest home covering all shifts; three registered nurses - one working all three shifts and two working morning and afternoon shifts), the facility manager/registered nurse, and the clinical services manager/registered nurse demonstrate a knowledge of the Code of Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. All care staff interviewed confirm they have received recent education on the Code as part of their regional study day. Review of education records and staff files (nine) evidences education provided in June 2013 and July 2013 via regional study days.</p> <p>Visual observations during the audit indicates staff are respectful of residents and incorporate the principals of the Code in their practice. Staff observed knocking before entering resident's bedrooms.</p> <p>Residents interviewed (four rest home and five hospital) confirm that staff respect their rights and most could recall receiving information on the Code. Family members interviewed (four hospital) confirm staff respect their family members rights.</p> <p>Resident and family satisfaction surveys completed August 2013 and collated results reviewed indicates residents and their family are satisfied with the amount of involvement in decisions affecting their care, their privacy is respected and staff treat them with dignity and respect.</p> <p>Copies of the Code observed at the entrances. All residents are provided with an information pack on admission and this includes information on the Code. Resident meeting minutes reviewed indicate a different Right from the Code is discussed at the monthly meetings.</p> <p>The ARC requirements are met.</p> | |

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.

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| 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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

The ARC requirements are met

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

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

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

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

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

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

The ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Service provider's documentation reviewed includes appropriate Māori protocols and a Māori health plan. There is currently one resident who identifies as Māori. Access to Māori support and advocacy services is available if required via a Minister / Kaumatua for the facility and via the Māori health unit from the local District Health Board (DHB) if required. Cultural support and advice is also available from three staff members one of whom provided Māori food for the one resident who identifies as Māori.

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

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education provided two yearly by the Minister / Kaumatua.

The ARC requirements are met.

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

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|------------------------------------|-----------------------|------------------------------|
| 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.

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| 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.

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| 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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Service provider's documentation provides evidence appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Policies list access details to appropriate expertise (e.g. cultural specialists, and interpreters). Residents' files sampled demonstrate that admission documentation identifies ethnicity, cultural and spiritual requirements and family/whanau contact details. All residents have a cultural assessment completed as part of the care planning process. Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. These findings supported during review of resident satisfaction survey completed in August 2013. Church services are held on site as part of the activities programme. Care staff interviewed confirm an understanding of cultural safety in relation to care, and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected. The ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

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

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|--|-----------------------|
| How is achievement of this standard met or not met? | Attainment: FA |
| <p>There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and staff codes of conduct. Policies and procedures which address any conflict of interest issues (e.g. the accepting of gifts and personal transactions with residents) reviewed. Expected staff practice is outlined in job descriptions and in staff codes of conduct reviewed on staff files. Job descriptions and employment contracts detail responsibilities and boundaries. A review of the accident/incident reporting system, complaints register and interview of the facility manager (FM) indicates there have not been allegations made against staff alleging unacceptable behaviour.</p> <p>Residents interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.</p> | |

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.

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

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.
ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

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

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| How is achievement of this standard met or not met? | Attainment: FA |
| <p>Systems are in place to ensure service providers receive a range of opportunities which promote good practice within the facility. Service provider's documentation evidences that policies and procedures are based on evidence-based rationales. Education by specialist educators is provided as part of the in-service education programme and this was confirmed during review of education records and interview of the facility manager (FM) and clinical services manager (CSM) who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. Manager advises RNs are able to attend DHB education sessions and that they have access to online learning packages from the DHB.</p> | |

The ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

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

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

The ARC requirements are met

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.10 Informed Consent

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

Residents/family are provided with various consent forms on admission for completion as appropriate. Resident files reviewed have copies of advance directives (where available) and EPOAs where EPOAs are recorded.

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

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

The ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11 Advocacy And Support

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The service has appropriate policies regarding advocacy/support services that specify advocacy processes and how to access independent advocates. Resident meetings are held monthly and provides evidence of discussion on the Code.

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

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

The ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

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

The ARC requirements are met.

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.13 Complaints Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The service has appropriate systems in place to manage the complaints processes. A complaints register is maintained at the facility there are eight complaints recorded for 2013 (verbal and written complaints). A complaints register is also maintained at The Ultimate Care Group (UCG) Head Office for complaints that are escalated up to them (not reviewed during this audit). Reporting of complaints occurs via monthly meetings and via FMs reports to the UCG Head Office. The FM reports there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

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

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

The ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.2 ORGANISATIONAL MANAGEMENT

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

STANDARD 1.2.1 Governance

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The Ultimate Care Group Limited (UCG), the governing body, has established systems in place which defines the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems. Interview of Manager Audit and Compliance from UCG Head Office confirms reporting processes and monitoring of quality and risk management goals.

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

'Business Plan 2013 - 2014' with goals and UCG organisational chart reviewed. Also reviewed a written quality and risk management plan/policy identifying the organisation's quality goals, objectives, scope of service delivery, and includes statements about quality activities and review processes. 'Ultimate Care Group Quality and Risk Management Plan 2012 - 2014' reviewed along with documented values, mission statement and philosophy, which are displayed.

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

Bishop Selwyn Lifecare is managed by a registered nurse (RN) with a current annual practising certificate who has worked in the aged-care sector for just over three years and was appointed to their current position in November 2011. The facility manager is supported by a clinical services manager who is an experienced registered nurse who was appointed to their current position in July 2007. The facility manager and clinical services manager have current annual practising certificates. The CSM is participating in the Gerontology Acceleration Programme (GAP) which is part of the strengthening the health of older persons nursing workforce initiative. This is a 12 month pilot programme run in conjunction with the University of Otago and Canterbury DHB. This programme commenced in May 2013 and is scheduled for completion in June 2014.

Review of the managers' personal files and interview of the FM and CSM indicates the managers undertake training in relevant areas. Twenty four hour RN cover is provided and the CSM, and FM in their absence, is responsible for oversight of clinical care provided to residents. There is an experienced enrolled nurse working as the team leader in the rest home area. Support for the FM is provided by the Southern Regional Operations Managers for UCG.

Bishop Selwyn Lifecare is certified to provide hospital level care and rest home level care and there are 78 beds provided (32 rest home and 46 hospital). On day one of this audit there are 33 hospital residents and 34 rest home residents. T

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

The ARC requirements are met.

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

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|------------------------------------|-----------------------|------------------------------|
| 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.

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

Corrective Action Required:

Timeframe:

STANDARD 1.2.2 Service Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There are appropriate systems in place to ensure the day-to-day operations of the service continues should the manager be absent. The CSM or another senior RN relieves the manager as required and assumes responsibility for clinical management in conjunction with other RNs from Bishop Selwyn Lifecare. An UCG Regional Operations Manager, and other personnel from UCG Head Office are also available for assistance and support as required. Twenty four hour RN cover is provided. Services provided meet the specific needs of the consumer groups within the facility. Job descriptions and interviews of the FM and CSM confirms their responsibility and authority for their roles.

The requirements of the ARC are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The Ultimate Care Group quality and risk management systems have been implemented at Bishop Selwyn Lifecare over the last 12 months. A 'Quality and Risk Management Plan for Bishop Selwyn Lifecare Hospital and Rest' reviewed and includes a vision statement, core values, quality objectives, quality indicators and quality projects. A quality manager is employed for eight hours a week to oversee the quality programme.

Family/whanau and residents surveys completed in August 2013 via UCG head office and collated results reviewed. There are documented quality and risk management systems in place, including an internal audit programme and completed internal audits for 2013 reviewed. The Ultimate Care Group (UCG) 'Quality and Risk Management Plan - 2012 - 2014' is used to guide the quality programme and includes quality goals and objectives.

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

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

Clinical indicators are recorded on various registers and forms and reviewed during this audit. There is documented evidence of collection, collation, and reporting of quality improvement data including reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in the monthly quality and staff meetings. Staff interviewed report they are kept well informed of quality and risk management issues including clinical indicators. Copies of these meeting minutes are available in nurses' stations along with graphs of clinical indicators which are attached to the meeting minutes. The manager is responsible for providing 'Weekly and Monthly Report' to the UCG Head Office and these provide evidence of reporting of clinical indicators and quality improvements - including education and internal audits. Other areas reported on include occupancy, staffing and HR, Resident Ins and Outs, Property/Environmental Issues, Financial, General Comments, Compliance/Indicator Summary.

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

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

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

The requirements of the ARC are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

This shall include, but is not limited to:

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

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| 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.

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| 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.

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

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.4 Adverse Event Reporting

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

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

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

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

ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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| 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

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| How is achievement of this standard met or not met? | Attainment: FA |
| <p>Written policies and procedures in relation to human resource management are available and reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (nine of nine) along with employment agreements, criminal vetting, completed orientations and competency assessments.</p> <p>There is evidence available indicating an in-service education programme is provided for staff including the provision of regional study days that staff attend annually as well as monthly in-service education sessions which are often provided prior to the monthly staff meetings. Individual records of education are maintained for each staff member and copies reviewed on staff files. Also viewed competency assessment, education records, and in-service education programmes.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff advise they are 'buddied' for at least three shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided i.e.: The quality improvement plan; Policies and procedures; Health and safety requirements; The physical layout of the facility; The authority and responsibility of their individual positions; The organisation's vision, values & philosophy.</p> <p>The human resource management system provides for the implementation of processes both at the commencement of employment and on-going in relation to staff education. The FM and CSM are responsible for oversight of the in-service education programme. The ACE 'Supporting the Older Person' education programme is provided and staff are supported to complete this programme. There are two RNs on site who are ACE assessors. All RNs are required to complete the ACE Dementia education modules.</p> <p>An appraisal schedule is in place and current staff appraisals sighted on all staff files reviewed. Annual practising certificates are current for all staff who require them to practice.</p> | |

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

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

ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

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

Ten of 10 clinical staff interviewed (three RNs and seven caregivers) and the CSM confirm they know how to maintain confidentiality of resident information. Historical records are held on site and accessible.

ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.1 Entry To Services

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Policy and procedures for entry to services are recorded and implemented. The service provides information to potential referral sources. This facility operates 24 hours a day, seven days per week. The admission agreement defines scope of service and includes all contractual requirements.

Eleven of 11 residents' files were sampled. All residents' admission agreements sampled evidence residents' and facility representative sign off.

The facility manager interview confirms access and entry processes are followed. There is a facility information pack available for residents and their family. Resident information pack is sighted and contains all relevant information.

Residents' files sampled demonstrate all needs assessments are completed for either rest home or hospital levels of care.

Interviews with nine of nine residents and four of four family members confirm the admission process was conducted by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.

Related ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.2 Declining Referral/Entry To Services

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

ARHSS D4.2

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

How is achievement of this standard met or not met?

Attainment: FA

Systems to decline resident entry to the service are documented. The scope of the service provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the facility manager. The facility manager states resident will be declined entry if not within the scope of the service or if a bed is not available at the time.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.3 Service Provision Requirements

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Low

In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and the service is coordinated to promote continuity of service delivery.

Ten of ten clinical staff (three RNs and seven health care assistants) and one clinical services manager /RN interviews confirm residents and/or family members are involved in all stages of service provision.

Nine of nine resident (four rest home and five hospital) interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews.

Eleven of 11 residents' files (four rest home and seven hospital) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations. Admission agreements sighted evidence resident and facility representative sign off.

Family communication sheets are maintained, sighted in all 11 residents' files reviewed. The auditor evidenced verbal briefing from morning to afternoon shift.

General practitioner (GP) interview was conducted and confirms the GP has been providing medical services for the facility for over 17 years. The interview with the GP confirms that staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff.

Staff competency assessments are current and staff competency registers record competencies for clinical staff in hand hygiene, restraint, medication, hoist, blood glucose monitoring and insulin administration, fire warden /safety, nebuliser and oxygen competencies.

Lifecare audit was conducted in March 2013 by the Ultimate Care Group compliance team and corrective actions are addressed.

Assessment and lifestyle plan audit was conducted in March 2013 and corrective actions are addressed.

Total clinical record audit of 10 residents files was conducted in June 2013 with corrective actions addressed.

There is one area requiring improvement around long term care plans to be developed within the three week timeframe post admission to the facility.

Related ARC requirements are not fully met.

Tracer Methodology Hospital.

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

Tracer Methodology Rest Home.

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: PA

Risk level for PA/UA: Low

One long term care plan is not conducted within three weeks of admission to the facility. There is recorded evidence of this long term care plan completion to be at two months post admission to the facility.

Finding Statement

One long term care plan has not been recorded within three weeks of admission to the facility. This care plan was recorded two months post admission to the facility.

Corrective Action Required:

Provide evidence resident's long term care plan is developed within three weeks of resident's admission to the facility.

Timeframe:

Six months

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.4 Assessment

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Residents' needs, outcomes and goals are identified via the assessment process and are recorded. The organisation has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. Policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.

Residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider (NASC) assessments are available. The facility has appropriate resources and equipment. The RN interviews confirm that assessments are conducted in a safe and appropriate setting including visits from the doctor.

Nine of nine residents interviewed confirm their involvement in their assessments; care planning, review, treatment and evaluations of care.

Resident files evidence risk assessments are conducted on admission and reviewed along with the resident long term care plan at three monthly intervals or when resident's condition alters.

Related ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.5 Planning

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The residents' files sampled evidence residents' care plans are individualised and up-to-date. The long-term and short-term goals are identified by the residents and service providers and reviewed at regular intervals, at least three monthly or as needs change. Residents have input into their care planning and review, confirmed at all nine resident interviews.

Ten of ten clinical staff and one clinical services manager / RN interviewed confirm that care plans are accurate and up to date.

Residents' files sampled evidence the clinical care/treatment/support or interventions that is to be provided by the staff is current, the risk assessment findings are recorded on the care plans and there is evidence of discussions and sign off by residents and family members.
 The facility ensures access to regular GP care, confirmed at GP interview.
 Related ARC requirements are met.

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

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

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

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| 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

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.
Residents' files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement.
Nine of nine residents and four of four family interviewed confirm their and their relatives current care and treatments they are receiving meet their needs. Family communication sheets record family communications, sighted in all residents' files sampled.
Related ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.7 Planned Activities

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Interviews with diversional therapist (DT) and diversional therapist assistant (DTA) confirm the activities programme meets the needs of the service group and the service has appropriate equipment. There is one diversional therapist and two diversional therapy assistants employed at the facility. The DT is employed at 40 hours a week. The DTA's are employed part time. There are three activities programmes; one for the rest home, one for hospital and one for the villa

residents. Sighted rest home and hospital activities programmes, which are provided from Monday to Friday. Activities attendance records are maintained and were sighted.

Residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.

Residents' meetings are held separately for the rest home and the hospital residents and minutes of meetings were sighted for May, July and August 2013.

Residents' files sampled demonstrate the individual activities care plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being.

Activities programme audit was conducted in April 2013 with 100% compliance. Activities documentation audit was conducted in July 2013 with corrective actions addressed. Transport and outings audit was conducted in July 2013 with 100% compliance.

Nine of nine residents and four of four family interviewed confirm residents' and their family members' past activities are considered and there is a choice to participate in activities.

Related ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes.

Evaluations are conducted by the RN with input from the resident, family, health care assistants, diversional therapist and GPs.

Family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews.

Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. Residents' files evidence referral letters to specialists and other health professional. Multidisciplinary reviews are current. Related 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.

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| 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.

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| 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

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| How is achievement of this standard met or not met? | Attainment: FA |
| <p>Service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services.</p> <p>Residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. Residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented. Related ARC requirements are met.</p> | |

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.

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

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

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

ARC D21 ARHSS D21

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

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| How is achievement of this standard met or not met? | Attainment: FA |
| <p>Resident's files evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files.</p> <p>Related ARC requirement is met.</p> | |

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

There are two medication areas in the facility (one in rest home and one in hospital) and both areas evidence an appropriate and secure medicine system, free from heat, moisture and light, with medicines stored in original dispensed packs.

There are two controlled drug storage areas in the facility and these are secure. The controlled drug registers are maintained and evidence weekly quantity stock account checks. Interview with the pharmacy staff member was conducted and confirms the weekly quantity stock account checks replace the six monthly stocktakes. There is one medication fridge at the facility and the medication fridge temperature checks are conducted and recorded.

Residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given).

Medication round was observed and evidences staff are knowledgeable about the medicine administered and sign off, as the dose is administered.

There are 19 staff competent to administer medicines (nine RNs, one EN and nine care givers). Care givers administer medicines in the rest home and studio units only. All staff authorised to administer medicines have current competencies, sighted in the staff files sampled and on the staff competency register. Additional staff competencies are conducted and these include; insulin administration; oxygen administration; nebuliser use, sighted on competency registers.

Medication errors are recorded separately for rest home and hospital and indicate details of; wrong resident; wrong drug; wrong dose; wrong time; wrong route and wrong records. Medication error incident records from January to August 2013 were sighted and evidence there was one reported medication error in June in the rest home. Medication errors for hospital evidence two medication errors in February 2013; one in May 2013; one in June 2013 and two in August 2013. Quality manager interview confirms medication competency reassessment is conducted following a medication error, evidence of this was sighted.

Staff education in medicine management was conducted in July 2012 by the pharmacy staff member, attended by 16 staff.

Twenty medicine charts were sampled (10 rest home and 10 hospital). All 20 medication charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated

and signed by the GPs. Residents' photo ID's are checked three monthly for resident's likeness in the photo ID. Standing orders are current. Staff and GP signature logs are completed.

There are three rest home residents at the facility who self-administer medicines and one hospital resident who self-administers medicines when on leave from the facility. There is recorded evidence of residents' competency assessments to self-administer medicines and safe storage of medicines. Interviews with four of four residents who self-administer medicines were conducted and evidence the residents are competent and aware of the responsibilities with self-administration of medicines. There are no recorded medicine administration data for the residents who self-administer medicines.

Sighted medication audit result for February 2013 with the corrective actions addressed.

Medication audit was conducted by the pharmacy practice manager in February 2013 with 100% compliance.

Audit of medication charts was conducted in May 2013 with corrective actions addressed and audit in August 2013 with 100% compliance.

There is one area requiring improvement around medication monitoring review system to be fully implemented for residents who self-administer medicines.

Related 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.

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: PA

Risk level for PA/UA: Low

There are three rest home residents at the facility who self-administer medicines and one hospital resident who self-administers medicines when on leave from the facility. There is recorded evidence of residents' competency assessments to self-administer medicines and safe storage of medicines. There are no recorded medicine administration data for the residents who self-administer medicines. The Ultimate Care Group (UCG) has developed a system of monitoring residents who self-administer medicines. This is to be conducted on each shift, however this is not implemented for the three residents' who self-administer medicines. Sighted was an email from the Project Manager of the UCG (dated 20th September 2013) requesting for the medication monitoring review to be conducted on each shift.

Finding Statement

There are no recorded medicine administration data for the residents who self-administer medicines. The Ultimate Care Group (UCG) have developed a system of monitoring residents who self-administer medicines. As per direction from UCG head office, this is to be conducted on each shift, however this is not implemented for the three of four residents' who self-administer medicines. One of four residents who self-administer medicine conducts this when on leave from the facility and this has not occurred in the last three months.

Corrective Action Required:

Provide evidence the medication monitoring review system has been fully implemented for residents who self-administer medicines.

Timeframe:

Six Months

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

Food service policies and procedures are appropriate to the service setting with a new seasonal menu being introduced six monthly. The winter menu was last reviewed by a dietitian in April 2013 and the summer menu was last reviewed August 2013. The kitchen manager is aware of residents who have been identified with weight loss and the resident's individual dietary needs, confirmed at interview. Residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review. There are current copies of residents' dietary profiles in the kitchen. Kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the kitchen manager. Food safety training for kitchen staff have been conducted in March 2013. Residents' files sampled demonstrate monthly monitoring of individual resident's weight. Resident's nutritional needs and interventions are identified and documented on the care plans. Residents interviewed were satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided. Food temperatures are recorded, sighted. Fridge, chiller and freezer temperatures are recorded, sighted. All decanted food is dated. Food services audit was conducted in April 2013 and corrective actions were addressed. Audit of infection control cleanliness of kitchen was conducted in February and May 2013, with corrective actions addressed. Sighted external contractor pest control checks in March 2013. Management of nutritional status audit was conducted in September 2013 with corrective actions addressed. Related ARC requirements are met.

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

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| 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.

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| Audit Evidence | Attainment: FA | Risk level for PA/UA: |
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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 MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facility and are accessible for staff. Hazard Register sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and chemical safety last provided 28 August 2013. Monthly visits by Ecolab who reviews kitchen, cleaning and laundry processes and cleaning. Copies of these reports reviewed during this audit.

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

ARC requirements are met

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

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

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

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

STANDARD 1.4.2 Facility Specifications

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Two maintenance persons are employed for 80 hours a week and one of them is interviewed during this audit. Maintenance person interviewed confirms there is a maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and reviewed during this audit along with current calibration / performance verified stickers in place on medical equipment. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 30 June 2014.

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

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

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

ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

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

ARC E3.3d ARHSS D15.3c

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

How is achievement of this standard met or not met?

Attainment: FA

Bedrooms provide single accommodation and have wash hand basins. Several of the bedrooms have their own ensuite and there is an adequate number of communal toilet and shower facilities.

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

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

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

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| 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

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| How is achievement of this standard met or not met? | Attainment: FA |
| Visual inspection evidences that adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. Twenty nine of the hospital bedrooms have double leaf doors and all hospital rooms allow for easy access for mobility aids. | |

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

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

ARC E3.4b ARHSS D15.3d

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

How is achievement of this standard met or not met?

Attainment: FA

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

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.6 Cleaning And Laundry Services

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

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

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

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| How is achievement of this standard met or not met? | Attainment: FA |
| <p>Cleaning policy and procedures, and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons.</p> <p>All linen is washed on site in the laundry and although the laundry is on the small side, there is adequate dirty / clean flow. Laundry person interviewed and describes management of laundry including transportation, sorting, storage, laundering, and return to residents.</p> <p>Visual Inspection evidences the implementation of cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning reviewed, along with monthly Ecolab reports.</p> <p>Visual inspection of the facility evidences: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste - i.e. sluice room/facilities in both areas; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.</p> <p>Residents and family interviewed state they are generally satisfied with the cleaning and laundry service and this finding confirmed during review of satisfaction surveys completed August 2013.</p> <p>ARC requirements are met.</p> | |

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

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

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

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| Audit Evidence | Attainment: FA | Risk level for PA/UA: |
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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 D15.3j; D19.6

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

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

Letter from New Zealand Fire Service reviewed dated 25 November 1993 advising approval of fire evacuation scheme. The last trial evacuation was held on 24 July 2013.

All registered nurses, diversional therapist, some of the care givers, and maintenance person are required to complete first aid training. There is at least one designated staff members trained on each shift with appropriate first aid training.

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

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

The FM advises a Capex request has been made to upgrade the call bell system as there are two systems in the facility (rest home and hospital) that are not linked. The call bell system in place is used by the resident or service provider to summon assistance if required and is appropriate to the resident group and setting, e.g. call bell system. Call bells are accessible / within reach, and are available in resident areas, e.g. bedrooms, ablution areas, ensuite toilet/showers, dayrooms, dining rooms. Residents interviewed confirm they have a call bell system in place which is accessible and staff generally respond to it in a timely manner. .

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.

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| 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.

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| 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.

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| 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.

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| 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.

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| 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 Ma V CQ SQ STQ Ma L

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| How is achievement of this standard met or not met? | Attainment: FA |
| There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area. Residents interviewed confirm the facilities are maintained at an appropriate temperature. | |

ARC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

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| <p>How is achievement of this standard met or not met?</p> | <p>Attainment: FA</p> |
| <p>Documented systems are in place to ensure the use of restraint is actively minimised and the use of least restrictive practices are encouraged where required. Restraint Minimisation and Safe Practice (RMSP) policy definitions of enablers and restraint align with the NZS 8134.2 Standard.</p> <p>The service has an overarching risk and quality management system that demonstrates compliance with the Standard. The process of assessment and evaluation of enabler use is documented in policies and procedures to guide staff.</p> <p>The role of the “Restraint Coordinator” is delegated to the facility manager. Sighted position description of the restraint coordinator.</p> <p>There are no residents using restraint and one resident using an enabler (bedrails).</p> <p>Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques.</p> <p>Staff education programme on RMSP /Enabler training and challenging behaviour was conducted in the compulsory study days in June and July 2013, confirmed at staff interview and evidenced in staff files sampled.</p> <p>Management of challenging behaviour audit was conducted in March 2013 and corrective actions have been addressed and in September 2013 with 100% compliance.</p> <p>Restraint audit was conducted in May 2013 and indicates no restraint used at the facility.</p> <p>Staff competency register records restraint competencies for all clinical staff are current.</p> <p>Restraint register evidences one restraint was used and commenced in March 2012 and stopped in June 2012. No other restraints have been used since then. Enabler register evidences one enabler is currently used at the facility. The resident's file was sampled and evidences enabler assessment is conducted, consent obtained, enabler care plan is documented and monitoring is conducted. Restraint and enabler use is discussed at facility meetings. Restraint is discussed at quality meeting, monthly, sighted meeting minutes from meetings in July and August 2013.</p> | |

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.

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

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The infection control (IC) policy meets the needs of the organisation and provides information and resources to inform the service providers on infection prevention and control, confirmed at staff interviews.

The delegation of infection control matters throughout the organization is clearly documented along with an IC nurse job description, sighted. The IC nurse is the clinical services manager /RN. There is documented evidence the governing body receives regular reports on infection related issues by regular reporting systems.

The IC programme is reviewed annually by the Ultimate Care Group head office staff.

Related ARC requirement is met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

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

ARC D5.4e ARHSS D5.4e

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

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

The infection control programme meets the needs of the organisation and provides information and resources to inform and guide staff.

The IC nurse is the clinical services manager/ RN, who has been in this position for five years. The IC nurse has access to relevant and current information, which is appropriate to the size and complexity of the organization, including but not limited to; IC manuals, internet, access to experts (DHB and Lab), and on-going in-service education. The IC nurse is a member of the Infection Prevention and Control Nurses College and confirms at interview that regular IC updates are received and attendance at meetings occurs.

Related 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.

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

STANDARD 3.3 Policies and procedures

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

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

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

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| How is achievement of this standard met or not met? | Attainment: FA |
| Policies and procedures on the prevention and control of infection include written material that is relevant to the organisation and reflects current accepted good practice and relevant legislative requirements. Policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interview. IC policies and procedures identify links to other documentation in the organisation e.g. health & safety, quality and risk. Related ARC requirement is 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.

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| Audit Evidence | Attainment: FA | Risk level for PA/UA: |
| Finding Statement | | |
| Corrective Action Required: | | |

Timeframe:

STANDARD 3.4 Education

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

Service provider's documentation evidences that infection control education is provided to all staff, as part of their initial orientation and is provided as part of the on-going in-service education programme.

Staff interviewed advise that clinical staff identify situations where IC education is required for a resident such as; hand hygiene, cough etiquette, multi-resistant micro-organisms and education is conducted.

IC nurse has conducted "Bug Control" training in 2011 (7 hours) and CPIT post grad paper in IC (50 hours) in 2010.

Staff education was provided in June 2013 by a microbiologist as part of the compulsory training / education day.

IC nurse specialist conducted an education session in 2012. All education sessions have evidence of staff attendance and content of the presentations. Related ARC requirement is met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.5 Surveillance

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

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

How is achievement of this standard met or not met?

Attainment: FA

The IC programme / policy details surveillance processes, including the surveillance objectives, priorities and methods at a level of detail relevant to the service setting and its complexity. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes.

Infection control monthly data is completed for each resident and includes type of infection, lab results, sensitivities, antibiotics prescribed, dose, duration, intervention, review and outcome. Infection logs are maintained.

Numbers of infections are collated at the end of each month and reported as a clinical indicator to management and to staff at meetings. Care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, and daily handovers.

Hand hygiene techniques/ equipment review audit was conducted in January and April 2013 with 100% compliance.

Audit of compliance with antimicrobial usage policy was conducted in April 2013 with 100% compliance.

Norovirus outbreak occurred in June 2012 and documentation evidences notification of the outbreak to the Public Health Service at DHB. Summary of the outbreak data was sighted. As a result of the outbreak an improvement was made by developing mobile outbreak management trolleys, which are ready for use with the required equipment when outbreak occurs.

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: