Glenbrook Rest Home

Certification audit, Audit Report

Audit Date: 28-Jun-11

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Glenbrook Rest Home

Premise Name	**Street Address**	**Suburb**	**City**
Glenbrook Rest Hone	131 Wymer Road		Waiuku

Proposed changes of current services (*e.g. reconfiguration*)**:**

Type of Audit	Certification audit and (*if applicable*)	
Date(s) of Audit	**Start Date:** 28-Jun-11	**End Date:** 28-Jun-11
Designated Auditing Agency	Verification New Zealand Limited	

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	Linda Edge	NZRN Comp, BHSc Nsg, post grad dip advanced nsg, RABQSA Lead Auditor	8.00	8.00	28-Jun-11
Auditor 1	Jan Bennett	NZRN, Auditor	8.00	4.00	28-Jun-11
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	Dorothy Kennard				

Total Audit Hours on site	16.00	**Total Audit Hours off site** *(system generated)*	12.00	**Total Audit Hours**	28.00

Staff Records Reviewed	4 of 14	**Client Records Reviewed** *(numeric)*	5 of 18	**Number of Client Records Reviewed using Tracer Methodology**	1 of 5
Staff Interviewed	8 of 14	**Management Interviewed** *(numeric)*	2 of 2	**Relatives Interviewed** *(numeric)*	3
Consumers Interviewed	4 of 18	**Number of Medication Records Reviewed**	10 of 18	**GP's Interviewed (aged residential care and residential disability)** *(numeric)*	1

Declaration

I, (full name of agent or employee of the company) Linda Edge (occupation) registered nurse and lead auditor of (place) Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofVerification New Zealand Limited, an auditing agency designated under section 32 of the Act.*

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

Dated this 10th day of July 2011

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

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

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

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

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

Services and Capacity

				Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
Premise Name	**Total Number of Beds**	**Number of Beds Occupied on Day of Audit ****	**Number of Swing Beds for Aged Residential Care**	Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Glenbrook Rest Hone	19	18	0	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐

** For DHB audits: Day of audit is to be day one (1).

Executive Summary of Audit

General Overview

Glenbrook Rest Home is situated in a rural setting south of Auckland. The rest home is owned and run by a couple, one of whom is a registered nurse with extensive experience in aged residential care. The facility is homely with pleasant, well maintained mature grounds and safe outdoor areas. There are pigs and chickens onsite and residents enjoy the company of a dog and cat. Staffing is relatively stable. There is an education plan implemented to ensure staff are kept up to date with current knowledge related to their practice.

Staff demonstrate a good rapport with residents and each other. Residents and relatives express the atmosphere is nurturing and family-like. They express their satisfaction with all aspects of the service.

1.1 Consumer Rights

Both residents and families confirm they are very happy with the services provided and that their rights are respected at all times. A chaplain is engaged to provide spiritual and advocacy care to residents and staff. Education is provided to both staff and residents on consumer rights. A code of conduct for staff is included in their orientation. Policies and procedures are in place and Sharon the registered nurse owner manager oversees the clinical care. There are systems in place that ensure that resident's physical and personal privacy is maintained in both the eleven single and the four shared bedrooms, and shared bathroom amenities. There are appropriate guidelines relating to visitors, and the code of rights includes visitor access. Sufficient space to ensure privacy for discussions is provided. There is a documented complaints process in place which is provided at the time of admission to residents . There have been no complaints in the last three and a half years.

1.2 Organisational Management

The organisation is managed by husband and wife owners, Sharon the full-time registered nurse oversees all clinical care, while Peter provides day to day operational oversight. The philosophy of the organisation is " we make our home your home" The objectives of the organisation are documented and provided to residents at the time of admission. Strategic and business planning includes risk management and is completed and reviewed annually. An internal audit programme that includes satisfaction surveys, risk reporting and quality data is feed into the staff meeting and any areas of deficit addressed. Clinical policies and procedures are in place. Human resources processes are documented and well managed with a low staff turnover. A comprehensive orientation and education programme is in place with most staff currently completing ACE education programme modules. All staff have a current first aid certificate. The staff roster meets rest home contractual requirements.

1.3 Continuum of Service Delivery

Residents are assessed as requiring rest home level care prior to entry. There is accurate and detailed information about the service on line. Prospective residents and families are encouraged to visit prior to entry to meet staff and view the facility. On admission residents undergo a comprehensive assessment by the registered nurse. The general practitioner assesses residents within 48 hours of admission. Residents and family members are encouraged to express their preferences and to identify their own goals. These are used as the basis for developing a plan of care.

Clinical files reviewed during the audit show that care is tailored to the needs and preferences of residents. Care plans are reviewed on an ongoing basis and formally at six monthly intervals. Residents and families are invited to participate in care plan reviews. The general practitioner reviews residents three monthly if they are stable or more often if required. This includes review of medications. When the needs of residents change or progress is less than expected, residents are reassessed by the registered nurse who communicates with the general practitioner when needed. Families are kept informed. Care plans are updated to reflect the current needs of residents.

There is an activities programme in place that enhances physical, mental, social and spiritual well being. Residents are asked about their personal interests and hobbies and these are used to plan activities. Residents are encouraged to give feedback about the activities programme. Residents are able to access the services of other health care providers. This is facilitated by staff at Glenbrook. When residents transfer to another facility, this is a planned process and any risks to the resident are managed safely.

Medication management is safe and complies with legal requirements. Allergies and sensitivities are recorded and flagged on medication charts. Staff are required to demonstrate competency before being able to administer medications. this is reassessed at least annually. Residents are able to take herbal and nutritional supplements if the general practitioner has determined there would be no interaction with regular medications.

A summer/winter dietitian approved menu is in place. Resident personal food preferences and needs are met. Residents are weighed regularly and recorded in the clinical files. Food training is provided.

1.4 Safe and Appropriate Environment

There are policies and procedures implemented for the management of waste and hazardous substances. Chemicals are stored in a locked room. Appropriate personal protective equipment is used.

Glenbrook is a nineteen bed rest home that has both single and shared room accommodation. A planned maintenance programme is in place. Medical equipment calibrated annually. There is a current building warrant of fitness and an approved evacuation plan in place. As a result of an ongoing refurbishment programme fourteen of the fifteen bedrooms now have hand basins in them. Adequate toilets and showers are provided within the communal facilities. Outdoor areas are provided for residents for seating and shade, with the provision of a designated smoking area.

2 Restraint Minimisation and Safe Practice

There are policies and procedures fully implemented that avoid the use of restraint and ensure safe practice. Staff receive training in the policies and procedures during orientation and at regular intervals. Where residents ask for a type of restraint to assist them or keep them safe this is provided within a safe and transparent process. Currently there is no use of restraint at Glenbrook Rest Home.

3. Infection Prevention and Control

Policies and procedures for the prevention and control of infection are in place. The registered nurse is responsible for all aspects of infection control in conjunction with all staff. External expertise is available if required. Staff receive training on infection control practice during orientation and at regular intervals. Training is based on current issues and best practice in infection control matters. Data is collected on all infections. This is collated at monthly intervals and reported to the owners and to staff. The results show that there are relatively low rates of infection and infections are well managed and controlled.

Summary of Attainment

1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	Met	0	1	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	Met	0	4	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect	Met	0	7	0	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs	Met	0	6	0	0	1	7
Standard 1.1.5	Recognition of Pacific values and beliefs	Not Applicable	0	0	0	0	2	2
Standard 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	Met	0	2	0	0	0	2
Standard 1.1.7	Discrimination	Met	0	2	0	0	3	5
Standard 1.1.8	Good practice	Met	0	1	0	0	0	1
Standard 1.1.9	Communication	Met	0	3	1	0	0	4
Standard 1.1.10	Informed consent	Met	0	6	1	0	2	9
Standard 1.1.11	Advocacy and support	Met	0	3	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	Met	0	2	0	0	0	2
Standard 1.1.13	Complaints management	Met	0	3	0	0	0	3

Consumer Rights Standards (of 13):		Met:12	Not Met:0	N/A: 1	
Criteria (of 50):	CI:0	FA:40	PA:2	UA:0	NA: 8

1.2 Organisational Management

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

Organisational Management Standards (of 9):		Met:7	Not Met:0	N/A: 2	
Criteria (of 42):	CI:0	FA:33	PA:0	UA:0	NA: 9

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	Met	0	4	0	0	1	5
Standard 1.3.2	Declining referral/entry to services	Met	0	2	0	0	0	2
Standard 1.3.3	Service provision requirements	Met	0	4	0	0	2	6
Standard 1.3.4	Assessment	Met	0	4	0	0	1	5
Standard 1.3.5	Planning	Met	0	4	0	0	1	5
Standard 1.3.6	Service delivery / interventions	Met	0	3	0	0	2	5
Standard 1.3.7	Planned activities	Met	0	3	0	0	0	3
Standard 1.3.8	Evaluation	Met	0	3	0	0	1	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	Met	0	2	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	Met	0	2	0	0	0	2
Standard 1.3.11	Use of electroconvulsive therapy (ECT)	Not Applicable	0	0	0	0	4	4
Standard 1.3.12	Medicine management	Met	0	6	0	0	1	7
Standard 1.3.13	Nutrition, safe food, and fluid management	Met	0	5	0	0	0	5

Continuum of Service Delivery Standards (of 13):		Met:12	Not Met:0	N/A: 1	
Criteria (of 55):	CI:0	FA:42	PA:0	UA:0	NA: 13

1.4 Safe and Appropriate Environment

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

Safe and Appropriate Environment Standards (of 8):	Met:8	Not Met:0	N/A: 0		
Criteria (of 36):	CI:0	FA:36	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	Met	0	6	0	0	0	6
Standard 2.2.1	Restraint approval and processes	Not Applicable	0	0	0	0	3	3
Standard 2.2.2	Assessment	Not Applicable	0	0	0	0	2	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	6	6
Standard 2.2.4	Evaluation	Not Applicable	0	0	0	0	3	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	1	1
Standard 2.3.1	Safe seclusion use	Not Applicable	0	0	0	0	5	5
Standard 2.3.2	Approved seclusion rooms	Not Applicable	0	0	0	0	4	4

Restraint Minimisation and Safe Practice Standards (of 8):	Met:1	Not Met:0	N/A: 7	
Criteria (of 30):	CI:0	FA:6	PA:0	UA:0	NA: 24

3 Infection Prevention and Control

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

Infection Prevention and Control Standards (of 6): Met:5 Not Met:0 N/A: 1

Criteria (of 34): CI:0 FA:29 PA:0 UA:0 NA: 5

Total Standards (of 57) **Met:** 45 **Not Met:** 0 **N/A:** 12

Total Criteria (of 247) **CI:** 0 **FA:** 186 **PA:** 2 **UA:** 0 **N/A:** 59

Corrective Action Requests (CAR) Report

Provider Name: Glenbrook Rest Home
Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:28-Jun-11 End Date: 28-Jun-11
DAA: Verification New Zealand Limited
Lead Auditor: Linda Edge

Std	Criteria	Rating	Evidence	Timeframe
1.1.9	1.1.9.1	PA Low	**Finding:** The resident and family are not informed of costs prior to entry to the facility. **Action:** Residents and families be informed of costs prior to entry to the facility.	6 months
1.1.10	1.1.10.3	PA Low	**Finding:** Four of five admission agreements viewed were not signed by the resident or (family) EPOA on the day of admission. **Action:** All admission agreements be signed by both the organisation and resident or (family) EPOA on the day of admission.	6 months

Continuous Improvement (CI) Report

Provider Name:	Glenbrook Rest Home
Type of Audit:	Certification audit
Date(s) of Audit Report:	Start Date:28-Jun-11 End Date: 28-Jun-11
DAA:	Verification New Zealand Limited
Lead Auditor:	Linda Edge

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

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

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

Residents receive care in line with the Health and Disability Code of Rights.

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

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

There is a resident rights policy in place that complies with the Code. The staff induction/orientation policy includes the words " It is a requirement of this organisation that all staff have knowledge of legislation which affects the wellbeing of residents in our care. This covers: Resident Code of Rights, Privacy Code, Complaints Procedure, advocacy service and emergency protocols." The June 2010 staff meeting minutes evidenced that at that meeting staff received training on confidentiality, privacy and informed consent.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.

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

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

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

Consumer rights and information is provided to residents on admission and also displayed in the upstairs lounge. Documented resident's rights and responsibilities are provided at the time of admission. Advocacy information is displayed and information available.

Criterion 1.1.2.1 The Code of Health and Disability Services Consumers' Rights is clearly displayed and easily accessible to all consumers.

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

A copy of the code of health and disability services consumers' rights is displayed inside the front entrance and in the upstairs lounge. A copy of the code of health and disability services pamphlet is given to residents at time of admission

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.2.2 Information about the Code and other rights is provided at the earliest opportunity in languages and formats suited to the needs of consumers who use the service.

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

Written information regarding the code, and other rights is provided at the time of admission. The code is available and copies are displayed throughout the facility. Copies of the code are also available in Maori and in large print. Documented resident's rights and responsibilities are given at the time of admission.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

At the time of admission the registered nurse manager sits with the resident and family and discusses the code. A copy of the Health and Disability code of rights is given to the residents at this time.

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:**

A laminated poster about the Nationwide Health and Disability Advocacy Service is displayed with information is available in the upstairs lounge.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

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

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

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

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

Residents and family members express that resident's privacy and independence is respected, and they are always treated with respect and dignity, and staff are responsive to their needs.

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:**

There are eleven single and four double bedrooms. In the double bedrooms curtains separate each resident's individual space and ensure privacy. All residents have their own bedside locker, wardrobe and shelving for placement of their personal possessions. On the day of the audit it was noticed that resident bedroom doors were closed to ensure privacy and staff were observed to knock prior to entering bedrooms. There are two separate lounges available for residents use. Toilets and showers had engaged / vacant privacy signs.

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:**

Residents and relative interviews confirm that services are provided that are responsive to their needs, values and cultural beliefs. There is a cultural safety and an advocacy policy in place. A regular inter - denominational church service is held in the upstairs lounge each month for residents.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.3 Consumers shall be addressed in a respectful manner by their preferred name.

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

On admission the preferred name that residents wish to be called by is identified and is documented in their clinical file and identified on the label outside each resident's bedroom door.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.4 Consumers have access to spiritual care of their choice.

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

Spiritual care of choice is identified at the time of admission and information is included in the 'Welcome to Glenbrook' booklet that residents receive as part of the admission process. A chaplain visits regularly and planned church services are held in the upstairs lounge. One resident plays the organ for the church services. A spirituality policy is in place.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.5 Consumers' intimacy and sexuality are supported in a manner that ensures the rights of the individual are protected and intervention only occurs to maintain balance between the personal rights and/or well-being of the consumer and those of others.

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

A sexuality policy is in place. Sharon the registered nurse owner manager stated she is booked in to attend a training session on sexuality in the elderly on 29 June 2011.

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:**

There are polices in place to guide staff to ensure that a residents independence is maximised and reflects their wishes. Advanced directive education provided June 2008, five staff attended.

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:**

There is an abuse policy in place. The staff house rules include under care of residents that 'any abuse of residents will result in instant dismissal if proven'. In July 2009 elder abuse and neglect education was provided, eight staff attended.

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:** Met

Maori values and beliefs are incorporated into policy, education and guidelines in a way that respects and acknowledges the individual and cultural beliefs of those who identify as Maori.

Criterion 1.1.4.1 Māori consumers receive services consistent with their cultural values and beliefs.

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

Cultural safety policy in place which includes guidelines for the provision of culturally safe services for Maori residents. The residents rights policy and the privacy policy have been written in both English and Maori.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

There is a cultural safety policy in place which includes a procedure to support cultural responsiveness for Maori residents. The resident rights policy and the privacy policy have both been written in English and Maori.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The cultural safety policy includes guidelines for provision of care in line with cultural safety and the Treaty of Waitangi expectations.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.4 Māori consumers' right to practise their cultural values and beliefs while receiving services is acknowledged and facilitated by service providers.

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

The cultural safety policy recognises Maori consumers' rights and includes guidelines to ensure that services are culturally sensitive, and that Maori protocols, values and beliefs are recognised and that services delivered are seen to be appropriate by Maori residents and their whanau.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The cultural safety policy includes the importance of whanau and their involvement and gives examples of how this may occur during service delivery. An example given is being flexible with visiting times and visitor numbers. Cultural awareness is signed off as part of the orientation check list for all new employees. Culturally safe care education was provided for all staff in September 2009 at the staff meeting.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.6 Tangata whenua are consulted in order to meet the needs of Māori consumers.

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

The cultural safety policy includes the importance of consultation and the need for Maori consumers to maintain community links .

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

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

Cultural values and beliefs are documented at the time of admission and access is facilitated when required. There are policies in place to support residents receiving culturally safe services.

Criterion 1.1.6.1 Consumers receive services in a manner that takes into account their cultural and individual values and beliefs.

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

There are cultural safety policies implemented that ensure the organisation delivers services in a culturally appropriate manner. Cultural awareness is signed off as part of the orientation check list for all new employees. Residents cultural needs are identified on their clinical file. The staff code of conduct outlines key service delivery principles to ensure that the right of a resident to be an individual is maintained. Culturally safe education was provided in September 2009 at the staff meeting.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

The cultural safety policy includes the importance of responding to the needs of the consumer and their family and includes guidelines on how this may occur. Five of five clinical files viewed showed that residents are consulted on their individual values and beliefs which is then incorporated into their plan of care

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

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

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

There are policies and procedures in place to protect residents from discrimination, harassment and exploitation.

Criterion 1.1.7.1 Services have policies and procedures to ensure consumers are not subjected to discrimination, coercion, harassment, and sexual or other exploitation.

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

There is a sexual harassment policy in place, and the admission agreement contains information relating to naming of property and finance. Complaints information is provided at the time of admission and residents' rights and responsibilities are documented. A code of conduct is included in the staff handbook. Individualised pocket money accounts are maintained for each resident with computer generated printouts able to provided to the resident/family at any time.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

A code of conduct is included in the staff handbook which requires staff to maintain professional boundaries. There have been no complaints of breach of this.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

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

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

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

Policies, procedures and treatment guidelines are in place. Comprehensive education programme and networking opportunities are provided. Delivery of services of an appropriate standard are evident. Three of three residents and families interviewed confirm they are very satisfied with the standard of services and care they receive.

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:**

Policies and procedures are in place and are monitored and evaluated through the quality review process. Treatment protocols and guidelines are in place. Staff confirm they have access to reference material, resources, Internet and education opportunities. Networking opportunities are available through Health Care provider membership . The aged care education training programme (ACE) and aged care dementia education training programme is available with a number of staff having completed ACE training modules.

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:** Met

Relatives and relatives confirm they are kept informed and that staff and management take the time to talk. Private spaces are available for private communication to take place. Interpreter services are arranged if required.

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

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

Relatives interviewed confirm they are notified as soon as possible of any change to the residents condition. One resident re-called the admission agreement. There is an open disclosure policy in place and residents' rights and responsibilities are documented. Five of five signed resident admission agreements were viewed in the files. Open disclosure education was provided in September 2009, five staff attended.

Finding Statement

The resident and family are not informed of costs prior to entry to the facility.

Corrective Action Required:
Residents and families be informed of costs prior to entry to the facility.

Timeframe:
6 months

Criterion 1.1.9.2 Service providers allow sufficient time and an appropriate space for discussions to take place.

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

Relatives and residents confirm there is sufficient time for discussions. Lounges or the manager’s office are available for private discussions for residents who are in shared rooms.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.9.3 Consumers are assisted to identify service providers involved in their care.

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

Service provides were viewed to be wearing name badges and uniforms to identify themselves. Inside the front entrance named photographs of all the staff are displayed on the corridor wall for relatives and residents to see. There is a low staff turnover which enable residents to get to know the staff. Residents interviewed confirm knowing the carers.

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:**

Interpreter services policy in place. Access to interpreter services is included in the 'Welcome to Glenbrook Rest Home' booklet that is given to residents on admission. On the day of the audit English was the first language of all rest home residents.

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:** Met

Appropriate policies and procedures are in place relating to informed consent and signed consent forms were viewed. Medical care plans are in place which include a resident resuscitation status. Residents and families confirm involvement in care planning and decision making. Staff education provided for informed consent.

Criterion 1.1.10.1 Informed consent policies/procedures identify:

(a) Recording requirements;

(b) Information (including documentation) to be provided to the consumer by the service;

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

There are informed consent policies in place that include recording requirements and information that is provided to the resident. Informed consent information is discussed with the resident on admission. Resident consents obtained include routine care delivery and sharing clinical information in specialist referral situations, medical care and information, collection of health information, resuscitation status and influenza vaccination. One staff member attended a four hour health information - privacy code workshop in August 2008, June 2010 staff meeting minutes viewed show that education was provided on informed consent, privacy and confidentiality. Staff feedback was that this education was very helpful.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

Admission information includes financial and consent information, the use of interpreters and advocates if required. An admission agreement is completed for all residents and held on the clinical file. Residents interviewed confirm their involvement in their care planning. Training on open disclosure was provided on September 2009, seven staff attended.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.3 Information is made available to consumers in an appropriate format and in a timely manner.

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

Information is made available to consumers at the time of admission, this was confirmed by management and residents

Finding Statement

Four of five admission agreements viewed were not signed by the resident or (family) EPOA on the day of admission.

Corrective Action Required:
All admission agreements be signed by both the organisation and resident or (family) EPOA on the day of admission.

Timeframe:
6 months

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:**

Consents were viewed and included to display photographs, routine care delivery, collection of health information, access to and sharing clinical information in specialist referral situations, medical care which included not for resuscitation and influenza vaccination. Residents rights, consents audit completed March 2011 as per the annual schedule.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.5 Service providers have a thorough knowledge and understanding of how to meet their duties to consumers in relation to Rights 5, 6 and 7 of the Code.

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

The informed consent policy includes rights 5, 6 and 7 of the code. Informed consent education is covered at orientation. This was covered at the advocacy education in March 2010 with 29 employees attending. Informed consent included in Health and Disability education in 2008 and at staff meeting in September 2009.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.6 Consumer choices and decisions are recorded and acted on.

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

As part of the resident admission documentation their choices and decisions are recorded and are reviewed on an ongoing basis. Five of five clinical records viewed evidenced this.

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:**

Copies of advanced directives that are made are held on clinical files and advanced directives/resuscitation status is reviewed annually. Enduring powers of attorney copies are held on the file. Advanced directive training was provided in 2008, five staff attended. Sharon the registered nurse/manager attended a two hour advanced care plan in practice training in March 2009.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11 Advocacy And Support

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

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

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

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

Advocacy information is provided with independent advocates and an in-house chaplain is available. Information in advocacy pamphlets displayed and access to the chaplain are freely available to residents, families and staff.

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:**

Documented procedures are in place which includes how to access independent advocates. Residents' rights / responsibilities and advocacy service information is provided to residents at the time of their admission. Advocate information is displayed in the upstairs lounge for residents and families to access. The chaplain visits and can act as an advocate for residents, resident's families and staff if necessary. April 2011 resident meeting minutes confirmed that Sharon the registered nurse manager spoke to the residents about Code of Rights, each of the fifteen residents were given a copy of the code of rights pamphlet.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.11.2 The service has policies to facilitate the presence of advocates/support persons.

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

Documented policies and procedures are in place with advocacy information displayed in the upstairs lounge and available for residents and families. The in-house chaplain could also act as an advocate if required.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.11.3 Service providers are educated to recognise this right to have an advocate/support person present and identify and appropriately address situations where an advocate/support person is not possible or appropriate.

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

Advocacy education was provided by Health and Disability advocate on 21 May 2008, five staff attended

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:** Met

Residents confirmed able to have visitors of their choice. Information on visitors is included in the admission booklet. Community contacts are established and maintained by individual residents

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

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

Information on visitors is included in the Glenbrook Rest Home booklet which is provided to residents on admission. Open visiting hours. Visitors book at the front entrance. Residents confirm having access to visitors of their choice

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:**

Residents are able to access services in the community such as physiotherapist and local church groups. Some residents attend the local Waiuku community craft group weekly. Podiatrist, hairdresser, and Waiuku senior citizens visit the facility,

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.13 Complaints Management

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

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

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

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

Complaints processes are documented and provided to residents/family at the time of admission and copies of the complaint form are available in the upstairs lounge. Residents confirm they understand how to make a complaint. A complaints register is maintained and showed that there have been no complaints since the owners took over three and a half years ago

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:**

The service has a documented complaints policy, process and guidelines that comply with right ten of the code. Staff responsibilities and information to assist staff dealing with complaints is included within the complaints policy. The complaints form is printed on green paper. The complaints procedure audit completed February 2011 as part of the quality programme.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.13.2 Information about a consumer's right to complain and the complaints process is available. Copies are provided for the consumer.

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

The complaint policy includes the words 'everybody has the right to complain, which can be in writing or verbal, and complaints can also be made anonymously, although this means that these cannot be responded to individually.' Copy of complaint form is provided at time of admission. Information about how to complain is included in 'Welcome to Glenbrook Rest Home' booklet which is given to residents on admission.

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:**

The complaint register was viewed. There have been no complaints since July 2008 when the facility ownership changed

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:** Met

Values of the organisation are documented and underpin service delivery. Documented values are included in the resident admission information. An extensive internal audit programme and satisfaction surveys are completed. The organisation's owners manage the business and are present on a day to day basis providing both operational management, full time clinical registered nurse input and maintenance cover.

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

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

A business, quality risk and management plan is in place that drives the business and underpins all decisions made in policy making and budgeting. This document outlines the organisation's philosophy, objectives, goals, risks and also includes the organisation's projected five year plans, aims and ambitions. The business, quality risk and management plan is reviewed annually. New employees are introduced to the organisation's philosophy as part of the planned induction/orientation programme in place. A copy of the organisation's philosophy was viewed on the wall in the upstairs lounge.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.1.2 Organisational performance is aligned with, and regularly monitored against, the identified values, scope, strategic direction, and goals.

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

The organisation's performance is monitored through an internal audit programme. Satisfaction surveys are completed by the residents/relatives annually. Monitoring of the organisation's performance occurs through the regular monthly staff meetings, as a fixed agenda items. Corrective actions are developed from any incidents, accidents, the audit programme, satisfaction surveys and complaints Minutes of the June 2010 staff meeting at which quality is an agenda item were viewed, staff education on confidentiality, privacy and informed consent was provided at the meeting.

Residents have input into the management through a three monthly resident meeting, which has a fixed agenda that includes meals and refreshments, environment, activities and new business. Residents and employees are kept informed through minutes from the regular meetings held. Minutes of the April 2011 residents meeting were viewed

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The organisation is managed by owners Sharon and Peter. Sharon the full time registered nurse owner/manager has had many years aged care nursing and management experience. Peter who has a back ground in human resource management manages the maintenance and refurbishment building project. Residents, relatives and staff interviewed confirm either Sharon or Peter are readily available and respond. Staff interviews confirm the owner/manager leads the organisation and decision making. The owners provide twenty four hour on call cover as they live two minutes drive away.

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:** Met

During the owners absence a registered nurse is available to provide full time registered nurse and management cover.

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:**

A registered nurse who had many years aged care and management experience is available and able to stand in, in the owners absence. On the day of the audit she covered on the floor as the registered nurse.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.2.2 Services are planned to meet the specific needs of the consumer groups entering the service.

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

The facility has a contract to provide only rest home level of care for residents. The majority of new admissions come through Middlemore (Counties Manukau DHB) referral assessment system for long term or respite rest home care. One staff member attended an eight hour education session on promoting 'quality of life' for residents.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

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

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

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

A quality plan is in place which includes risk management and is reviewed annually. There is a comprehensive audit programme in place with corrective actions for any identified situations. Actual and potential risks are identified and strategies identified to manage. Monthly staff meetings with a fixed agenda are the forum where quality data and audit results are discussed, then minutes are posted up on the staff notice board. A monthly residents' meeting is held. Clinical files and policies and procedures are available for staff.

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:**

A business, quality risk and management plan is in place that drives the business and underpins all decisions made in policy making and budgeting. The quality plan includes a mission statement and philosophy, The organisation philosophy is included in staff induction for new employees. Monthly quality improvement activities are managed through the monthly staff meetings . Quality activities are covered as fixed agenda items as part of each monthly staff meeting. Copies of all meeting minutes and audit results are displayed for staff on the notice board. Minutes of the June 2010 staff meeting at which quality is an agenda item were viewed, staff education on confidentiality, privacy and informed consent was provided at the meeting.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.2 Management and service providers enable consumer participation and consultation wherever appropriate.

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

The quality and risk management programme is managed through the monthly staff meetings. Residents participate in the running of the facility through a three monthly minuted resident meeting that has a fixed agenda that includes meals and refreshments, environment, activities, and new business. Minutes of the April 2011 resident meetings were viewed.

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:**

Policies and procedures are available to staff through the nursing manual, quality and health and safety manual, environmental policies which are held at the nurses' station. There is a document control system in place for document control. Policies under revision are displayed and discussed at meetings prior to implementation

and the owner/manager documents policy changes in the handover sheets which all staff read. Staff interviews confirm their awareness of the policies and procedures and their location, and the process used to keep staff updated of policy changes.

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:

A document control system is in place which is managed by the owner/manager who implements any document changes. All policies are in hard copy and have a date of development, review number and page number. All manuals/policies viewed are current and up to date. Annual clinical records audit planned for December 2011.

Finding Statement

Corrective Action Required:

Timeframe:

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

The quality management system is reported through the monthly staff meeting that has a fixed agenda in place that covers:

1. Matters arising from previous minutes
2. Staff
3. Teaching sessions
4. Residents
5. Incidents/ Accidents
6. Health Safety / Infection control
7. Attached Infection Control stats.
8. Audits, results, corrective action
9. Concerns, Complaints and compliments.
10. Training
11. Risks and hazards
12. Housekeeping
13. Policies and procedures.

14. Restraint

15. New business

16. Ongoing Issues.

Minutes from the June 2010 monthly staff/quality meeting were viewed and confirm that all these agenda items were discussed.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

All quality data and issues are addressed through the monthly staff meeting by way of a fixed agenda that includes staff issues, teaching sessions, residents information, incidents/accidents, health and safety/infection control, audit results, concerns, compliments and complaints, training, risks and hazards, housekeeping, policies and procedures, restraint, new business and ongoing issues. Minutes from 13 April 2011 meeting were viewed and confirm these items were discussed, under new business it was documented a new washing machine for the down stairs laundry had been purchased. Under housekeeping there was a reminder relating to recycling of rubbish to be put in the appropriate bins. Minutes 10 November 2010 viewed evidenced that a new handover sheet has been created.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The registered nurse carries out the monthly audits in line with the annual planned quality plan. On the audit plan form there is formal corrective action process that identifies the:

Area for corrective action/quality improvement,

Who is responsible for making the improvement

How to measure that improvement will occur

Final audit outcome

Did we achieve improvement

Sign off

An example of this audit process was viewed in minutes of the staff/quality meeting related to problems when residents clothing was laundered, the improvement processes identified that residents clothing needed to be turned in the right way out and pockets checked.

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:**

Corrective action plans are developed from reported incidents, accidents, exception reporting and adverse event reporting. An example of this audit process was viewed in minutes of the staff/quality meeting related to problems when residents clothing was laundered, the improvement processes identified that residents clothing needed to be turned in the right way out and pockets checked. An example viewed on audit corrective action plan,19 May 2011 was crockery cupboard would not shut properly. The improvement plan was for the cupboard to be replaced. The re-audit outcome on 12 June 2011 verified that the cupboard had been replaced.

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:**

Actual and potential risks are identified and documented and strategies put in place to manage identified risks. Identified risks are monitored through the internal audit programmes, health and safety programme, satisfaction surveys and the complaints management process, all of which are included in the monthly staff meeting where corrective actions are discussed. Staff interviewed are aware of the quality and risk management system and the availability of the minutes of meetings and the process for completing documentation.

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:** Met

A reporting system is in place for all incidents relating to residents, staff and the environment, from which an analysis is produced for the quality programme. Corrective actions are developed and implemented and included in the quality reporting process.

Criterion 1.2.4.1 The event reporting system is a planned and coordinated process that is an integral part of the management system.

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

Analysis, identification of trends, planned corrective action and review occur through the audit process and are discussed and managed through the monthly staff meeting. This process includes residents incidents and accidents, staff issues, infection surveillance, environmental and security concerns. All incidents and exception reporting is recorded and analysed and included in the monthly staff meeting. The monthly staff meeting is chaired by the owner manager and feedback to staff is through minutes being posted on the staff notice board.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

Sharon the registered nurse owner manager confirmed she is aware of the statutory and legal responsibilities in relation to reporting and notification. Examples discussed were notification of an outbreak in 2009 where the Public health were notified. In a clinical serious event the doctor would be responsible to notify the coroner. There is a policy in place that outlines the procedure for notification of serious staff injury.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

All adverse events are documented and include clinical, incidents and accidents relating to residents, staff, environmental and security . There is a system in place for complaints to be documented and analysed however the complaint register evidenced that no complaints had been received for a number of years. Corrective action plans are developed for all identified shortfalls and included in the quality plans.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.4.4 Adverse, unplanned, and untoward events are addressed in an open manner through an open disclosure policy.

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

There is a documented open disclosure policy in place. Staff training was provided in September 2009, seven staff attended

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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

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

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

There are human resource management policies and systems in place. An extensive orientation programme with a check list is provided for all new employees. Qualifications are validated and the organisation has an extensive education programme which is well attended in addition to the ACE programme.

Criterion 1.2.7.1 The skills and knowledge required of each position are identified and the outcomes, accountability, responsibilities, authority, and functions to be achieved in each position are documented.

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

Position descriptions are documented for all roles and include lines of reporting and expected outcomes. Two of two staff files viewed evidenced signed job descriptions in place.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

Practice certificates are validated by the nurse manager annually. Copies are kept on file. Copies were viewed for the two registered nurses and eight doctors.

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:**

Human resource processes are in place. All applicants are interviewed by the registered nurse owner manager. Reference checking and police checks occur. Staff do not work full time and so are able to fill planned leave vacancies or short notice sick leave. One of the two staff files viewed evidenced both a reference and police check. The manager explained that the staff member whose file had no evidence of both a reference and police check completed was employed prior to their taking over ownership of the facility.

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:**

New service providers complete a formal orientation/induction programme over three days. The orientation programme includes familiarising the staff member with policies and procedures and the organisations vision and values. An experienced staff member acts as a buddy and supervises practical consumer care delivery and completes a sign off checklist to ensure that service provider is competent to perform the role. A written test is completed and competency signed off by the registered nurse to establish medication administration competency. Health and safety induction training includes fire, hazard register and emergency procedures. Lifting and transferring training is provided by the registered nurse.

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:**

An annual education plan is in place and was viewed. Appraisals in the form of a sit down meeting with the registered nurse manager is initially completed after commencement of employment and then annually. The ACE and ACE Dementia programme is available with nine staff currently completing modules. Relatives and residents interviewed confirm satisfaction and commend the care received

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

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

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

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

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

There is a fixed roster in place. The registered nurse manager works full time. All residents and families interviewed felt they received a timely and safe service.

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:**

There is a fixed roster in place. As there is only one caregiver on night shift the registered nurse/owner who lives four houses away provides after hours back up. As staff employed are not on set hours or days the registered nurse manager fills the set roster for a four week period. This system allows leave requests to be met while safe rosters are maintained. As the facility is located in the country agency staff are not used so all replacement cover is found within the existing staff available. Staff interviewed gave an example that when there was increased work load due to changing resident status additional caregiver hours were put on to cover the increased resident needs. Two residents indicated that there ire always sufficient staff on duty.

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:** Met

All consumer information is maintained in individual resident paper files. The clinical records are clear and complete and contain sufficient information for the use to which they are put and up to date. Clinical records are stored securely and are archived in secure storage on site before disposal

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:**

Resident information is entered at the beginning of entry to the service. Five resident files viewed evidenced this.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.2 The detail of information required to manage consumer records is identified relevant to the service type and setting.

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

Information required to manage resident records is identified and documented prior to or at the time of admission. Five resident files viewed evidenced this.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.4 Where the service is not required to meet the data requirements of the NZHIS adequate consumer detail is collected to safely manage consumer information.

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

Resident records contain adequate and appropriate information in order to facilitate safe management of their information.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.5 The service keeps a record of past and present consumers.

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

Since the change of ownership three and a half years ago all past and present residents can be identified through an electronic recall data base computer system.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.6 Management of health information meets the requirements of appropriate legislation and relevant professional and sector Standards where these exist.

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

Management of all health information meets the requirements of appropriate legislation that includes the Health Information Privacy Code, Privacy Act, Health (Retention of Health Information) Regulations, Health Act, Human Rights Act. Appropriate polices are in place to support this. Sharon the registered nurse/owner manager acts in the role of Privacy officer.

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:**

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. Sensitive information, including consumer hard copy paper records, service plans and medication charts are kept in a locked cupboard in the nurses office. This cupboard was observed to be locked at all times. Visible information displayed does not include sensitive information from which the health status or needs of a consumer can be determined. As per the quality plan privacy of information audit planned for August 2011.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.8 Service providers use up-to-date and relevant consumer records.

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

Information is recorded in keeping with the organisations documentation policy. Five resident files viewed evidenced that resident records information was maintained up to date.

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:**

Five of five resident clinical paper records were viewed. Records were written clearly, objective and factual, using abbreviations which are listed and approved. Entries were signed with designation, time and date in a legible manner by the service provider making the entry.

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:**

All records pertaining to each residents service delivery are integrated. All parts of the record are clearly linked in order to locate them for retrieval. Clinical letters and specialist reports are linked to each residents records, at the time of admission or during treatment and are filed within the clinical hard file

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.1 Entry To Services

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

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

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

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

Entry criteria are documented and made known to referrers and prospective residents and families. The service operates 24 hours per day, seven days per week. Residents and relatives confirm they are provided with accurate information about the service prior to entry. Residents are assessed as requiring rest home level care prior to entry.

Criterion 1.3.1.1 Access processes and entry criteria are clearly documented, and are communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

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

The preadmission entry policy was sighted. This specifies that residents are needs assessed prior to entry. This is communicated to prospective residents via the needs assessment service and is posted on the Glenbrook Rest Home and Eldernet websites. Review of five clinical files confirmed that all residents had been assessed as requiring rest home level care prior to entry.

Interview with three relatives confirmed they were provided with information prior to entry.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.1.2 The service operates at times most appropriate to meet the needs of the consumer group.

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

The service operates 24 hours per day, seven days per week.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.1.3 Adequate and accurate information about the service is made available.

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

Information is available on the Glenbrook Rest Home and Eldernet website. There is also a leaflet available for people to take away. Any prospective residents or family are able to visit and meet staff and have tour of facility.

Interviews with three relatives confirmed adequate and accurate information about the service was provided.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

Entry criteria are specified in the preadmission entry policy. Evidence of email records were sighted where this was communicated to prospective residents and family members. The needs assessment service are informed of vacancies.

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:** Met

Those who are declined entry are informed of the reasons and provided with alternatives. A record of declined entries is kept on file. The safety of those declined is managed by referral back to the needs assessment service where applicable.

Criterion 1.3.2.1 Where a consumer is declined entry to the service this is recorded and the referrer is informed.

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

The preadmissione entry policy includes a section for declining entry. The booking file was sighted where records are kept of those declined entry. Reasons for declining entry included not assessed as rest home level and the consumer finding an alternative rest home closer to family. Email evidence was sighted where one consumer was not rest home level and the family was informed of the reason and possible alternatives.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

Email evidence was sighted where one consumer was not rest home level and the family was informed of the reason and possible alternatives.

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:** Met

Assessment, planning, provision and evaluation of all aspects of the service is delivered by competent and experienced health professionals with current practicing certificates. Residents and their family members with consent are actively involved in each stage of service delivery. Assessment, care planning and nursing and medical reviews occur according to the needs of the resident and meet the requirements of the aged related residential care (ARRC) contract. Staff from all disciplines work collaboratively to ensure care is comprehensive and meets the needs of residents.

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:**

Review of five clinical files and interview with three family members confirm that assessments are carried out by the registered nurse on admission - current annual practicing certificates were sighted for the two registered nurses. Both registered nurses have extensive experience in aged care. One family member on interview stated that the registered nurses are very knowledgeable and they feel reassured their parent is in good hands.

When residents are admitted from home or another facility they are assessed by the general practitioner usually within 48 hours of admission - current annual practicing certificates for six registered medical practitioners were sighted. Some residents are admitted from the DHB and are seen by a medical practitioner there.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.3.2 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is developed with the consumer, and where appropriate their family/whānau of choice or other representatives as appropriate.

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

Review of five clinical files and interviews with three family members and four residents confirm they are involved in assessment, planning and evaluation processes. Residents are asked their personal preferences on admission and during care plan reviews. Personal goals of residents are recorded on the care plans.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Review of five clinical files show that assessment by the registered nurse occurs on admission and a short term care plan initiated. Long term care plans are developed usually within one week and completed within three weeks of admission. Care plans are reviewed on a six monthly basis or whenever there are changes in the needs of residents.

Medical assessments occur either prior to admission (if from the DHB) or within 48 hours of admission. Residents who are stable are reassessed three monthly and a form is completed by the general practitioner to confirm the resident is medically stable. Otherwise medical assessments occur on an as needed basis. Medications are documented as being reviewed at least three monthly unless there are changes.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Interview with one caregiver confirmed there is a handover between shifts - this was observed on the day of the audit. There is a registered nurse and caregivers diaries in use to communicate information between staff members. The registered nurse completes a weekly handover sheet (sighted for the period ending 4 July and 27 June 2011) which records any changes or relevant information such as antibiotics commenced or care plan updated.

Staff were observed to be working collaboratively during the audit.

Review of five clinical files confirm that where advice from the general practitioner is needed or medical review required a medical advice request is completed and faxed to the general practitioner. On interview the general practitioner confirmed she is kept informed in a timely manner.

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:** Met

The registered nurse obtains information about residents from a range of sources including the resident and family. Assessments are comprehensive and detailed. Assessment information is used as the basis for care planning. Personal preferences and goals of residents are included. Privacy is maintained during assessment processes. Staff, residents and relatives are informed of assessment outcomes and the content of care plans.

Criterion 1.3.4.1 Service providers seek appropriate information and access a range of resources to enable effective assessment.

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

Review of five clinical files and interview with the registered nurse confirms that assessment information is obtained from the resident, family members, the needs assessment service, doctors notes, transfer summaries if transferring from another facility, and by observation. Additional information is obtained from other staff such as caregivers or the activities coordinator.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

Review of five clinical files show that assessments are comprehensive and detailed. Information is recorded regarding the physical condition and needs, likes/dislikes, social supports/contacts, interests/hobbies, behaviour, spiritual and cultural needs. Care plans are based on needs and personal goals of the residents. Care plans and assessment information is documented in an easy to read and understand format for all staff to follow. Assessment information includes personal preferences and goals of residents.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.4.3 Assessments are conducted in a safe and appropriate setting as agreed with the consumer.

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

On interview the registered nurse confirmed that assessments are conducted in bedrooms. Where residents share a room, assessments are only conducted when the other occupant is out of the room.

On interview three relatives and four residents confirm their privacy is maintained at all times.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.4.4 Assessment and intervention outcomes are communicated to the consumer, referrers, and relevant service providers.

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

Review of five clinical files and interview with three relatives confirm that assessment information and the care plan is explained to them once completed. Residents who are able sign their care plans to confirm their understanding. Staff members are informed of assessment outcomes and care plans via handover and weekly handover sheets - refer to criterion 1.3.3.4.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.5 Planning

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

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

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

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

All care plans are up to date and accurately reflect the current needs of residents. Personal preferences and goals are included. Care plans are in a format that is easily understood by all staff. Clinical files are fully integrated and there is evidence that information is shared and utilised from all disciplines. Residents and family members interviewed confirm their involvement in care planning.

Criterion 1.3.5.1 Service delivery plans are individualised, accurate, and up to date.

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

Review of five clinical files show evidence that care plans are based on individually assessed needs and preferences of residents. All care plans reviewed are detailed and accurately record the residents needs and interventions required to meet needs. Where there are changes, the care plan is updated at the time and regularly at six monthly intervals. All care plans reviewed are up to date and accurately reflect the current needs of the residents.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Care plans describe in easily understood language the interventions and care required to meet the needs and goals of residents. On interview two caregivers confirm care plans are utilised.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

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

All clinical records are filed in one chart and include medical, nursing, allied health, activities, diagnostic test results and referral reports.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.5.5 The service delivery plan is communicated in a manner that is understandable to the consumer and service provider responsible for its implementation and with the consumer's consent, their family/whānau of choice.

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

Three relatives and four residents confirm on interview they understand their care plans and have opportunity to have input into them. Residents who are able sign their care plan to confirm their understanding.

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:** Met

Care is tailored to individual needs and goals of residents. On interview both residents and family members express their satisfaction with all aspects of the rest home and care provided. Links with other service providers and community organisations are maintained and encouraged. Care is in accordance with current evidenced based best practice in aged residential care. Residents and relatives confirm they are treated with respect and dignity.

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:**

Review of five clinical files and interviews with three relatives and four residents confirm that care is tailored to individual needs, goals and preferences. All residents and relatives interviewed commented they particularly liked the homelike and family - type atmosphere of the rest home.

Where individual needs change, care plans are updated to cater for current needs.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.6.2 Appropriate links are developed and maintained with other services and organisations working with consumers and their families.

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

Interview with three relatives, four residents and the registered nurse and activities coordinator confirmed that links are maintained with other health care providers including podiatrist, dietitian, physiotherapist, chiropractor, clinical nurse specialist at Middlemore Hospital and other specialist services as required. Other agencies

residents have links with include senior citizen's, Civil Maimed Association, library, Presbyterian and Methodist churches, local kindergartens and community events such as the Age Expo in Pukekohe.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.6.4 The consumer receives safe and respectful services in accordance with current accepted good practice, and which meets their assessed needs, and desired outcomes.

Audit Evidence

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

Policies and procedures are in accordance with current literature and best practice guidelines for residential aged care. Review of five clinical files and interviews with three relatives and four residents confirm that care is tailored to the needs, goals and preferences of individual residents. All relatives and residents interviewed expressed their satisfaction with all aspects of care.

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:** Met

Activities are provided that enhance physical, mental, social and spiritual wellbeing. Personal preferences are identified and residents have input into the activities programme. Families are invited to social events. The activities programme includes input from external entertainers and agencies. Residents provide feedback regarding the activities programme both formally and informally. Crafts made by residents are sold and the proceeds are used to fund special activities.

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:**

The Activities Policy was sighted along with the activities schedule. A range of activities are provided including the following:

- mental: quizzes, scrabble, housie, storytelling (for example recounting holiday experiences)
- physical: walking, movement for joy (light exercise and yoga), bowls, darts, gardening
- social: celebrate Christmas and birthdays, annual family barbeque, sing - a - longs, entertainers, movies, outings in the van
- spiritual: Presbyterian church service on third Friday of month, Methodist church service on fourth Wednesday of month.

The activities coordinator assesses each resident on admission for interests and hobbies. Activities are planned to incorporate individual preferences.

The activities coordinator is employed Monday to Friday from 10.45 am to 3.15 pm. She has a certificate in social work and experience in providing activities for the elderly.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.7.2 Activities reflect ordinary patterns of life and include where appropriate the involvement of family/whānau of choice, or other representatives and community groups where appropriate.

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

A range of activities are provided that enhance mental, social, spiritual and social wellbeing. Outside input is included: entertainers, country and western singer, local kindergartens and local churches. Families are invited to an annual barbeque and to special birthdays.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.7.3 The preferences of consumers are sought and inform the development of planned activities.

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

Refer to criterion 1.3.7.1. The activities are planned around the interests of most residents. Three monthly residents meetings are held and residents are able to provide feedback or make suggestions. Minutes were sighted from 20 April 2011 and 21 October 2010. In addition, a craft table displays work for sale completed by residents, proceeds from sales are used to fund extra outings.

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:** Met

Evaluation processes are ongoing in addition to being conducted formally at intervals that meet the changing needs of residents. All care plans reviewed are up to date and reflect the current needs and preferences of residents. When the needs of residents change or progress is less than expected, residents are reassessed by the registered nurse. The general practitioner is informed where necessary and the family is notified. Care plans are updated in a timely manner.

Criterion 1.3.8.1 Evaluations are conducted at a frequency that enables regular monitoring of progress towards achievement of desired outcomes.

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

Progress notes are recorded every shift. The registered nurse reassesses and evaluates residents whenever there are changes and formally on a six monthly basis. Families and residents are involved in evaluation processes.

Care plans are updated to reflect current needs and goals.

Medical and medication reviews occur at three monthly intervals where the resident is stable and more often if their needs require it.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Evaluations are recorded on an evaluation form and cover all aspects of the care plan and needs of the resident. Where more interventions are required to meet the needs, care plans are updated to include these.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Five clinical files were reviewed in detail, one using tracer methodology for a resident who had become unwell and was transferred to hospital level care. In addition to the file review staff were interviewed and the resident's next of kin. The resident had cancer and was transferred to Middlemore Hospital. On return to Glenbrook Rest Home her condition gradually declined. On 6 June 2011 staff noticed she was weak and had a reduced intake of food and fluids. The daughter was notified that day. The following day the doctor and the palliative care team were notified and the resident was moved to a palliative care bed at a hospital. The daughter on interview stated she was very happy with the way her mother was treated and felt she had been notified in a timely manner.

All other clinical files reviewed showed evidence that where the condition of the resident changes or where new needs are identified, the registered nurse completes an assessment, notifies the family and general practitioner if necessary and updates the care plan. The general practitioner on interview stated that communication between herself and the registered nurse was timely and effective.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

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

Residents are able to access external services and this is facilitated by staff at Glenbrook Rest Home. Referrals are managed safely during referral by timely communication and ensuring any risks are mitigated.

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

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

Review of five clinical files and interview with three relatives and four residents confirm residents are given the choice of accessing other health services including chiropractor, podiatrist, dietitian, physiotherapist or other services where required or requested. Records are kept within the clinical files.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.9.2 The consumer's safety and right to be kept informed in a timely manner, is managed by service providers cooperating during the referral process.

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

Staff communicate with each other. During referral to external providers referral or transfer forms are completed which includes any risks to the resident. Access is facilitated by the registered nurse to ensure safety of residents.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

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

ARC D21 ARHSS D21

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

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

Discharge and transfer are planned processes. Any risks to the resident are identified and managed. Residents and family members are kept informed and involved.

Criterion 1.3.10.1 Service providers facilitate a planned transition exit, discharge, or transfer in collaboration with the consumer whenever possible and this is documented, communicated, and effectively implemented.

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

The discharge policy was sighted. Discharge and transfer are planned and coordinated processes that involve staff collaborating with residents and family members. Transfer forms are completed which identify any risks such as high falls risk, and how these risks are managed. The ongoing facility is supplied with a summary of the care plan and a list of medications.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

Risks to the resident are documented on the transfer form along with strategies to manage these. Family members are involved at all stages of the process.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

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

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

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

Policies and procedures for all aspects of medication management are fully implemented and comply with legislative requirements and safe practice. Responsibilities for all stages are documented in the policy and procedures. Staff are only able to administer medications when they have demonstrated competence. This is reassessed on an annual basis. Allergies are flagged on the clinical file and medication charts. Errors are reported via the incident reporting system and investigated by the registered nurse. Procedures are in place for the safe self administration of medicines. Prescription and administration records comply with legislative requirements.

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:**

Comprehensive policies and procedures are implemented for all aspects of medicine management. These comply with the drug regulations and best practice guidelines.

Medications were seen to be stored in a locked cupboard. Controlled drugs are stored in a locked cabinet that complies with the drug regulations. The key is held on the person of a staff member. Controlled drugs are counted when there are new supplies from the pharmacy and on a six monthly basis. The controlled drug register is completed as per the regulations and was seen to be accurate.

A medication round was observed. Administration was observed to be safe and according to the policy and procedures. Prescription and administration records are legible, signed, dated and written in ink. When medications arrive from the pharmacy, these are checked for correctness.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.12.2 Policies and procedures clearly document the service provider's responsibilities in relation to each stage of medicine management.

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

The policies and procedures detail each staff member's responsibility in relation to medication management.

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:

Caregivers are assessed for competency by the registered nurse prior to being able to administer medications and on an annual basis. Completed competencies were sighted for one caregiver from 16 September 2010 and 1 December 2009; and for another caregiver from 16 May 2011 and 24 July 2010. When errors are made staff are reassessed for competency. Staff receive ongoing education in relation to medicine management. Training records were sighted from 23 March 2011 for 15 staff members, and 3 December 2009 for seven staff members.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.12.4 A process is implemented to identify, record, and communicate a consumer's medicine-related allergies or sensitivities and respond appropriately to adverse reactions or errors.

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

Allergies are recorded on medication charts and in the clinical files. Procedures are in place to respond to adverse events. Errors are reported via the incident reporting system. There are relatively few errors and these are investigated by the registered nurse.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

A procedure is in place for the self administration of medicines. Currently there are no residents self medicating except for two using nasal sprays.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Prescription and administration records are legible, signed, dated and written in ink with no use of correction fluid. Each prescription entry is signed by the general practitioner. Specimen signatures are recorded.

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:** Met

The programme is well implemented and both residents and families expressed huge satisfaction with the meals provided. A summer/winter dietitian approved menu is in place. Resident personal food preferences and needs are met. Residents are weighed regularly and recorded in the clinical files. Food training is provided.

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

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

Documented food service policies are in place. Fluids, foods and nutritional needs were observed as appropriate for the residents who confirmed the food is wonderful. Fluids were observed to be offered on a regular basis and this was confirmed by residents. The presentation and portion sizes were viewed and appropriate

and what was served was verified against the planned menu. Monthly resident weights are documented with referrals made to a dietitian if required. Interviews and observation in the kitchen confirmed infection control practices and food safe handling, portion controls and individual diets are documented. All relatives interviewed commented on how satisfied they are with the meals provided. May 2011 food service audit viewed.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Special modified diets are provided and a dietitian is available for referral when required. On the day of the audit no resident required a modified diet however the cook gave an example of modified food being prepared for a resident with a swallowing difficulty. A diabetic dessert option is offered at each main meal. The registered nurse Sharon Jordan attended in July 2010 a two hour training on 'Diabetics Management in Residential Elderly Care'. A four week cycle summer and separate winter menu is provided and has been approved by the dietitian.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.13.3 The personal food preferences of the consumer are met where appropriate.

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

A list of Individual food preferences was viewed in the kitchen and used to ensure that resident likes, dislikes and allergies are considered when food is served, The presentation of the meals was viewed and appropriate. The main meal of the day is in the evening and breakfast is served to resident's in bed if wished. Most residents choose to have their breakfast in the dining room. Both residents and families interviewed complimented the food service that is provided.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.13.4 Special equipment is available as required.

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

Special equipment is available and lip plates were viewed being used. Modified cutlery and straws for drinking are available.

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:**

The food service policies and procedures reflect current legislation and guidelines and include the purchase, storage and transportation of food. Temperatures are recorded Monday to Friday by the cook for the refrigerators and freezers, temperature recordings viewed show recordings are at the recommended level. Stock rotation of goods is maintained. Food in the refrigerators is covered and labelled. Training on food safety was provided on 23 June 2010, twelve staff attended. On the day of the audit though kitchen renovations were being carried out the food service was still able to be delivered safely.

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:** Met

Policies and procedures for the management of waste and hazardous substances are fully implemented. A system is in place for reporting any related incidents. Procedures include those for cleaning up body substance spills. Staff receive ongoing training in the management of waste and hazardous substances. Chemicals are stored in their original containers in a locked room. Appropriate personal protective equipment is provided.

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

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

There are policies and procedures implemented for general household waste and handling, storage and disposal of hazardous waste that comply with current legislative requirements. Infectious waste is segregated. There are separate linen bags for linen, infectious linen and personal laundry. Underpants are soaked in Napisan prior to washing. Sharps containers are available for used sharps. Continence products are disposed of in double plastic bags.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.1.2 All incidents involving infectious material, body substances or hazardous substances are reported, recorded, investigated, and reviewed.

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

Any incidents would be reported via the incident reporting system. There have been no incidents in recent times.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.1.3 A procedure or emergency plan to respond to significant waste, or hazardous substance management issues, and/or accidents is documented, implemented and its effectiveness monitored.

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

There are procedures in place for cleaning up body substance spills. A bucket of sand is available for cleaning up spills.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.1.4 Service providers involved in the management of waste and hazardous substances receive training and education to ensure safe and appropriate handling.

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

Training records were sighted for the following:

- needle stick injury on 15 June 2011 for 13 attendees

- chemicals on 23 March 2011 for 15 attendees

- chemicals on 11 March 2009 for seven attendees

Staff are also trained during orientation - records for one care giver sighted from 1 June 2011.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.1.5 All hazardous substances are correctly labeled to allow for easy identification and safe use in line with current hazardous substance identification regulations and territorial authority requirements.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Chemicals were sighted as being stored in the laundry in original containers with intact labels. Bulk storage of chemicals is in the locked downstairs laundry. Chemicals are dispensed by automatic dispensers.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The following personal protective equipment was sighted:

- gloves
- aprons
- gum boots
- masks

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:** Met

A documented maintenance programme which includes planned and preventative maintenance is in place. Medical equipment is calibrated annually. While the physical environment is appropriate to the needs of residents, there has been an ongoing refurbishment programme in place that has resulted in bathrooms and bedrooms being upgraded.

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

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

There is a documented maintenance programme in place for all building, plant and equipment and is overseen by the owner manager. Service and calibration of medical equipment is completed annually, records were viewed for February 2011 for aspirators, blood glucose meters, nebulisers, sphygmomanometers and stethoscopes. There has been an ongoing refurbishment programme in place that has resulted in bathrooms and bedrooms being upgraded. Staff confirmed that at the nurses office there is a maintenance request and record book that they fill out if any maintenance repairs are required

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.2.2 Where there is a requirement under the New Zealand Building Code there is

(a) A current Building Warrant of Fitness for older buildings; or

(b) A code of compliance certificate and certificate of public use for new buildings.

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

A current building warrant of fitness dated 13 May 2011 is in place. A copy of this was taken

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.2.3 Amenities, fixtures, equipment, and furniture are selected, located, installed, and maintained with consideration of consumer and service provider safety, needs, and abilities.

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

Non slip surfaces are provided in wet areas and appropriate equipment, furniture and fixtures which are easily able to be cleaned were viewed and confirmed by staff. Furniture and equipment is appropriate to the consumer group. Since the surveillance audit a refurbishment programme that involved putting hand basins into bedrooms, on the day of the audit only one bedroom did not have a hand basin in it. In three bedrooms ceilings have also been lowered with insulation being put into the roof and walls re-gibbed. Equipment which maximises independence is available with raised seats, walker frames and hand rails all viewed. Residents have input into the management of the facility through the resident's monthly meeting

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:**

The environment minimises resident risk to harm through the provision of mobility aids, security, flat surfaces and transitions, ramps handrails and for the communal toilet areas the provision of raised toilet seats. Flip charts that cover emergency situations were viewed in the corridor opposite the nurses office. Hazard register was available and viewed.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.2.5 Where the facility is the consumer's home, rooms are provided that allow for familiar furnishings and personal possessions, while maintaining safety.

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

All resident bedrooms viewed had personalised their own rooms with bedspreads, photographs on the walls. Each bedroom had shelving that allowed possessions to be displayed.

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:**

An accessible outdoor area with raised planter gardens, seating and a covered outdoor deck area available for residents use was viewed. There is a no smoking inside building policy however residents are able to smoke outside in a covered area.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.2.7 Where a consumer is required to be transported by vehicle, there are policies and procedures which minimise risk.

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

There is a transportation policy in place. If residents need to attend a doctor appointment the owner/manager would transport the resident in the facility car or van,

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

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

ARC E3.3d ARHSS D15.3c

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

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

Adequate toilets and showers are provided and identified in the communal areas. Hot water is provided at an appropriate temperature. Wet areas are easily cleaned.

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

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

Four additional single toilets and two large communal toilet and shower facilities are provided. There is a system to indicate 'engaged' and 'vacant'. Raised toilet seats and hand rails were viewed in the shower and toilet areas.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.3.2 Hot water for showering, bathing, and hand washing is provided at the tap at a safe and appropriate temperature that minimises the risk of harm to consumers.

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

Water for showering and hand washing is provided at a safe temperature and was hand tested on the day at an acceptable level. Monthly audit water temperature readings carried out, records of January to June 2011 audit results were viewed.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.3.3 Consumers, service providers and visitors are provided with adequate hand washing facilities to ensure compliance with infection control policies.

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

Adequate hand washing facilities with hand care information posted throughout the facility were viewed in both visitor and staff areas. Hand sanitiser at front entrance and in corridors. Separate staff toilet downstairs.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.3.4 Fixtures, fittings, floor, and wall surfaces are constructed from materials that can be easily cleaned, which are in line with infection prevention guidelines.

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

Wet areas of toilets and showers are all constructed of materials which can be easily cleaned for infection control purposes. Floor surfaces were viewed to be maintained in good order and are identified when wet. Transition between surfaces without abrupt changes in levels is provided

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.3.5 Toilets/shower/bathing facilities have clear and distinguishable identification when appropriate to the consumer group and setting unless contra-indicated by the consumer group.

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

Communal toilets and showers have doors labelled for identification plus vacant/engaged signs.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.4 Personal Space/Bed Areas

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

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

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

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

All bedrooms have adequate space to manoeuvre and accommodate resident's personal needs.

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:**

All rooms were viewed and had adequate space for the consumers to manoeuvre with mobility aids if required,

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.4.2 Where consumers are required to be transported or transferred between rooms or services in their beds, doorways, thoroughfares, lifts, and turning areas can readily accommodate the bed, attached equipment, and any escorts.

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

All rest home residents - no bed transfers required.

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:** Met

Appropriate lounges and dining area provided with room to manoeuvre around areas provided

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:**

Adequate access provided to the two lounges and one dining area. Four dining tables in the dining area are well spaced for access

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.5.2 **Consumers are able to move freely within these areas either independently or with the assistance of one or more persons, or mobility aides.**

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

Residents were viewed to move freely around the well spaced lounges and dining area, and consumers confirmed the seating is appropriate

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.5.3 **Areas designated for communal services, such as a lounge or dining room, if combined, do not impinge on consumer choices, rights, or privacy.**

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

There is a separate dining area and two separate lounges.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.6 Cleaning And Laundry Services

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

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

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

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

Cleaning and laundry services are included in the quality programme. There are two separate laundry areas with adequate storage for cleaning trolleys and equipment.

Criterion 1.4.6.1 Written policies and procedures are implemented and describe each cleaning and laundry process appropriate to the service setting and consumer group.

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

Documented policies and procedures are implemented for cleaning and laundry processes. All laundry including personal laundry is done on site. Chemical training was completed by 10 employees in April 2009 and 13 employees in April 2010

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The cleaning and laundry processes are included in the quality programme. Resident interviews confirmed the effectiveness of the laundry and cleaning, and a comment was made that they keep the rooms immaculate. Cleaning audit February 2011 viewed, a recommendation was to vacuum the manager's office.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Cleaning and laundry chemicas arel dispensed from an automatic dispenser. There are designated areas for the storage of the cleaning trolleys/baskets and equipment. Laundry and cleaning chemicals are pumped to the machines through an automatic dispenser system. Material safety data sheets are available and viewed.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.7 Essential, Emergency, And Security Systems

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

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

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

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

Emergency planning is in place to cover a variety of emergencies. All staff hold current first aid certificates. An approved evacuation plan and regular evacuation drills are held. Alternative resources are available in the event of main supply failure.

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

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

Emergency contingency plans are in place to cover a variety of emergencies. All staff hold a current first aid certificate. An approved evacuation plan and regular evacuation drills are held. Alternative resources are available in the event of main supply failure. Health and safety education was provided on in April 2010, twelve staff attended.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.2 Service providers are able to provide a level of first aid and emergency treatment appropriate for the degree of risk associated with the provision of the service.

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

There is a disaster box in place for emergency situations which was viewed. The staff induction programme includes emergency training, and evacuation drills are held on a regular six-monthly basis. Emergency equipment is current and fire extinguishers were last tested in March 2011. Outbreak management policies in place. All staff have current first aid certificates.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Approved evacuation plan in place and a copy was taken

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Alternative energy and utilities are available in the event of main supply failure with provision of barbecue, camping stove, torches, additional medical and food supplies, continence products all of which were viewed. There are two boilers which provide hot water and heating which continue in the event of electrical failure with a contract to service quarterly programmed. These can also supply stored water. Sewerage gravity fed septic tanks.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

An electronic call bell system is in place and was viewed in bedrooms, lounge, toilet and bathroom areas. On the day of the audit a call bell was rung and staff responded immediately. One resident interviewed commented you only have to ring and staff come immediately.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

At the handover from evening to night shift staff check together all doors to ensure the place is secure. Lock up procedure included in shift task description

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.7 Consumers who require a greater degree of supervision receive the level of support necessary to protect the safety of the individual, the consumer group, service providers, and visitors to the service.

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

A reassessment process is in place to ensure that residents are appropriately placed

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.8 Natural Light, Ventilation, And Heating

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

ARC D15.2f ARHSS D15.2g

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

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

Appropriate heating and ventilation is provided, and all rooms have an external window. Designated smoking area in place.

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:**

Heating in bedrooms and lounges is provided by electric wall mounted radiators. Residents confirmed a warm and ventilated environment. All rooms have an external opening window.

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:**

All bedrooms and lounges have at least one large external window, with some rooms also having a sliding door that opens to the outdoors.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.8.3 Consumers are not put at risk by exposure to environmental tobacco smoke.

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

Documented smoking policy with no smoking inside but designated covered outdoor smoking area for residents and staff. Information on smoking is included in the resident admission information and in the staff house rules.

Finding Statement

Corrective Action Required:

Timeframe:

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

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

There are policies and procedures in place and fully implemented for the minimisation of restraint. Glenbrook Rest Home has achieved a restraint free environment. A form is in place to document a thorough assessment prior to the use of restraint which includes a risk assessment. The use of enablers is voluntary only. Staff are trained in their safe use.

Criterion 2.1.1.1 The service has policies and procedures that include, but are not limited to:

(a) The commitment to restraint minimisation, which may include but is not limited to:

(i) The service's philosophy on restraint

(ii) How the service communicates its commitment to restraint minimisation

(iii) How the service ensures its commitment is carried out in practice;

(b) The definition of restraint which is congruent with the definition in NZS 8134.0.;

(c) The process of identifying and recording any restraint use is transparent and comprehensive;

(d) How it will meet the responsibilities specified in NZS 8134.2.2 if and when restraint is used;

(e) The definition of an enabler which is congruent with the definition in NZS 8134.0.;

(f) The process of assessment and evaluation of enabler use.

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

The restraint policy was sighted. This specifies the organisations commitment to promoting a restraint free environment and to provide staff with good guidelines to enable them to prevent the need for restraint. The policy makes reference to this standard and the definition of restraint is in accordance with it. The policy specifies that any restraint use is to be approved by the Restraint Approval Group. A restraint coordinator is designated to oversee all aspects of the policy, monitor performance of staff, organise approval meetings and liaise with the general practitioner.

The restraint policy outlines the procedures for all aspects of restraint from assessment, consent, considerations prior to use, cultural needs, monitoring, evaluation and quality review.

The policy includes a definition of an enabler and specifies their use is to be voluntary with the aim of maintaining safety of residents and promoting independence. The policy includes a section on the use of enablers and outlines the procedures for assessment, informed choice, monitoring and evaluation.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.1.1.2 The service ensures risk assessment processes and the consumer's service delivery plans support the delivery of services that avoid the use of restraint. This shall include, but is not limited to assistance given to the consumer in the past, which may have prevented the use of restraint.

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

The restraint policy includes a section on considerations prior to the use of restraint which specifies that the following factors are to be considered:

- resident's physical and psychological health

- gender

- culture and cultural values

- degree of risk to the individual, others and the environment.

There are templates available for staff to complete a risk questionnaire, which includes questions for relatives, and a pre-assessment. These include consideration of previous experiences/behaviours.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.1.1.3 Where enablers are used the organisation ensures service providers are guided in their safe and appropriate use.

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

The restraint policy specifies that staff are trained in the use of enablers. The following training records were sighted:

- 17 February 2009 for five attendees

- 3 March 2010 for the activities coordinator

- 30 September 2010 for 14 attendees

- 24 March 2011 for three attendees

Currently enablers are not in use.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The restraint policy specifies that the use of enablers is to be voluntary and used to promote independence and maintain safety for residents. Currently there are no enablers in use. Two caregivers on interview demonstrate their knowledge of enablers and their use.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.1.1.5 Ongoing education, relevant to the service setting, is provided to service providers, which includes, but is not limited to:

(a) The service's restraint definition, restraint minimisation policy and process for identifying and recording restraint use;

(b) The service's enabler use policy and procedure;

(c) The service's responsibility to meet NZS 8134.2.2 if and when restraint is used;

(d) Alternative interventions to restraint;

(e) Prevention and/or de-escalation techniques.

Threats of restraint or seclusion shall not be used to achieve compliance.

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

The following training records were sighted:

- 17 February 2009 for five attendees
- 3 March 2010 for the activities coordinator
- 30 September 2010 for 14 attendees
- 24 March 2011 for three attendees

On interview the registered nurse stated that training occurrs on orientation and two yearly.

Interviews with two caregivers confirm that the following topics were included in training:

definitions of restraint and enablers, required documentation and approval processes.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.1.1.6 Services that have no reported restraint use do not need to comply with NZS 8134.2.2 and NZS 8134.2.3. However, if and when a restraint event occurs, NZS 8134.2.2 automatically applies to that event.

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

There is no use of restraint.

Finding Statement

Corrective Action Required:

Timeframe:

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

STANDARD 3.1 Infection control management

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

ARC D5.4e ARHSS D5.4e

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

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

Responsibility for infection control is documented in the infection control policy. The registered nurse is the designated infection control coordinator with all staff being involved in infection control practice. External advice is available if necessary via Counties Manukau DHB. Monthly reports are submitted to the owner and staff are informed of the results. There is a procedure for required notification of diseases. The infection control programme is reviewed annually. The infection control programme was developed in consultation with an external expert and approved by the owners. There is a position description in place for the infection control coordinator. There are policies and procedures in place to protect residents, staff and visitors from spreading infections.

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:**

The responsibilities for implementing the infection control programme, policy and procedure review, surveillance, education, auditing, risk management and reporting to the owners, doctor and staff are defined within the infection control policies and procedures. The registered nurse is the designated infection control coordinator and she has a documented role and responsibilities. The infection control team consists of the entire staff with external expertise as required from Counties Manukau DHB (clinical nurse specialist) and the microbiologist from the laboratory.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.2 Reporting lines and frequency are clearly defined within the organisation including processes for prompt notification of serious infection control related issues.

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

The infection control coordinator is responsible for reporting to the owners, doctor and staff on a monthly basis results of monitoring activities and identified trends. The infection control coordinator is required to seek advice from the general practitioner, the clinical nurse specialist at Counties Manukau DHB or the Public Health Team in the event of an outbreak or notifiable disease.

The infection control policies include a section on notifiable diseases and the process for notifying the MOH.

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:**

There are comprehensive policies and procedures in place for infection prevention and control. The infection control coordinator is designated to develop, implement and undertake an annual review of the infection control programme. The infection control policy records at the footer the date of last review as being 6 February 2010.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.4 **The infection control programme is developed in consultation with relevant key stakeholders, taking into account the risk assessment process, monitoring and surveillance data, trends, and relevant strategies. The governing body/senior management shall approve the programme.**

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

The infection control policies and procedures record that the programme was developed in consultation with Terry Rings - an infection control consultant from Counties Manukau DHB. The infection control programme was approved by the owners.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.5 **There is a defined process for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation.**

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

The infection control policy specifies that advice is to be sought from the general practitioner, the clinical nurse specialist from Counties Manukau DHB and a microbiologist from the laboratory if necessary.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.6 **There is an infection control team/personnel and/or committee that is appropriate for the size and the complexity of the organisation which is accountable to the governing body/senior management and monitors the progress of the infection control programme.**

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

The registered nurse is the designated infection control coordinator. The entire staff comprise the infection control team.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.7 **The role of the infection control team/personnel and/or committee shall be clearly identified.**

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

The role and responsibilities of the infection control coordinator and staff is defined in the infection control policies and procedures.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.8 There is a clear process for early consultation and feedback with the infection control person/team, when significant changes are proposed to staffing, practices, products, equipment, the facility, or the development of new services.

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

Due to the small nature of the organisation, the infection control coordinator is involved in any decisions relating to staffing, practice, products, equipment, facility or development of services.

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:**

There are procedures in place for cough/sneeze etiquette, staff, residents and visitors with infections which minimise the risk of spread of infections. There is alcohol based hand sanitiser at the entrance and at strategically placed positions in the rest home and a sign on the door to alert visitors to use hand sanitiser on entry into the facility.

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:** Met

External advice is available. The infection control coordinator has received external training in infection control practice. The infection control coordinator in collaboration with all staff have implemented the programme. Diagnostic test results are filed in the clinical files.

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

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

The infection control policies and procedures specify that external advice is available from the general practitioner, a clinical nurse specialist at Counties Manukau DHB and a microbiologist from the laboratory. The infection control coordinator has attained a certificate in infection control from the polytech in 2007 in addition to attending the following external training:

- gastroenteritis on 10 March 2009

- management of multi resistant organisms (MROs) on 11 August 2009

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.2.2 The infection control team/personnel and/or committee shall facilitate implementation of the infection control programme.

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

The infection control coordinator is designated to implement the infection control programme in collaboration with staff.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.2.3 The infection control team/personnel members shall receive continuing education in infection control and prevention.

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

The infection control coordinator has attained a certificate in infection control from the polytech in addition to attending the following external training:

- gastroenteritis on 10 March 2009

- management of multi resistant organisms (MROs) on 11 August 2009

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.2.4 The infection control team/personnel shall have access to records and diagnostic results of consumers.

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

Results of diagnostic tests and other records are filed within the clinical records which the infection control coordinator had ready access to.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.3 Policies and procedures

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

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

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

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

The infection control policies and procedures are in accordance with current best practice for aged residential care and with this standard. All required policies and procedures are in the infection control manual. Policies and procedures have been developed with the help of an external advisor.

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

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

There are comprehensive policies and procedures in place for infection prevention control which make reference to current literature and are aligned with this standard and currently accepted good practice.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.3.2 Policies and procedures shall include but are not limited to:

(a) Hand hygiene;

(b) Standard precautions;

(c) Transmission-based precautions;

(d) Prevention and management of infection in service providers;

(e) Antimicrobial usage;

(f) Outbreak management;

(g) Cleaning, disinfection, sterilisation, and reprocessing of reusable medical devices (if applicable) and equipment;

(h) Single use items; and

(i) Renovations and construction.

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

All policies and procedures required by this standard are included in the infection control manual.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.3.3 **Policies and procedures (whether or not developed by contracted services or in-house services) that may affect the transmission of infection shall clearly identify who is responsible for the policy development and implementation, and shall be consistent with infection control policies and principles. Processes shall be in place to ensure ongoing infection control team/personnel involvement.**

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

The infection control coordinator in collaboration with a consultant from Counties Manukau DHB have developed the policies and procedures for infection prevention and control.

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:** Met

Staff receive ongoing education in infection control practice. This is provided by the infection control coordinator who is suitably qualified. Training is given during orientation and at regular intervals. The infection control coordinator tailors the content of education on current issues and current best practice. Residents and family members receive relevant education on infection control.

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:**

Infection control education is provided by the infection control coordinator who has attained a certificate in infection control and regularly attends external training - refer to criterion 3.2.3.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.4.2 **All service providers and support staff receive orientation and ongoing education on infection control that is relevant to their practice within the service or organisation.**

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

Training records were sighted for the following infection control education:

- 16 September 2009 for seven attendees
- 23 March 2010 for two attendees
- 3 September 2010 for 14 attendees
- 24 March 2011 for three attendees.

Staff are provided with training on infection control during orientation - confirmed by one caregiver on interview. Orientation records for one caregiver sighted from 13 April 2011.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.4.3 **Infection control education is evaluated to ensure the content is pertinent to the scope of service and reflects current accepted good practice.**

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

The infection control coordinator is designated to evaluate the content of infection control education. Content of infection control educations is determined by current issues, an example given was during the 2009 norovirus outbreak. On interview the registered nurse stated that attendees complete a questionnaire following education sessions - sighted for one caregiver from 24 March 2011.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.4.4 The content of infection control education sessions is documented and a record of attendance maintained.

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

Records of training sessions were sighted. This included names of attendees. Content of a session conducted on 9 February 2011 on ESBL and 12 May 2010 on infection control, and 15 June 2011 on standard precautions.

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:**

Residents are informed by the registered nurse about hand washing frequently and before meals. Otherwise education occurs on an individual basis as needed. An example described was a resident who had frequent urinary tract infections was provided with education on hand washing techniques.

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:** Met

Surveillance is conducted on a range of infections common in aged residential care. This includes multi resistant organisms. Surveillance is carried out by the infection control coordinator. Standardised definitions are used. Surveillance data are collated monthly and reported to the owners and staff. Results indicate there are relatively low rates of infection. There is evidence of communication between staff when residents have infections.

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:**

There is a section on surveillance in the infection control policies and procedures. This specifies that surveillance is conducted on infections common to long term care facilities and include wound and skin, urinary tract, respiratory tract, eye, nose and mouth, gastrointestinal tract, systemic infections and those caused by multi resistant organisms (MROs) including MRSA and ESBL.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.2 Surveillance shall be conducted on multi-resistant organisms and organisms associated with antimicrobial use.

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

Surveillance includes infections caused by MROs including MRSA and ESBL.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.3 Senior management and all service providers shall take responsibility for surveillance activities and promote surveillance monitoring as one of the premier quality assurance programmes impacting on consumer safety.

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

The policy designates the infection control coordinator as being responsibility for surveillance. On interview she confirmed she carries out surveillance activities.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.4 Standardised definitions are used for the identification and classification of infection events, indicators, or outcomes.

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

Definitions are detailed in the infection control policies and procedures. Standardised definitions are used in all documentation related to clinical issues and infection control.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.5 The type of surveillance to be undertaken should be appropriate for the organisation, including:

(a) Size;

(b) Type of services provided;

(c) Acuity, risk factors, and needs of the consumer;

(d) Risk factors to service providers.

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

Refer to criterion 3.5.1. Surveillance is undertaken on a range of infections common to residential aged care facilities.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.6 The surveillance methods, analyses, and assignment of responsibilities are described and documented.

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

Surveillance methods, analyses and responsibilities are detailed in the policy and implemented by the infection control coordinator. The infection control coordinator collates data on a monthly basis and records an analysis. This is tabled at monthly staff meetings - minutes viewed for 14 April, 11 May and 15 June 2011.

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:**

Results are analysed on a monthly basis and communicated to staff at monthly meetings - refer to criterion 3.5.6.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.8 **There is evidence of communication between services on consumers who develop infection.**

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

Review of five clinical files provides evidence of communication between care giving staff, registered nurses and general practitioner for residents with infections.

Finding Statement

Corrective Action Required:

Timeframe: