Brackenridge Estate Limited

Certification audit, Audit Report
Audit Date: 17-Aug-10

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Brackenridge Estate Limited

Premise Name	**Street Address**	**Suburb**	**City**
Brackenridge Estate - House 1	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 2	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 3	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 4	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 5	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 6	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 7	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 8	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 9	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 10	150 Maddisons Road	Templeton	Christchurch
Brackenridge Estate - House 14	150 Maddisons Road	Templeton	Christchurch
Oakhampton	71 Oakhampton Street,	Hornby	Christchurch
Iroquois	5 Iroquois Crescent,	Wigram	Christchurch

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

Type of Audit	Certification audit and (*if applicable*)	
Date(s) of Audit	**Start Date:** 17-Aug-10	**End Date:** 20-Aug-10
Designated Auditing Agency	Health and Disability Auditing New Zealand Limited	

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	Lisa Cochrane	RCompN, Health auditor cert	34.00	10.00	17 Aug- 20 Aug 2010
Auditor 1					
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor	Sandy Linton	Health auditor cert	34.00	7.00	17 Aug- 20 Aug 2010
Peer Review Auditor	Jim DuRose			1.00	

Total Audit Hours on site	68.00	**Total Audit Hours off site** *(system generated)*	18.00	**Total Audit Hours**	86.00
Staff Records Reviewed	14 of 215	**Client Records Reviewed** *(numeric)*	28 of 70	**Number of Client Records Reviewed using Tracer Methodology**	2 of 28
Staff Interviewed	32 of 215	**Management Interviewed** *(numeric)*	3 of 3	**Relatives Interviewed** *(numeric)*	4
Consumers Interviewed	18 of 70	**Number of Medication Records Reviewed**	42 of 70	**GP's Interviewed (aged residential care and residential disability)** *(numeric)*	

Declaration

I, (full name of agent or employee of the company) Lisa Cochrane (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.*

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

Dated this 12 day of October 2010

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
Brackenridge Estate - House 1	10	8		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge Estate - House 2	7	7		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge Estate - House 3	6	5		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge Estate - House 4	6	6		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge Estate - House 5	6	5		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge Estate - House 6	6	5		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐

Brackenridge Estate - House 7	3	6		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge Estate - House 8	6	5		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge Estate - House 9	6	5		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge Estate - House 10	6	5		☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐
Brackenridge Estate - House 14	6	4		☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐
Oakhampton	5	5		☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐
Iroquois	5	4		☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐

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

Executive Summary of Audit

General Overview

Brackenridge is a fully owned subsidiary company of the Canterbury District Health Board . The service mission is: “To provide a quality service which maximises the potential and enhances the quality of life for each resident of Brackenridge”. Brackenridge has its administrative base at 150 Maddisons Rd Templeton where they have 14 houses and an administration building. However they also operate an additional 15 houses in the greater Christchurch area and their plans for the future include further growing their services and for this future growth to occur in community settings throughout the Canterbury province.

As part of the scope of the audit, 11 houses were included at Maddisons Rd and two houses in the greater Christchurch area - Oakhampton house and Iroquiois house. The service continues a process of downsizing Maddisons Rd and developing wider community living options that are designed to meet the support and living options of the people using our services.

The service continues to have in place comprehensive policies and procedures to provide residential care for people with intellectual disabilities and the service clearly indicates that it is aware of appropriate direction for services for people with intellectual disabilities (to live an ordinary live).

In the 2010/2011 year a client service priority is to ensure all people at Brackenridge supports have circles of support in place. Circles of support are seen as fundamental to Brackenridge achieving its goals of clients living great lives as values, active and contributing members of their community.

The service provides a broad scope of services and this includes: a) to people with profound intellectual disabilities who are also physically impaired, b) to people with intellectual disabilities who require complex behaviour management, c) to people with intellectual disabilities who live in small community homes, and d) respite services.

1.1 Consumer Rights

Information is available to clients/family/whanau/guardians on the services provided and the Code of Rights. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Staff training reinforces an understanding of the rights of clients and their ability to make choices. Complaints are recorded and used for quality improvements. Care planning accommodates individual choices of clients.

Three clients, thirteen staff and 4 families interviewed confirmed the service promotes clients independence in activities of daily living.

There are improvements identified around documenting personal belongings, and informed consent forms

1.2 Organisational Management

Strategic, business (annual) and risk planning occurs. Statement of service objectives and performance measures include long and short term objectives. The annual Plan includes goals and objectives July 2010 - June 2011 for client objectives, vocational/employment, human resources, finance and business, quality, H&S, risk management and future directions. There is a documented risk register with mitigation strategies as part of the annual plan.

All objectives include performance measures and progress to meeting these is reported through meetings and reports to the board.

The current manager has been with the service for the last 11 years and has a number of years experience in management, health and with CYF.

The service has a quality and risk management system that is structured to support the safe provision of services as indicated by the service mission and philosophy statements. The service implements a comprehensive organisation monitoring system and data is analysed and reviewed by various committees to facilitate improvements to service delivery and mitigate risk. The board provides oversight to the performance of the organisation. Discussions with management identified that clients are involved at a house level and regular house meetings are encouraged in all houses.

The service has arrangements to access staff from agencies on an as required basis. The service has a well developed orientation programme that includes relevant aspects of service delivery to support entry of new staff into the service. Each house has a 'checklist for bureau staff'.

There is a comprehensive annual training programme and competencies have being implemented. Staffing levels reflect the needs of the people and the number of people in the house.

There are improvements identified around improving meetings and documentation at the houses, completing internal audits/action plans across all houses, I&A reporting, and sighing/dating documents.

1.3 Continuum of Service Delivery

26 files were reviewed (two in each 13 houses). Risk management plans and annual reviews were completed on files. Other plans were in place (where required) including epilepsy management plans, and 4 stage behaviours plan. All long term residents are assessed by a needs assessment coordination service prior to entry to the service. Personal plans are developed on entry by coordinators. In House one and two, the residents have greater phsyical needs and risk management plans are completed by the registered nurses. Person Centred Plans and My Goal action plans are developed and reviewed with the inclusion of relevant people such as the resident and were appropriate their family/whānau/guardian. Files continue to identify (where relevant) that behaviour and other associated plans are developed.

The level of resources, expertise and equipment provided by the service for residents is appropriate to meet their care and support needs. The service continually reviews different roles and responsibilities within the organisation to better meet the needs of the clients. They have experienced, trained and dedicated staff around behaviour support and vocational support. Person centred coordinators individualise the service received by clients.

There is a medication management system implemented across the homes in the Brackenridge estate and community homes within the wider community. While management of prn medication has clear guidelines in place . There are food policies/procedures for food services and menu planning is appropriate for this type of service. Dietitian input has been obtained for clients' requiring specialised dietary needs. Each house operates as a normal household. Clients' food preferences are identified and this includes consideration of any particular dietary preferences or needs.

There is improvements identified around managing medications and documentation, storing an dating of food, and completing all relevant documentation on client files.

1.4 Safe and Appropriate Environment

The estate was purpose built ten years ago, eleven of the houses being audited are part of an estate of fourteen houses providing services to people with an intellectual disability. The service is on a large area of land and is located in a semi rural environment south of Christchurch.

The estate is fenced around the perimeter boundaries. An automated gate is the main entrance way. Two community houses from the service are included in this audit. The Oakhampton house is located on a back section in the suburb of Hornby. The Iroquois house is in a cul

de sac in the suburb of Wigram. The thirteen houses are well maintained and have landscaped surroundings. Each house provides access to safe internal and external environments for the client groups. Outdoor seating and shade is available. The houses have an open plan kitchen/dining/lounge.

Another communal room is available at each house on the estate for use by clients. All bedrooms are single and personalised with clients belongings.

The thirteen houses are staffed twenty four hours a day. Furniture and fittings are selected with consideration to clients' abilities and functioning. Furniture is appropriate to each house setting and arranged to enable clients to mobilise safely. House one and two is larger and allows for mobility equipment. Floor surfaces are appropriate for the services provided and equipment is obtained as identified. There are adequate numbers of toilets and showers with access to a hand basins at each house. The service has in place policies and procedures for the management of laundry and cleaning practices. Implemented policies and procedures for civil defence and other emergencies are in place. There is staff on duty at each house with a current first aid certificate.

General living areas and client bedrooms are appropriately heated and ventilated. Clients have access to natural light in their rooms and there is adequate external light in communal areas of the houses. The service has a smoke free policy. 2 clients who smoke have designated smoking areas.

There are some improvements identified around Personal protective equipment, building warrant of fitness was not available at the Iroquois house.

The 2 community houses have no documentation for the testing of hot water temperatures, civil defence kits were not all regularly checked. Iroquois house has no civil defence kit or an emergency supply of water stored, Personal alarms for emergency situations are not worn by staff as per policy and a slide bolt lock is on a fire exit doorway.

2 Restraint Minimisation and Safe Practice

There is a restraint: policy & procedure that is appropriate for this type of environment. The purpose of the service restraint minimisation policy is to ensure that the implementation of any physical intervention is used safely, as a last resort after all de-escalation/redirection strategies have failed and in line with Non Violent Crisis Intervention (NVCI) best practice, with full regard and respect for the individual concerned and for all associated legal constraints. Extensive and comprehensive staff education in place – Non violent crisis intervention programme. The restraint policy includes management of equipment such as chair harnesses used as enablers.

There are clearly documented roles and accountability for restraint. The Restraint Coordinator is responsible for maintaining the restraint register and providing relevant information to the Restraint Review Committee. The Brackenridge restraint monitoring committee reviews / evaluate all episodes of restraint Intervention on a quarterly basis.

Any restraint intervention is identified in appropriate Person Centred Plans and Support plans developed in conjunction with the individual and / or their family / whanau / advocate / guardian and / or clinician and supported by employee training;

Brackenridge evaluates /review the use of restraint. This is done initially by the Service Coordinator and Manager upon receipt of the Restraint Management Form during their review. Each episode of non NVCI is documented on incident/accident forms, the restraint register includes reason for restraint and outcome.

The service continues to complete evaluations of restraint use and these are usually completed at plan reviews and also through the review committee.

Restraint has been reviewed by the service and records of this are maintained. Individual use of restraint continues to be reviewed through the use of incident reports and other documentation. Reports on the use and frequency of restraint are provided to the service board monthly.

3. Infection Prevention and Control

The Infection Control coordinator has in place a monthly reporting process for collecting a broad range of infection data and reporting this to the committee. The programme is reviewed annually. The service links with med lab south and this includes annual training for staff. The Infection Control Committee includes key management staff. Annual Infection control training is provided to staff. The infection control policies have been updated to reflect the Infection Control standards NZS 8134: 3 :2008.

Records of infection control education are maintained and were sighted on sampled staff files.

There is an infection control surveillance and analysis policy which outlines the purpose and methodology for the surveillance of infections. Antibiotics prescribed are identified and linked with the infection control system and all infections including multi resistant organisms are included on the house IC registers. Infection control data continues to be collated monthly and reported to the infection control committee. The service infection control committee monitors and tracks infection trends. Internal audits are still inconsistently completed across all houses.

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	4	0	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:41	PA:1	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	6	3	0	0	9
Standard 1.2.4	Adverse event reporting	Met	0	3	1	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	4	1	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	8	1	0	1	10

Organisational Management Standards (of 9):		Met:7	Not Met:0	N/A: 2	
Criteria (of 42):	CI:0	FA:27	PA:6	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	3	1	0	2	6
Standard 1.3.4	Assessment	Met	0	4	0	0	1	5
Standard 1.3.5	Planning	Met	0	3	1	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	4	2	0	1	7
Standard 1.3.13	Nutrition, safe food, and fluid management	Met	0	4	1	0	0	5

Continuum of Service Delivery Standards (of 13):		Met:12	Not Met:0	N/A: 1	
Criteria (of 55):	CI:0	FA:37	PA:5	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	5	1	0	0	6
Standard 1.4.2	Facility specifications	Met	0	6	1	0	0	7
Standard 1.4.3	Toilet, shower, and bathing facilities	Met	0	4	1	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	3	4	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:29	PA:7	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	5	1	0	0	6
Standard 2.2.1	Restraint approval and processes	Met	0	3	0	0	0	3
Standard 2.2.2	Assessment	Met	0	2	0	0	0	2
Standard 2.2.3	Safe restraint use	Met	0	6	0	0	0	6
Standard 2.2.4	Evaluation	Met	0	3	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	Met	0	1	0	0	0	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:6	Not Met:0	N/A: 2		
Criteria (of 30):	CI:0	FA:20	PA:1	UA:0	NA: 9

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	7	1	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:28 PA:1 UA:0 NA: 5

Total Standards (of 57) **Met:** 50 **Not Met:** 0 **N/A:** 7

Total Criteria (of 247) **CI:** 0 **FA:** 182 **PA:** 21 **UA:** 0 **N/A:** 44

Corrective Action Requests (CAR) Report

Provider Name: Brackenridge Estate Limited
Type of Audit: Certification audit
Date(s) of Audit Report: Start Date:17-Aug-10 End Date: 20-Aug-10
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: Lisa Cochrane

Std	Criteria	Rating	Evidence	Timeframe
1.1.10	1.1.10.1	PA Low	**Finding:** On twenty six files viewed (2 at each house), informed consent forms are being signed for by people other than a welfare guardian. **Action:** Ensure any informed consent forms are signed only by an appointed welfare guardian.	6 months
1.2.3	1.2.3.2	PA Low	**Finding:** Of the 13 houses visited, 10 houses did not demonstrate regular house meetings or documented follow up of any concerns raised. Client surveys are yet to be completed **Action:** Encourage houses to complete regular resident house meetings and follow through on concerns raised. Continue to work through developing client surveys	6 months
1.2.3	1.2.3.6	PA Low	**Finding:** Although the quality system is well established, many of the houses have not completed their required internal audits and action plans. Meeting folders in houses do not all have completed meeting minutes or records/feedback on quality data. **Action:** Ensure implementation of internal audits/corrective actions at house levels and feedback and feedback on the quality system at a service level	6 months
1.2.3	1.2.3.8	PA Low	**Finding:** Meeting minutes at all the houses (except house 7) have not consistently been completed including, there is lack of documentation to reflect discussions, no action plans and follow up **Action:** Meeting minutes at house level to occur on a regular basis, reflect discussion, and action plans	6 months

			were required.	
1.2.4	1.2.4.3	PA Moderate	**Finding:** A review of incident/accident report forms across all the houses identified that the forms were not always fully completed. The I&A register at each of the house was not kept up to date and in many cases did not differentiate who was a client and who was a staff member. **Action:** Ensure incident and accident forms are fully completed and the I&A register kept up to date	3 months
1.2.7	1.2.7.3	PA Low	**Finding:** 14 staff files were reviewed., a management confirmed that have been completing an overhaul on staff files to identify where documentation is missing and files are more structured. While noting the improvement that is made, 7 of 14 files did not have all completed documentation including orientation, appraisals. **Action:** Continue to update staff files to ensure all documentation is up to date and appraisals are regularly completed	6 months
1.2.9	1.2.9.9	PA Low	**Finding:** Of the 26 files that were reviewed across the service, 22 of 26 files had examples of documentation that was not signed by the writer or dated. **Action:** Ensure client records include signatures of the writers and dates.	6 months
1.3.3	1.3.3.3	PA Low	**Finding:** A review of 26 files across the 13 houses identified that although documentation was in client files, 14 of the files included plans that were not dated and signed and the monthly review action plans in four files from house one and two were not dated and signed. On weight charts viewed of twenty six clients' (2 at each house), twenty clients had not been weighed monthly. Documentation indicated weighing was irregular and in one case the client had been weighed once this year. **Action:** Ensure client goals, support plan, monthly reviews, risk management plans are signed and dated. To weigh clients' on a monthly basis as policy requires.	6 months
1.3.5	1.3.5.1	PA Moderate	**Finding:** Not all of the 26 client files reviewed (across 13 houses) had completed documentation as per policy, such as up to date goals, action plans, risk management plans, and weight records. **Action:**	3 months

			Ensure all required documentation is in client files and this is monitored.	
1.3.12	1.3.12.1	PA High	**Finding:** a) Across all houses, not all medications charted included dates; b) Transcribing onto drug charts and a number of blister pack signing sheets (where the pharmacy had not computerised what meds were included on the signing sheet) was completed in the two high needs houses (1& 2) also house eight; c) Documentation around management of prn medication had not been fully completed by staff in majority of houses, designation of staff member not documented in all records; d) In house two only 1/6 prn forms completed identified who had made the request; e) house four, six, seven and eight included a number of different prn forms; f) In house eight there were three signing sheets for Lorazepam, a number of signing sheets in the drug chart for old creams (not currently being given). One prn chart for resperidone had expired tabs, a further 28 tabs were added to the prn register without the expired resperidone tabs returned to pharmacy; g) in the majority of houses medication folders included a number of obsolete procedures around the management of prn medication and h) Iroquois medication documentation includes a number of errors. **Action:** The service should review the medication folders in all houses to a) remove obsolete procedures, and drug charts that are not current, b) ensure prn medication forms being used are current and all staff are implementing as per policy, and c) complete a regular audit of medication folders in all houses.	1 month
1.3.12	1.3.12.2	PA Moderate	**Finding:** In house four an incident form identified that resperidone tabs had been lost in the van during transportation of a client. The policies and procedures do not include the management of transportation of medication for those clients that are transported daily to outside activities. **Action:** Develop a procedure around management transportation of medication	3 months
1.3.13	1.3.13.2	FA Moderate	**Finding:** Fortisip (high energy, nutritionally complete drinks) with expired dates were found at house 2. **Action:** Ensure fortisip is not past expiry date.	1 month
1.3.13	1.3.13.5	PA Low	**Finding:** Fridge/freezer temperatures are not recorded at the houses. Uncovered food is in the fridge of house four. Food in the fridge at house ten had been taken out of the freezer and stored in the same bags as purchased in. These bags had labels with the date of purchase and use by date. It presented as food being 3 weeks past the use by date. **Action:**	6 months

			Record and document fridge/freezer temperatures. To store, date and label food taken out of freezer. To keep food covered in the fridge.	
1.4.1	1.4.1.6	PA Moderate	**Finding:** To provide PPE as per service policy. Protective aprons are not available in house 2. House four has one plastic apron. **Action:** To ensure personal protective clothing is available and stored in the designated areas at each house.	3 months
1.4.2	1.4.2.2	PA Low	**Finding:** The building warrant of fitness for the Iroquois house was not found at the time of the audit. **Action:** To obtain/produce the Iroquois house building warrant of fitness.	3 months
1.4.3	1.4.3.2	PA Low	**Finding:** The Oakhampton and Iroquois community houses have no documentation to support water temperatures are monitored. **Action:** To test and record hot water temperatures at the 2 community houses.	3 months
1.4.7	1.4.7.1	PA Moderate	**Finding:** House 2 has a slide bolt lock on the door to the laundry. This is a fire exit door and if the lock is in use, the door cannot be opened from the outside. **Action:** Remove the slide bolt lock.	1 month
1.4.7	1.4.7.3	PA Moderate	**Finding:** Oakhampton house and Iroquois house do not have copies of approved evacuations by the New Zealand fire service available . Oakhampton house and Iroquois house do not have documentation with dates of the last trial evacuations available. **Action:** For the Oakhampton and Iroquois houses to have an approved NZFS evacuation scheme. To have trial evacuations as per service policy.	3 months
1.4.7	1.4.7.4	PA Moderate	**Finding:** Civil defence kits in ten of the thirteen houses are not checked as required by the service. Iroquois house does not have a civil defence kit or water stored.	3 months

			Action: To ensure civil defence kits are regularly checked in all houses.Iroquois house to include stored water	
1.4.7	1.4.7.5	PA Low	**Finding:** Staff at the houses on the estate do not wear the personal security alarms (apart from house 6). **Action:** To wear the personal alarms as required by the service.	3 months
2.1.1	2.1.1.3	PA Low	**Finding:** Two residents in house one with physical disabilities and enablers in wheelchairs did not include completed documentation. **Action:** Ensure documentation is completed for all residents that are utilising enablers for safety/independence	3 months
3.5	3.5.7	PA Low	**Finding:** Internal audits are still inconsistently completed across all houses. **Action:** Ensure all internal audits are completed in each house and the results are analysed through the IC Committee.	6 months

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.

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

Client rights during service delivery are respected. Knowledge and understanding of rights is demonstrated by staff. Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights and relevant legislation.

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:**

On the 4 day audit, staff were observed to be incorporating knowledge of consumer rights and obligations as they carried out their duties.
Four family members interviewed stated their family person is treated with respect. Consumer Rights is included as a topic in the orientation introductory training package.
The learning and development training schedule has informed consent/advocacy scheduled for one and a half hour sessions. Dates are recorded for March, May, June, July, August, September, October and November 2010.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.

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 Code of Health and Disability Consumer's Rights 1996 is made available in appropriate formats when required. Clients and their families/whanau/guardian are informed of their right to complain and access an advocate. There is a policy on abuse and neglect.

Services are provided in a manner that is respectful of clients rights, facilitates choice, minimises harm and acknowledges cultural and individual values and beliefs. Staff receive training on the Code of Rights annually.

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:**

Policy requires a copy of the Code to be displayed in each house. A simplified version of the Code is in the houses where this is deemed appropriate. The majority of the houses included copies.
Where required a Maori version of the Code is to be in the house/s. Staff receive training on the Code at the time of orientation and thereafter at informed consent/advocacy education.

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:**

The Code of Health and Disability Consumers' Rights 1996 can be made available in appropriate formats to the communication preferences or needs of clients and their family/whanau/guardian.
A family information pack is available.
It contains: a) keeping safe when visiting, b) Code of rights, c) the latest newsletter, d) home agreement, e) the privacy act 1993, f) disclosure form information, and g) 'What you need to know about us' is a booklet. This includes the service mission statement, values, residential/accommodation service of what you should expect and what we expect of you. Your rights are listed and information on the health and disability commissioner is included.

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:**

The service indicated they can support clients in understanding the Code.
It can be read and explained to the client, family/whanau/guardian as required. This was confirmed through discussions with four relatives.

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:**

The service has advocacy processes available to clients. These include involving family/whanau/guardians or other representatives.
Information on the Nationwide Health and Disability Advocacy Service is available. The service will facilitate independent advocacy if requested or identified.

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.

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

Privacy of information policies and procedures is in place. The privacy officer is the general manager. Discussion about individuals are conducted in private. A physical and personal property policy is to ensure the privacy and dignity of individuals within the service is respected and met during service provision. It describes how this is achieved. Individuals' medical practitioner's records are kept in locked in storage in the house at all times. These notes remain the property of the Medical practitioner. Clients have their own bedrooms. Values and beliefs information is gathered on admission with family involvement and integrated with the client plans. Preferred names are identified and used by staff members. Thirteen support staff interviewed were respectful of clients' privacy. Independence and choice is identified. There is a policy on abuse and neglect.

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:**

Clients' have their own bedrooms to keep their possessions and personal property in. A record of personal belongings is held on personal files.
Staff are required to sign client confidentiality statements. Staff were maintaining visual and auditory privacy for clients' over the audit time.
13staff (across the 13 houses) said when they assist or attend to clients' personal hygiene and intimate care requirements they ensured privacy.
Client files were safely stored at the houses.
Improvement Note:
Review that person belongings are updated on client files.

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:**

Information of values and beliefs is gathered at the time of admission with client/family/whanau involvement and documented in the client plan.
Spiritual care needs are recorded and documented in the client file. Specific policies and procedures on Death and Dying are in place.
Interpreter services in the community are identified. Guidelines for cultural needs are identified in clients' personal files and plans.
There are thirteen clients' identifying as Maori.
Cultural training is provided to ensure the cultural and individual beliefs of clients are acknowledged and respected at all times.
There is a cross reference to the treaty of Waitangi in service documentation.

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:**

The clients' preferred name is clearly identified. Staff referred to clients' by their preferred name over the 4 days of the audit.
Staff observed addressed clients' respectfully.

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:**

A policy for spirituality and religious beliefs is in place. The service undertakes to support people and their family/whanau/welfare guardian to meet their spiritual needs as required, to respect the right of people to believe in their own religion or to have no religious beliefs.
Clients spiritual wishes are met as requested / indicated and supported to attend preferred church or other venue. Documented in personal plans as appropriate.
Brackenridge also works closely with a Chaplain (ENRICH Chaplaincy Services) who is able to provide supports for clients and their family / whanau in times of need.

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 friendship, relationships and intimacy policy recognises all individuals have the right to develop relationships and to decide the nature of those relationships.
Discussions with 13 support workers identified that the service acknowledges individual's choices and these are respected. Staff assist clients to access support and provide education on developing friendships/relationships as required.
The service acknowledges and respects consenting relationships.
Advised by coordinators that the service will intervene in any relationship that may be abusive or causing harm to the individual as guided by law.

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:**

Policy states clients will receive supports as required to meet any identified needs in the following areas: Communications, Participation in social valuing roles and meaningful activities, c) Life skills, d) Self care, e) Anger management, f) Sexuality, g) Mobility, and h) Cultural / Spiritual
Clients' preferences are identified through the planning process and recorded in their plans.
Each house has a structured daily routine for clients'. Discussion with clients confirmed they were happy and supported in their environment.
Staff at the houses support and encourages clients' involvement in attending community outings and recreational activities.
Discussions with four family and eighteen support workers confirmed client choice is supported.

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:**

Protection of individual's personal safety policy refers to the need to be safe from abuse, neglect and mistreatment.
This includes sexual, physical, financial and emotional or psychological abuse and neglect. The policy defines the types of abuse and types of neglect.
It states the actions that must be taken by the support staff, service co coordinator, manager and general manager.
Possible consequences if abuse is confirmed describes internal investigation and external investigation.
Thirteen staff interviewed (1 staff at each house), said they were not aware of any abuse and neglect issues.
4 family members interviewed said they had never seen any abuse or neglect.

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.

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 service recognises the specific needs that Maori clients may have. Policies are in place that recognise Maori and other cultural values, spiritual beliefs and practices. Policies discuss cultural safety in practice and identifies the importance of whanau for Maori.

The service has links to advisors and contacts. The 2010 learning and development training schedule includes 8 hours of cultural training.

The service has thirteen clients identifying as Maori. The Treaty of Waitangi is recognised in documentation and acknowledges spiritual, physical, mental and whanau needs of clients. Interpreter service are available to eliminate barriers. Values and beliefs are identified on lifestyle plans to support Maori residents and whanau, to ensure their needs are met safely.

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:**

Policies are in place to support Maori clients and whanau. The Treaty of Waitangi is recognised in key documentation.
The spiritual, physical, mental and whanau needs of clients is recognised.
Currently, the service has thirteen clients identifying as Maori.
13 staff interviewed were confident in their ability to respond to Maori clients and discussions with four person-centred coordinators and one health service coordinator described how planning the clients care includes considering cultural safety and needs.

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 are policies for the provision of culturally safe services for Maori clients.
Barriers to Maori are minimised by identifying and meeting clients' individual needs.
Care plans identify cultural needs and specific cultural interventions as they relate to the individual client.
The service can obtain further advice from a cultural aspect and support from various sources including whanau.
Cultural training is included in the 2010 learning and development training schedule.

Each Maori client at Brackenridge is treated as an individual and staff members work with their family / whanau to put in place what involvement they would like their person to have in relation to their culture, iwi and other things associated in being Maori. Advised that as with all clients the service recognises that the level of involvement can be dependent on the degree of involvement the person and / or their family / whanau wish.

The management team confirmed that the service recognises the special place that Maori have in New Zealand and recognise that the service needs to move forward in embracing cultural diversity. As a subsidiary company of the CDHB they have access to be able to receive cultural support on occasions that demand a more formal process.

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 service has policies in culturally safe practice for Maori in place. They provide guidelines to staff.
Cultural training for 8 hours is scheduled for September 2010. The policies around cultural and Maori responsiveness ensures clients identifying as Maori, receive services to meet their needs. Identified needs are recorded on their care plan.

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:

Currently the service has thirteen clients' identifying as Maori.
From viewing 2 files of clients identifying as Maori, the service supports and encourages them to practise their cultural values and beliefs. Staff have researched the lineage of descent and family history for these clients. Contact with whanau/family is maintained whenever possible.
A policy on cultural safety identifies the holistic framework of Te Whare Tapa Wha and acknowledges aspects of care and support that refer to the mental, physical, and spiritual and whānau for the well being of the person.
There are definitions of culture and a description of cultural safety.

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 importance of whanau and their involvement with the client is recognised and supported by the service in their policies.
The service states they involve whanau and their knowledge of the client during any service delivery.
This was evident on viewing 2 clients' personal files.

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 service recognises whanau play a vital role in the well being of Maori.
This is reflected in service policies.
The service can link to a local Maori Advisor and local Maori contacts.
Links are maintained with whanau.
Staff across the thirteen homes confirmed that families are involved as appropriate.

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.

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 and beliefs information is gathered on admission with client/family/whanau involvement. This is recorded and integrated on 'the what you need to know about me' plan for the client. Interpreter services are identified in the community. Practices are in place to observe cultural and or spiritual beliefs for death, dying and grief. Services are provided that are culturally safe and respect the identified values, beliefs and practices of clients'.

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:**

On admission, the service has a process to identify the clients' values and belief requirements. The service is respectful and supportive of the clients' rights to participate in their usual practices. Information is gathered at the time of entry to the service, with client and family/whanau involvement. This information is then placed on 'the what you need to know about me' plan. Opportunities are provided to allow clients' to practice their beliefs.
Values and beliefs of an individual are considered at all times.

Brackenridge has concentrated on improving the input / relationships of the clients' family both as an organisation and on an individual basis for clients. Management stated that it has been apparent that this has been easier to achieve with new families entering the service in comparison to families of clients who have come through the de-institutional process.

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:**

Twenty six personal files viewed (2 at each house), showed discussion and consultation with clients and family /whanau to identify client individual values and beliefs and likes and dislikes have occurred.
These are reviewed, assessed and updated as required.
Family is identified at the time of admission.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

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

Discussions with eighteen support staff indicated they are aware of the negative impact of discrimination. Clients are not coerced, harassed or exploited in any way. Family/whanau and welfare guardians are identified on personal files.

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 are Policies and Procedures in place that include (but not limited to): a) abuse and neglect, b) code of rights, c) complaints and neglect.
Human Resource policies include police checks.
The Code of Rights and Responsibilities states clients will not be subjected to discrimination, harassment, coercion and sexual or other exploitation in decision making.
Discussions with eighteen staff indicated they are aware of the expectations around these issues. House meetings allow freedom for discussion of any concerns.

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:**

The service has policies for staff to ensure ethics and professional boundaries are maintained.
Discussions with eighteen support staff reinforced professional boundaries. Regular training sessions are provided to staff around 'Positive behaviour support'. Coordinators oversee a number of houses each and support staff to ensure professional boundaries are maintained.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

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 service has policies and procedures and associated systems implemented to provide a good level of assurance that they are meeting accepted good practice and adhering to relevant standards. The service has ongoing internal staff training and education with an annual learning and development training schedule. Reporting systems are linked to open disclosure and quality improvement processes.

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:**

The service has policies and procedures for providing consistent and continuity of quality of care with ongoing training for staff.
Reporting systems are linked to quality improvement processes.
The annual learning and development training schedule shows a range of ongoing opportunities for internal training and education.
Recruitment processes are in place to ensure staff employed are fit to carry out their roles in a competent manner.
Ongoing training, supervision and budding is offered so the services are of a consistently acceptable level and is flexible to change where the need arises and any new practices are learnt.
Care plans are available for staff to follow and to provide consistency of care.
Professional assistance/guidance/advice is sought from appropriate health professionals in an effort to seek/provide the best care possible.
Policies and procedures encourage good practice.
The manager stated that where practice was below standard it is identified and managed appropriately.

The service provides staff orientation for new staff. It operates an orientation programme for all new/transferring employees and/or students on placement called 'Being a Buddy'. The new staff person works alongside of a staff member. There is a support staff orientation task sheet to support this process.
There are 'behaviour support' specialists on staff.

All staff attends induction training and are buddied with senior staff when initially commencing employment. Staff education programme in place.
All homes we operate are maintained to a high standard and provide warm, dry appealing living environments that are homely. By providing a quality living and work environment we believe this contributes to staff working at an optimum level of performance.

At Brackenridge we have a high commitment to training and self development and have invested heavily in the Careerforce programme as they inherently believe that having a better trained and skilled workforce will lead to higher standards of practice across the organisation. .

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.

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 environment at the service is conducive to effective communication. Staff do not wear uniforms or name tags and this is appropriate for the service. Interpreters can be accessed locally. Sufficient time for discussion to take place in an appropriate place is provided to clients/family/whanau and staff.

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

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

An open disclosure policy is in place. The policy requires that any client harmed as a result of a mistake or error must be acknowledged to the client and their family/whanau/representative as soon as possible after the event is identified.
It includes acknowledgement, openness, timeliness and clarity of communication, apology, recognition of the reasonable expectations of clients and their family/whanau/representative, confidentiality and ongoing care.

Finding Statement

Corrective Action Required:

Timeframe:

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:**

The management said the service allowed plenty of time for discussions to take place. There are ongoing opportunities for staff and families to ask questions if necessary and privacy was assured. Discussions with eighteen support staff and four families supported this.
Some clients' living in the houses are limited in their communication abilities but staff said they were included as much as possible and this was visualised on visiting the houses.

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:**

Staff do not wear a uniform or name tags. This is appropriate for the service.
Visitors are identified at the front door by staff.
The service tries to maintain consistency for staff placement in houses.
Casual staff and bureau staff are usually placed with a staff known to the client group.

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:**

The service can access local translation services if required.
Currently there is no need for interpreters to be used in the service.

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.

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 policy for the Code of Health and Disability Consumer's Rights, Informed Choice and Informed Consent is in place. This includes implemented policies/procedures for informed consent. Informed consent training is identified on the 2010 learning and development training schedule.

Routine situations for informed consent are identified. The service does not record advanced directives for their clients. This is appropriate for the service. Discussions with staff at the thirteen houses showed an understanding of the key principles for the Code of Consumer Rights and informed consent. Informed consent forms are being signed by people other than a welfare guardian.

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

An informed consent policy is in place.
The service has documentation for recording informed consent for routine situations.

Finding Statement

On twenty six files viewed (2 at each house), informed consent forms are being signed for by people other than a welfare guardian.

Corrective Action Required:

Ensure any informed consent forms are signed only by an appointed welfare guardian.

Timeframe:

6 months

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:**

The service acknowledges any client requiring particular treatments or therapy, would be given the information in a manner that would be best understood by the client.
They would be included as much as possible in any planning of care and support systems put into place for them as required and as necessary.
Interpreter and advocacy services are identified and can be accessed if required.

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

The service acknowledges informed consent is a process and not a one-off event.
18 support staff and four coordinators interviewed said they try to give clients' information in a manner that they can understand.
Staff interviewed demonstrated an awareness of the differing communication needs of clients'.
This was observed on the day of the audit.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The service has policies and procedures that address the requirements of recording requirements, information and consent processes.
Twenty six personal files (2 at each house), viewed had routine consent processes documented.

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 learning and development training schedule for 2010 identifies informed consent training was provided for staff in March, May, June, July, August and is scheduled for September, October and November.
A record of names of staff attending is maintained.
Discussions with eighteen support staff across the thirteen houses indicated they are aware of the residents right to effective communication.

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:**

On twenty six client files viewed (2 at each house), documentation supported clients' have choice.
Discussions with thirteen staff indicated clients' at each house are supported to ensure their wishes are implemented.
The staff described client choices were recorded and discussed ways in which they were acted on for the clients' at each house.
There is a lifestyle plan for each client called 'what you need to know about me' on their personal file.

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:**

The service does not record advance directives and this is appropriate for the service.

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.

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

Client access to advocacy meets the requirements of the Code of Health and Disability Services Consumers' Rights. The service acknowledges the clients' right to an advocate and can assist the client/family/whanau to access advocacy services. Staff are aware of the right for advocacy.

Advocacy training for staff is included in the annual learning and development training schedule.

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:**

An advocacy policy encourages people to have an identified personal advocate who may be a family member, friend, welfare guardian or someone selected by an advocacy service. It includes information on accessing the Advocacy Services South Island.
The service will facilitate advocacy as required or requested.
2 of 4 family members interviewed knew how to access independent advocacy service.

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:**

The service has policies in place to facilitate advocacy and independent advocates.
Advocacy training is included annually on the learning and development training schedule.

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:**

Service providers receive training on advocacy.
The 2009 learning and development training schedule records training was provided on advocacy in February, March, April, May and June.
For 2010, training on advocacy occurred in March, May and June.
18 support workers interviewed were able to identify when advocacy would be appropriate and knew how to access independent advocacy. Information on Advocacy services is available.

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.

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 service has visiting arrangements that are suitable to clients/ and family/whanau. Clients are fully supported to access services and outings within the community and to maintain family links.

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

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

A policy for visitors is in place.
Visitors are free to visit whenever they choose within normal waking hours.
Visits outside these hours need to be pre arranged.
Visitors are asked to respect others living in the house.
People may entertain visitors in their own rooms as appropriate and eight clients described having visitors/friends come to visit.
Support workers stated that they monitor the appropriateness of visitors.

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:**

The service provides transport and fully supports and encourages clients to access and to be involved in a variety of community outings and community services. 18 support workers interviewed said clients' are supported to access services within the community, both on an individual basis and in organised groups. Discussions with four family supported this.
Clients attend schools and community based day programmes. There are opportunities provided for clients' to participate in a variety of activities, programmes and social opportunities in the community. Examples are: art classes, shopping, cafes, RDA, holidays, outings The staff encourage residents to have an active social life. Each residential house has a van and during the audit clients were busy accessing a number of outside activities with support by support workers.

Management stated that Brackenridge has really worked hard for people to have inclusive living experiences and the range of experiences people are now involved in is very extensive. People who have historically experienced difficulty in community participation are now engaged in a more inclusive lifestyle with appropriate supports. Through the Vocational Service they have people involved in delivering Meals on Wheels / a number have their own business and have community based contracts. The range of activities and social events people are involved in is huge and continues to grow.
While visiting house one, a vocational worker was assisting a client with computer activities/learning.

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.

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 service has in place relevant complaint management policies and procedures. The complaint process is in a format that is able to be understood and it is accessible to clients'/family/whanau and staff. The complaints process supports access to advocacy services. The right to complain is understood and respected by clients'/family/whanau and staff. The complaints process is fair and responsive.

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 complaints policy purpose is to ensure complaints are dealt with promptly and thoroughly and in a fair and equitable manner.
The process includes timeframes for responding. The policy identifies the need to keep the complainant informed.
Support can be arranged through advocacy services if required. Complaints are viewed as tools to improve and develop the quality of service provided.

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 process is in a format that is able to be understood and it is accessible to residents/family/whanau..
Clients/family/whanau are provided with relevant complaints information at the time of admission.
The complaints process is available at each house.
Three clients and four family members interviewed said they knew how to make a complaint.

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 service has a register to maintain complaints. Complaints received include the dates and actions taken.
The register is up to date.

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.

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 service is a fully owned subsidiary company of the Canterbury District Health Board . The service mission is: "To provide a quality service which maximises the potential and enhances the quality of life for each resident of Brackenridge".

Strategic, business (annual) and risk planning occurs. Statement of service objectives and performance measures include long and short term objectives. The annual Plan includes goals and objectives July 2010 - June 2011 for client objectives, vocational/employment, human resources, finance and business, quality, H&S, risk management and future directions. There is a documented risk register with mitigation strategies as part of the annual plan.

The service continues a process of downsizing Maddisons Rd and developing wider community living options that are designed to meet the support and living options of the people using our services.

Brackenridge has its administrative base at 150 Maddisons Rd Templeton where they have 14 houses and an administration building. However they also operate an additional 15 houses in the greater Christchurch area and their plans for the future include further growing our services and for this future growth to occur in community settings throughout the Canterbury province.

As part of the scope of the audit, 11 houses were included at Maddisons Rd and two houses in the greater Christchurch area - Oakhampton house and Iroquois house. All objectives include performance measures and progress to meeting these is reported through meetings and reports to the board. The current manager has been with the service for the last 11 years and has a number of years experience in management, health and with CYF.

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:**

The service is a fully owned subsidiary company of the Canterbury District Health Board.

The service mission is: "To provide a quality service which maximises the potential and enhances the quality of life for each resident of Brackenridge".
The service values continue to recognise the inherent worth in every person and recognition of the uniqueness of each person.
The service philosophy remains: "To provide the support necessary to ensure that there is a maximum level of independence and all residents have the opportunity to access the range of services required to meet their individual needs within a culturally safe environment in keeping with national and international 'best practice' standards."

The service has identified five priority areas as part of their 2009 - 2012 strategic plan:

1. Ensuring all people we support are living very good lives.
2. Ensuring all people we support have the option to live in their own home with people they choose to live with.
3. All people we support have the right to work and we will make strong efforts to find employment for people who want to do paid work. We also recognize and foster entrepreneurship
4. All people we support should have active Circles of Support in place which include family, friends and important others.
5. We want to have a well trained, qualified workforce.

Strategic, business (annual) and risk planning occurs. Statement of service objectives and performance measures include long and short term objectives for a) He Korowai Oranga, b) Client Services, Quality / Continuous Improvement, c) Develop our Workforce, d) Successful Renegotiation of Collective Contract 2010 -2012, and e) Employment and Vocational Services

The annual Plan includes goals and objectives July 2010 - June 2011 for client objectives, vocational/employment, human resources, finance and business, quality, H&S, risk management and future directions.
There is a documented risk register with mitigation strategies as part of the annual plan.

The service continues a process of downsizing Maddisons Rd and developing wider community living options that are designed to meet the support and living options of the people using our services.
Brackenridge has its administrative base at 150 Maddisons Rd Templeton where they have 14 houses and an administration building. However they also operate an additional 15 houses in the greater Christchurch area and their plans for the future include further growing our services and for this future growth to occur in community settings throughout the Canterbury province.
As part of the scope of the audit, 11 houses were included at Maddisons Rd and two houses in the greater Christchurch area - Oakhampton house and Iroquois house.

All objectives include performance measures and progress to meeting these is reported through meetings and reports to the board.

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:**

As a wholly owned subsidiary company of the Canterbury District Health Board, Brackenridge has its own Board of Directors. Currently the board reports on its activities quarterly to its shareholder (CHDB) and quarterly reporting on operations performance to Moh. The Board currently meets monthly with a sub-committee available for Finance and Risk Management.
The general manager provides monthly reports to the board that includes reports from vocational services report, client service report, support services reports, organisational development, finances reports, risk management report and special projects.

There is an internal audit programme in place that covers finance, health and safety and risks to the organisation.

The quality council meeting occurs monthly and includes the general manager, manager organisational development, person centred coordinator and one staff member from each home. Meeting minutes are available at each house for all staff.
Quarterly reporting of high-level risks is monitored and reported to the board.

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 current manager has been with the service for the last 11 years and has a number of years experience in management, health and with CYF. He is supported
Master of Arts Social Work. There is an organisational chart and a number of managers in a variety of roles across the organisation with key responsibilities.

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.

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 service ensures the availability of appropriately trained and designated replacement when the manager is temporarily absent. The service continues to have in place comprehensive policies and procedures to provide residential care for people with intellectual disabilities and the service clearly indicates that it is aware of appropriate direction for services for people with intellectual disabilities (to live an ordinary live).

In the 2010/2011 year a client service priority is to ensure all people at Brackenridge supports have circles of support in place. Circles of support are seen as fundamental to Brackenridge achieving its goals of clients living great lives as values, active and contributing members of their community.

The service provides a broad scope of services and this includes: a) to people with profound intellectual disabilities who are also physically impaired, b) to people with intellectual disabilities who require complex behaviour management, c) to people with intellectual disabilities who live in small community homes, and d) respite services.

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:**

The service ensures the availability of appropriately trained and designated replacement when the manager is temporarily absent. This is the manager organisational development. There is also a senior management structure that is able to provide support.

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 service continues to have in place comprehensive policies and procedures to provide residential care for people with intellectual disabilities and the service clearly indicates that it is aware of appropriate direction for services for people with intellectual disabilities (to live an ordinary live).
In the 2010/2011 year a client service priority is to ensure all people at Brackenridge supports have circles of support in place. Circles of support are seen as fundamental to Brackenridge achieving its goals of clients living great lives as values, active and contributing members of their community.

The service provides a broad scope of services and this includes: a) to people with profound intellectual disabilities who are also physically impaired, b) to people with intellectual disabilities who require complex behaviour management, c) to people with intellectual disabilities who live in small community homes, and d) respite services.

Key roles in the organisation are completed by qualified staff to ensure the needs of the clients and the goals of the organisation are met including (but not limited to) a) behaviour support coordinator, b) person centred coordinators, c) vocational manager, d) communication and technology coordinator, e) health service coordinator.

There is a focus on vocational activities through employment/activities and volunteer work. Support staff are provided with a comprehensive orientation and ongoing training programme.

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.

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 service has a quality and risk management system that is structured to support the safe provision of services as indicated by the service mission and philosophy statements. The service implements a comprehensive organisation monitoring system and data is analysed and reviewed by various committees to facilitate improvements to service delivery and mitigate risk. The board provides oversight to the performance of the organisation. Discussions with management identified that clients are involved at a house level and regular house meetings are encouraged in all houses. The service is also working towards developing a suitable client survey tool. The service policies, procedures and practices are structured to meet the requirements of the standards that relate to this service as identified in the Health and Disability Services (Safety) Act. The service continues to implement an internal monitoring system and a computer based analysis system enables the aggregation of key data into performance measurement information. The service continues to have a process in place for measuring achievement against its quality and risk plans. There is a current annual plan which is reviewed through the quality council and at a board level. The service has an established health and safety programme. Risks are identified and communicated at health and safety meetings. H&S meetings are held regularly and they include representation (where possible) from some of the homes. There are improvements identified around improving meetings and documentation at the houses, completing internal audits/action plans across all houses.

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:**

The service has implemented systems for the management of quality and risk.
There is an implemented system of monitoring that includes (but is not limited to): a) the collection of incidents and accidents data, b) collection and responding to complaints, c) collection of infection data, d) medication records monitoring (including errors recording), and e) training records are retained. Data is collated and reports completed that enable the organisation to assess risk and determine the effectiveness of the implementation of the quality management system.
The supervisor positions are now established and these roles are structured to support service delivery (including identifying and managing risks). Relevant committees are established to guide service development and management of risk; e.g., health and safety committee, infection control committee. The service has also facilitated staff into formal training as part of the overall programme of development. While quality and risk processes are being implemented at an organisational level, some improvements have been identified around coordination from the house level.

The board provides oversight to the performance of the organisation.

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

Discussions with management identified that clients are involved at a house level and regular house meetings are encouraged in all houses. The service is also working towards developing a suitable client survey tool.
A relative survey has been sent out 6 weeks ago and advised that results will be collated and analysed on return. (previous survey 2008)
There is an appointed family member on the board. The service runs annual family information evenings (at least three a year).

Finding Statement

Of the 13 houses visited, 10 houses did not demonstrate regular house meetings or documented follow up of any concerns raised. Client surveys are yet to be completed

Corrective Action Required:

Encourage houses to complete regular resident house meetings and follow through on concerns raised. Continue to work through developing client surveys

Timeframe:

6 months

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:**

The service policies, procedures and practices are structured to meet the requirements of the standards that relate to this service as identified in the Health and Disability Services (Safety) Act.
The service also has established health and safety policies and procedures and discussions with staff confirm that the service take action to minimise the risk to staff, visitors and residents.
There are relevant employment practices in place.
The service has reviewed and updated its policies and procedures and associated systems to align with HDSS 2008.
Policies reflect current good practice, are resident focused and includes managing of behaviours and de escalation. There is also clinical policies and procedures to manage some of the high physical needs of clients in house 1 and 2.

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:**

Policy and procedure documents no longer relevant are to the service are removed and archived in an obsolete policy procedure folder.
The service maintains a master folder and all discontinued documentation is stored off site by a professional company. Policies and procedures are reviewed on a regular basis and policies into reference to related documents and resources.

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 system is managed through the monthly quality council.

a) Incidents and accidents are reported at house level and forwarded to coordinators. There is an I&A register at each house that includes clients and staff. Event reporting is analysed at the quality council. The person centred co-ordinator monthly report includes analysis of incidents and accidents across the service
b) Complaints are an agenda item at the quality council meeting and manager reports to the board include complaints.
c) The service has maintained its infection control monitoring system. Infection control data continues to be collated monthly and reported to the infection control committee. Trend data is analysed monthly and monthly data is aggregated into annualised data.
The service senior management are provided with monthly infection control information and trends are communicated to the board.
d) There is a H&S committee that meets regularly, hazards and staff incidents/workplace issues are addressed at the meeting. Minutes are forwarded to staff and kept in folders in each house.
e) Restraint is an agenda item at the quality council and any episode is reviewed through the behaviour support coordinators.

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

Internal audit programme 2010 for H&S, medication, and documentation.
The service continues to implement an internal monitoring system and a computer based analysis system enables the aggregation of key data into performance measurement information.
Internal monitoring includes (but is not limited to): a) incidents and accidents reporting, b) medication error reporting, c) infection control monitoring, d) retaining maintenance records, e) some internal audits, f) complaints and g) health and safety records.
The meetings structure continues and this includes (but is not limited to): a) board meetings, b) executive management meetings, c) management meetings, d) health and safety and quality meetings, e) coordinator meetings, f) infection control meetings, and g) house meetings.
Reports are provided to the quality council from key staff.

Finding Statement

Although the quality system is well established, many of the houses have not completed their required internal audits and action plans. Meeting folders in houses do not all have completed meeting minutes or records/feedback on quality data.

Corrective Action Required:
Ensure implementation of internal audits/corrective actions at house levels and feedback and feedback on the quality system at a service level

Timeframe:
6 months

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 service continues to have a process in place for measuring achievement against its quality and risk plans.
There is a current annual plan which is reviewed through the quality council and at a board level.
The service also has included a risk management plan that his reviewed annually be the board.
The general manager reports to the board in relation to the overall performance of the organisation and service development issues are also communicated to the board.
A staff performance review structure exists which supports an assessment of performance aligned with the intent of the organisation.
The general manager reports to the board in relation to quality targets including (but not limited to): a) use of PRN, b) assaults on staff, c) assaults on residents, d) medication errors, e) client activity, and f) service demand. Reports are also submitted from the manager organisational development and these reports include information in relation to key aspects of organisation development such as: a) quality, b) occupational safety and health, c) infection control, d) education. Service development issues are also communicated to the board.

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: PA

Risk level for PA/UA: Low

There is a comprehensive meetings structure that is used to communicate the results of monitoring data.
The meeting structure includes (but is not necessarily limited to): a) board meetings, b) executive management meetings, c) management meetings, d) health and safety and quality meetings, e) coordinator meetings, f) advanced practitioner, and g) house meetings.
Organisation meeting minutes are well structured. Minutes indicate that the service takes actions to address service delivery, quality, staffing and risk.

Finding Statement

Meeting minutes at all the houses (except house 7) have not consistently been completed including, there is lack of documentation to reflect discussions, no action plans and follow up

Corrective Action Required:
Meeting minutes at house level to occur on a regular basis, reflect discussion, and action plans were required.

Timeframe:
6 months

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:**

The service has an established health and safety programme. There is a health and safety manual that guides health and safety practices.
Risks are identified and communicated at health and safety meetings. H&S meetings are held regularly and they include representation (where possible) from some of the homes. H&S Committee Minutes identifies action points.
Visitors to the service are required to be identified.
The service has implemented systems to increase the level of security.
An organisation wide risk assessment has been developed and is approved by the general manager. Roles have been developed within the organisation to manage some of the identified risks i.e.: behaviour support coordinators.
The internal monitoring framework is used to identify emergent risks. Information relating to incidents and risks are reported to the board and discussions with the service indicate that the board is responsive to the reports and that it seeks assurance that risks are mitigated strategy 2008 - 10. Hazard forms are implemented and an annual hazard register is reviewed.
The service is currently working towards obtaining ACC WSMP.

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.

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 service has incident and accident reporting procedures and it documents and analyses incidents and uses this to adjust service delivery. Incidents are collated and reported to the board. Incidents are broken down in relation to type of incident and from which house. Monthly analysis reports are provided.
The service has identified situations in which it would need to report and notify statutory authorities and this includes: a) notifiable diseases, b) death, c) abuse and neglect, d) notification and serious harm. A review of incident/accident report forms across all the houses identified that the forms were not always fully completed. The I&A register at each of the house was not kept up to date and in many cases did not differentiate who was a client and who was a staff member.

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:**

The service has an accident / incident process that is documented.
The service identifies accidents and incidents (e.g., through Hazard Identification forms and accident and incident report forms).
The incident reporting system is implemented and an analysis of incidents occurs. Incidents data is analysed and reported to the board. Data is collated monthly and comparative data between years is reported.
Incidents are collated and reported to the board. Information provided to the board is aggregated. Incidents are broken down in relation to type of incident and from which house. Monthly analysis reports are provided.

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:**

The service has identified situations in which it would need to report and notify statutory authorities and this includes: a) notifiable diseases, b) death, c) abuse and neglect, d) notification and serious harm.
Discussions with staff confirm that they report essential notifications and that authorities are notified for relevant events.

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

The service has incident and accident reporting procedures and it documents and analyses incidents and uses this to adjust service delivery. The service has processes and behaviours support staff to manage incidents of behaviour including identifying those at risks and implementing comprehensive risk management plans.
Staff can describe the incident reporting process and communicate that they are aware of the need to complete incident and accident reports.
Risk management plans are in place to manage incidents and reporting occurs when incidents happen.
There are various meetings between staff and management that are structured to address risks and events that emerge, although note some improvements have been indented at a service level.

Finding Statement

A review of incident/accident report forms across all the houses identified that the forms were not always fully completed. The I&A register at each of the house was not kept up to date and in many cases did not differentiate who was a client and who was a staff member.

Corrective Action Required:
Ensure incident and accident forms are fully completed and the I&A register kept up to date

Timeframe:
3 months

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:**

Brackenridge has developed a robust policy around open disclosure and from discussions with management identified that they are committed as an organisation to the intent of the policy and endeavour in all cases to be open and transparent in our dealings with our clients staff and families. Staff are currently engaged in ongoing education around this. Four families confirmed excellent communication.

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.

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 job descriptions in place and appropriate human resource policies/procedures in place for staff recruitment, training and support. There are position descriptions for all staff and these detail relevant information to guide performance. There is a comprehensive annual training programme and competencies have being implemented. Professional qualifications are validated. The service has a selection process for the appointment of new staff and this includes relevant recruitment, screening and selection processes. The service has arrangements to access staff from agencies on an as required basis. The service has a well developed orientation programme that includes relevant aspects of service delivery to support entry of new staff into the service. Each house has a 'checklist for bureau staff'. 4 staff files were reviewed, management confirmed that have been completing an overhaul on staff files to identify where documentation is missing and files are more structured. While noting the improvement that is made, 7 of 14 files did not have all completed documentation including orientation, appraisals. There is a comprehensive annual training programme and competencies have being implemented.

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:**

There are job descriptions in place and appropriate human resource policies/procedures in place for staff recruitment, training and support. There are position descriptions for all staff and these detail relevant information to guide performance.
The service continues to review their current structure and are in the process of changing some of the roles for effectiveness.
The service has a number of specialised positions including two Behaviour Support Coordinators trained through Institute of Applied behaviour analysis (IABA), Vocational manager and communication and technology coordinator.
The service has job descriptions for the new positions. Job descriptions include (but may not be restricted to): a) statements of organisation mission and values, b) purpose of the position, and c) key tasks. Performance contracts are identified with senior staff and these identify goals and objectives of the role.

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:**

Professional qualifications are validated. Practicing certificates of health professionals operating in the service are indicated as being retained. Checks are made of general practitioner practice registration and copies of these are available.

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

The service has a selection process for the appointment of new staff and this includes relevant recruitment, screening and selection processes. The service has arrangements to access staff from agencies on an as required basis. Each house has a 'checklist for bureau staff'. In House 1there is a RN/EN duty list and guidelines for agency staff.
The service has a recruitment/employment procedure that requires (but is not limited to) that: a) applicants are interviewed by an interview panel consisting of 2 coordinators, consumer representative or family, b) applicants permission to contact referees is obtained and records of contacts made, and c) applicants are required to sign a consent to disclosure of convictions form.
The recruitment process identifies supporting documents including: a) collective employment agreement, b) staff application pack, c) job description, d) privacy act, e) referee check, f) consent to disclosure of convictions form, and g) staff orientation programme.

Finding Statement

14 staff files were reviewed., a management confirmed that have been completing an overhaul on staff files to identify where documentation is missing and files are more structured. While noting the improvement that is made, 7 of 14 files did not have all completed documentation including orientation, appraisals.

Corrective Action Required:
Continue to update staff files to ensure all documentation is up to date and appraisals are regularly completed

Timeframe:
6 months

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:**

The service has a well developed orientation programme that includes relevant aspects of service delivery to support entry of new staff into the service.
The orientation includes both on-site support of staff in the service and the provision of training in relation to: a) communication, b) essential information, c) overview of intellectual disability, d) introduction to challenging behaviour, e) worker responsibilities, f) introduction to infection control, and g) health and safety. The mission and values of the service are included in the orientation pack.
An orientation task sheet and orientation checklist.
A buddy system has been set up. For staff to be a buddy supporting new staff they must be an advanced practitioner and have assed level 1 medication, NVCI and fire training.

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:**

[There is a comprehensive annual training programme and competencies have being implemented. The service maintains training records of training and education provided to staff. The service has training plans (e.g., for the Non-violent Crisis Intervention programme).

There is an education facility and education opportunities are provided. There is a careerforce assessor and the service currently has 40 support workers in the process of completing either foundations two or three.

There is regular training sessions completed at regular intervals during the year to ensure all staff can access them including ; a) Non-violent Crisis Intervention programme, b) medication training/competency, c) what you need to know about me training, d) positive behaviour support training, e) epilepsy training and f) fire training.

The specific behaviour support coordinators and active support trainer that provides 'current best practice' training to staff.

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.

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 staffing policy. The service policy is that (in the absence of unusual circumstances) if there are six people in a house there are two staff per shift (day & evening) and awake staff at night. Complexities of clients impact on this. Staffing levels reflect the needs of the people and the number of people in the house.

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:**

The manager advised that staffing levels in each house are determined by the level of revenue coming in to the house as well as the number of people living there and their needs. There is a staffing policy. The service policy is that (in the absence of unusual circumstances) if there are six people in a house there are two staff per shift (day & evening) and awake staff at night. Complexities of clients impact on this. Staffing levels reflect the needs of the people and the number of people in the house.
For House 1 and 2; with 8/10 clients and 7/7 clients, staffing is at one RN & ENs per shift as well as 2 support staff and awake staff at night.
Staffing may vary with the number and abilities of the people being supported.

There are a number of key staff in the organisation including (but not limited to); a) 4 person centred coordinators, b) 2 vocational support p[persons, c) Health Service Coordinator, and d) Communication and Technology Coordinator

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.

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 service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered at admission/entry with the involvement of the family. There are resident files in use appropriate to the service. There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Resident records are integrated and support the effective provision of care services. They are accessible to relevant staff. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner. Of the 26 files that were reviewed across the service, 22 of 26 files had examples of documentation that was not signed by the writer or dated.

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:**

There are paper based files appropriate to the service type available. The service requires that relevant initial information relating to clients who have entered the service is collected promptly on entry to the service.

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:**

The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered prior to entrance which may include (but not necessarily limited to): a) current needs assessment, b) copies of all specialist referral reports, c) behaviour management plans, d) comprehensive and current care plan and risk management plan, e) relevant family history, and f) relevant medical history.
The service retains relevant and appropriate information to identify consumers and track records. This includes (but is not necessarily limited to): a) individual profile b) contact list, c) individual support plan/person centred plan d) behaviour management and risk plans e) My Goals, f) restraint consent (where relevant), g) monthly review and a property list, i) incident forms etc.

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:**

The service retains sufficient consumer information to manage the safety of residents which includes (but not limited to): a) current needs assessment b) copies of all specialist referral reports c) accurate behaviour management plans d) comprehensive and current care plan and risk management plan e) relevant family history f) relevant medical history.

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:**

the service keeps a current register of all clients and records of past clients. House 3 is a permanent respite house and clients regularly come in and out. All records are kept of all current respite clients in the house.

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:**

There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Resident records are generally integrated and support the effective provision of care services. They are accessible to relevant staff. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner.

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:**

No information containing sensitive resident information is displayed in a way that can be viewed by other residents or members of the public. Resident information and plans is protected from unauthorised access.
A confidentiality clause is contained in the staff contract and any breach of an individual's confidentiality will result in disciplinary action.

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:**

Client records are up to date and staff have access to them. Staff are aware of the importance of privacy of the people they support.

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

Records across all thirteen houses were legible, however of the 26 files that were reviewed across the service, 22 of 26 files had examples of documentation that was not signed by the writer or dated.

Finding Statement

Of the 26 files that were reviewed across the service, 22 of 26 files had examples of documentation that was not signed by the writer or dated.

Corrective Action Required:

Ensure client records include signatures of the writers and dates.

Timeframe:

6 months

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

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

Resident's records support the effective provision of care services and are accessible to relevant staff. Medical care interventions are recorded and relevant records are maintained in a single 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.

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

An eligibility for services policy is in place. An admissions committee accepts or declines entry to the service. Certain criteria for entry to the service is required. There is a planned transition process. Referrals are accepted from a number of agencies. The service has an information brochure with admission and other relevant information. There is a home agreement.

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:**

An eligibility for services policy is in place with the specific criteria stated.
There is an admissions committee with terms of reference. This has been established to review and assess all referrals to the service to ascertain eligibility and suitability for services.
Acceptance decision for entry in to the service is made by the admissions committee.
The service offers specialised individual support services for people with intellectual disabilities and/or who require high levels of support needs.
Referrals are accepted from NASC and CYF agencies and others as appropriate.

Clients are expected to have a current assessment. The service liaises with assessment services and service coordinators as required. This was described by the Behaviour support coordinators.
There is an exclusion criteria for people who do not have an intellectual disability and people who have identified behaviours for whom the service is unable to provide adequate supports.

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 is a 24 hour care service supported by an administration service which is open during normal working hours. Individual houses operate around the principles of a normal community home and are accessible at any reasonable time.

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:**

The service has an information package available on entry to the service.
This information provides an overview of the service, the home agreement and information on complaints and Code of Rights.
Improvement Note:
Discussions with 2 clients who had signed the home agreement when shown the agreement said they did not understand it.

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:**

The service has an eligibility for services policy in place which described the entry process.
Clients are required to be assessed and funded for the care provided at the service and to accept appropriately assessed clients with consideration given to the current mix, safety and harmony of clients in the houses.
Service Information is available. Two behavioural support coordinators described the entry process and all new referrals are forwarded to the entry committee.

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.

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 service has a process for declining entry. This includes informing persons and referrers (as applicable) the reasons why the service has been declined.
Declining entry to service policy reserves the right to decline entry to the service if the criteria for eligibility for entry to the service is not met.

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 admissions committee makes the decision on declining a client to the service. The referral agency is informed of the reasons for declining entry.
A record of individuals who are declined entry to the service is maintained by the admissions committee.

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:**

The manager advised that the service would discuss with the assessor or referrer the reasons for declining entry to the service. They may be able to suggest other options.

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.

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

26 files were reviewed (two in each 13 houses). Most files had required risk management plans and evidence of annual reviews. Other plans were in place (where required) including epilepsy management plans, and four stage behaviours plan. All long term residents are assessed by a needs assessment coordination service prior to entry to the service. Personal plans are developed on entry by coordinators. In House one and two, the residents have greater physical needs and risk management plans are completed by the registered nurses. Person Centred Plans and My Goal action plans are developed and reviewed with the inclusion of relevant people such as the resident and were appropriate their family/whānau/guardian. Not all files were dated and signed.

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:**

All long term residents are assessed by a needs assessment coordination service prior to entry to the service. Personal plans are developed on entry by coordinators.
In House one and two, the residents have greater physical needs and risk management plans are completed by the registered nurses.
"What do you need to know about me' document is completed by the coordinator with input by the client/family.
26 files were reviewed (two in each 14 houses). Most files had required risk management plans and evidence of annual reviews. Other plans were in place (where required) including epilepsy management plans, and 4 stage behaviours plan. Daily record books are completed in each house by support workers. While documentation was completed, these were not often signed and dated by the writer.
The service has identified two skilled staff (Behavioural support coordinators) to conduct the screening process.
There are entry and admission procedures in place.
Caregivers complete a communication sheet at the end of each shift. Residents entering the service are required to have: a) current needs assessment b) copies of all specialist referral reports c) accurate behaviour management plans d) comprehensive and current care plan and risk management plan e) family history were relevant f) relevant medical history.
The Person Centred Plan "What you need to know about me" are supported by "My Goals" goal setting/planning. There is a staff hand-over briefing between shifts.

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:

Person Centred Plans and My Goal action plans are developed and reviewed with the inclusion of relevant people such as the resident and were appropriate their family/whānau/guardian. A review of 26 files identified involvement of clients and family (where appropriate).
There is a document in clients files ' important people contact list' and 'instructions for informing families of aspect of care'.
In the individual planning process for each client they discuss with the individual and their family the service provision and any other identified needs for the person being supported by Brackenridge. Home Agreements are also discussed and outline the responsibilities of each party.
The manager advised that it has been apparent that service development in partnership with families / whanau has been easier to achieve with new families entering the service in comparison to families of clients who have come through the de-institutionalisation process.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Services provided policy states each client has a person centred plan - what you need to know about me. The policy states that support plans are developed and reviewed with the client and their family /whanau input and support through a person centred meeting process. Meetings are held annually or more often as individual needs dictate.

- Client needs and expected outcomes are identified through the planning process and form the basis of the support plan.
- Long term and short term Goal planning is identified through this process and reviewed monthly as part of an individual monthly review process.
- Each client has individualised active support goals that reflect 'ordinary' patterns of life i.e.: leisure, community participation and vocational opportunities with a focus on individualised interests and choice.

Of the thirteen houses visited there are 3 houses weighing clients monthly

Finding Statement

A review of 26 files across the 13 houses identified that although documentation was in client files, 14 of the files included plans that were not dated and signed and the monthly review action plans in four files from house one and two were not dated and signed. On weight charts viewed of twenty six clients' (2 at each house), twenty clients had not been weighed monthly. Documentation indicated weighing was irregular and in one case the client had been weighed once this year.

Corrective Action Required:

Ensure client goals, support plan, monthly reviews, risk management plans are signed and dated. To weigh clients' on a monthly basis as policy requires.

Timeframe:

6 months

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

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

The service has a "key worker" for each resident to ensure individual needs are being met. Communication sheets provide a review of the progress of resident care and support needs as well as any achievements which are completed at the end of each shift. There is a handover between staff members at shift change over time. A review of 26 client files included correspondence from dietitian, occupational therapy, medical and CYF. .

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.

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

Person centred plans are developed and reviewed with the inclusion of relevant people such as the resident and were appropriate their family/whānau/guardian. Needs are assessed in the initial assessment and the information gathered at assessment is used to set care plan goals and objectives for residents. Assessments are completed in a setting that suits the client and family.

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:**

Person centred plans are developed and reviewed with the inclusion of relevant people such as the resident and were appropriate their family/whānau/guardian.
Needs are assessed in the initial assessment and the information gathered at assessment is used to set care plan goals and objectives for residents.
Daily records book is completed by support workers that includes comments on sleeping, diet, activities, behaviour and communication, support needs, and health. There are other plans that include assessment/risks and management plans and include (but not limited to); epilepsy management plans, risk management plans included identified risks and interventions.
'What you need to know about me' is completed with the clients.

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:**

A review of the Person Centre Plan “What you need to know about me” identified that the following information was identified to support residents in service delivery: a) my daily routine, b) family/whānau/important people contact list, c) what I need to keep myself safe, d) communication, e) personal communication dictionary, f) topics I like to talk about g) complex behaviour, h) things that bug me, i) important people in my life (which includes birthdays that are important in my life and what I like to do for them on their birthday), j) proud achievements, k) things I like doing at school/work, l) activities I enjoy/activities I don’t enjoy, m) things I can do, n) when I go to bed o) things I do around the house, p) current medication situation, q) support I need to keep fit and healthy, r) special dietary requirements, s) the persons food programme, t) foods I like and dislike, u) physical mobility, and v) opportunities – goals, short term and long term.

My Goals planning identifies specific lifestyle goals for residents including (but not limited to): a) actions, b) review dates, and c) people responsible.
My goals action plan was identified in the 26 client files reviewed.
In House one and two, clients with high medical needs had these identified in risk management plans.

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:**

Assessments are completed in a setting that suits the client and family.

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:**

The service has a “key worker” for each resident to ensure individual needs are being met. Communication sheets/daily record books provide a review of the progress of client care and support needs as well as any achievements which are completed at the end of each shift. There is a handover between staff members at shift change over time. Discussion with support workers identified that they review individual goals with the clients on a regular basis. Although note # 1.3.3.3 as this could not be verified due to lack of documented dates.

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.

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 review 26 files across 13 houses identified that the clients have individual support plans. Files continue to identify (where relevant) that behaviour and other associated plans are developed. Comprehensive risk management plans are in place where appropriate. Files are integrated. The majority of the client files reviewed (across 13 houses) did not have completed documentation as per policy. Not all of the 26 client files reviewed (across 13 houses) had completed documentation as per policy, such as up to date goals, action plans, risk management plans and weight records.

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

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

A review 26 files across 13 houses identified that the clients have individual support plans that include (but are not limited to): a) description of activities I enjoy, b) description of activities I do not enjoy, c) ways I like you to help me, d) communication (expression and reception) e) health needs, f) personal communication dictionary, g) important people in my life, h) achievements, i) support needed to keep fit and healthy, j) things I do around the house, k) things I do with important people in my life, l) things I need encouragement with, m) short and long term opportunities and goals, n) mobility, o) special dietary requirements.

Files continue to identify (where relevant) that behaviour and other associated plans are developed. Comprehensive risk management plans are in place where appropriate.
In addition, files included (but were not necessarily limited to): a) financial records, b) weight records, c) health recording sheet, d) family/guardian contact record, e) day programme record, f) incidents records, g) individual profile information, i) epilepsy management plans

Running records are retained for all residents. The diary records identify key areas of consideration including: a) sleeping pattern, b) diet / menu, c) activities, d) behaviour and communication, e) support needs, and f) health.

For those clients with high physical/medical needs, these were well documented in client files.

Finding Statement

Not all of the 26 client files reviewed (across 13 houses) had completed documentation as per policy, such as up to date goals, action plans, risk management plans, and weight records.

Corrective Action Required:
Ensure all required documentation is in client files and this is monitored.

Timeframe:
3 months

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:**

[Individual support plans include identified goals and other aspects of support and care required by individuals who use the service. Plans include a description of the supports required. Plans in house one and two included management of Pegs, and other medical needs.

Risk management plans include (but not limited to); physical injury, aspiration, loss of skin integrity, seizures, infection, allergies, weight, constipation, meds, med side effects, hyperthermia, dehydration, burns, sunburn, sexual abuse, and social etc

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:**

A review of 26 client files identify that plans and records are integrated. Plans and files include (but are not limited to): a) individual profile information, b) family/whanau contacts, c) details of situations for informing families, d) individual support plans, e) restraint consent (as relevant) f) needs assessment, g) my goals, h) day services (description), i) monthly plan reviews, j) therapy records, k) correspondence, l) completed incident forms, and m) completed medication charts.
Files include personal plans and they are supported by diary records.

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:**

Discussion with four families and 28 clients identified that their files are discussed with them and goals/behaviour plans are developed together.

In the individual planning process for each client the service discuss with the individual and their family the service provision and any other identified needs for the person being supported by Brackenridge

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.

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 care being provided is consistent with the needs of clients as demonstrated on the overview of the client files and discussion with staff, clients, family and management. The level of resources, expertise and equipment provided by the service for residents is appropriate to meet their care and support needs. The service continually reviews different roles and responsibilities within the organisation to better meet the needs of the clients. They have experienced, trained and dedicated staff around behaviour support and vocational support. Person centred coordinators individualise the service received by clients.

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:**

The care being provided is consistent with the needs of clients as demonstrated on the overview of the client files and discussion with staff, clients, family and management.
"What you need to know about me" person centred planning is implemented. The service has a communications coordinator who fills an important role in meeting the communication needs of the residents within the service.
The service has also introduced the 'circles of support'. There are other key roles such as vocational support Service, and behavioural support coordinators.
Tracer 1:
Client (young child) admitted for emergency respite May 10. Arrived via social welfare and included records from CYF. 'All you need to know about me' was completed by coordinator and emergency foster carers (no date/signature). Medication chart faxed to GP and arrived with boxes of medication. Client under Paediatric neurology and records/correspondence include input from physiotherapist, OT, speech language therapist. OT notes in client file for staff but no records from physiotherapist. Client has epilepsy, epilepsy management plan included in file, included tonic clonic seizures (up to 40 per day). Anticonvulsant medication and prn medication charted and records include administration. The client also has fully adapted wheelchair with positioning aids. A harness and waist belt in place but not documented in file. On admission weighted 12kg, weight 11.48kg Aug 2010. Presented with flu-like symptoms May 2010, seen by GP and commenced on antibiotics.

Tracer 2:
Client admitted June 2010. Transfer notes included from previous facility. Admission profile completed July 2010. Individual profile has no record of who completed and o detail of medical history. 'What I'd like you to know about me completed 14/8/10. File included SNL 13/3/10 and risk management plan July 2010. Current health issues include William syndrome, asthmatic, and heart condition. No weight documented.
Incident forms reviewed in client file include personal comments documented to the person completing the form , there is no documented records to demonstrate that recommendations were actioned.
As per # 1.3.3.3 and 1.3.5.1, documentation is not always reflective in client files or signed and dated

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:**

The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. Client files reviewed include links with (but not limited to); Therapy Professionals ChCh, Day Service Providers, Hillmorton Hospital / AT&R and Lifelinks.

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:**

The service's process for integrating new residents includes the compatibility of the person with the current residents.
The level of resources, expertise and equipment provided by the service for residents is appropriate to meet their care and support needs. The service continually reviews different roles and responsibilities within the organisation to better meet the needs of the clients. They have experienced, trained and dedicated staff around behaviour support and vocational support. Person centred coordinators personalises the service received by clients.

The service provides (but not limited to), a) 'active support', b) Vocational/ Employment Service, c) respite service that includes policies and procedures, d) children's service that is supported by experienced psychopeadic nurses and e) there is wider community living options.

Participation in community based events and activities is encouraged and supported by the service.

The policies/procedures, staff and residences are appropriate for providing residential disability care and support for persons with intellectual disability. The service continues to make improvements around implementing Circles of Support, Active Support, having a more qualified workforce and electronic records management.

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.

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 structured to support the clients residing in the service to experience an ordinary life as much as possible. Eighteen staff (across 13 houses) and 4 family members confirmed clients participate in everyday community life with the identified supports in place. Encouragement to participate is supported. The service recognises participation in activities is voluntary. Clients have a supported lifestyle plan 'what you need to know about me', identifying and reflecting their interests and the different activities they are involved in.

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:**

Clients' are supported by the service to access activities in the community.
Community based goals and supports needed are identified for the client. Staff at each house provide support to enable this.
Activities are recorded within the 'this is what you need to know about me' plan.
A vocational manager is employed. The position looks at employment for clients' based on their individual need.. Currently the programme has various opportunities on the open market, work programmes, voluntary or work experience either supported by staff on a one to 1 to 1 or 1 to 2 basis. Examples are working at City Firewood for 2 hours for a day, a work crew working on an hourly rate or by contract and delivering the Star newspaper 2 nights a week.

Clients live as independent a life a possible based on the Active Support philosophy. As well many are involved in vocational activities through employment / volunteer work. Client's preferences are accounted for as often as possible. Opportunities are provided for people to participate in a variety of activities out of working hours i.e.: Art classes / Zumba classes / Fire Training / First Aid / Health & Safety / Active Movement / Special Olympics / Drama / swimming etc

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:**

Client plans show documented support for clients in accessing a wide variety of activities supporting an ordinary life.
Staff members at each house support and assist clients to access a range of community activities such as shopping, recreational opportunities and social outings.
4 families of the clients confirmed they were involved in planning.
Each house has their own vehicle used for transporting clients.

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:**

Conversations with thirteen staff (1 at each house), 4 family members and the client plans, indicate clients contribute and are involved in planning their activities as much as possible.
The plans have a wide and varied goals in place.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

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

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 plans/goal plans are evaluated by key staff person with the client 6 monthly - annually. There are monthly reviews of resident's progress and support needs. There is at least a 6 monthly review by the medical practitioner

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:**

Care plans/goal plans are evaluated by key staff person with the client 6 monthly - annually. There are monthly reviews of resident's progress and support needs. There is at least a 3 - 6 monthly review by the medical practitioner.

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:**

My goals have timeframes set and these function as review points for assessment of progress. Risk management plans are reviewed and updated as required.

The service My Goals process has a My Goals Action Plan which indicates the: a) The Goal b) Environment c) Support needed d) Action plan e) Timeframe f) Person/s responsible g) Review date h) Family/Whānau/Guardian. This plan is supported by a Breaking Down Goals document which breaks down the Goals into short/long term goals and the steps required to achieve them. Personal records books include client progress and current health status.

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:**

Discussions with staff and a review of a sample of files identified that reviews and changes to care and my goals plans (and risk profile management plans) occur more frequently than scheduled where changes occurred. Although note # 1.3.3.3, not always dated.

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.

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 service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. Clients' and or their family/whānau are involved as appropriate when referral to another service occurs. In managing the referral process the service provides: a) appropriate transfer of relevant information, and b) follow-up occurs where appropriate.

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:**

The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. Clients and or their family/whānau are involved as appropriate when referral to another service occurs. In managing the referral process the service provides: a) appropriate transfer of relevant information and b) follow-up occurs where appropriate.

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:**

Clients' and or their family/whānau are involved as appropriate when referral to another service occurs. The service has a policy on exit from the service which supports the client transfer to other services.

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.

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 service provides necessary relevant support when residents exit/transfer from the service.

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 service has transfer and discharge procedures. The service confirms that it provides necessary documentation to enable the effective transfer of residents. Staff and the service could describe their commitment to providing all necessary documentation and maintaining contact with other services or life situations when residents were transferred. There has been emergency situations when clients have been transferred to other houses within the service. The service exit policy is coordinated and planned and relevant people are informed.

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:**

The service provides necessary relevant support when residents exit/transfer from the service.

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.

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 medication management system implemented across the homes in the Brackenridge estate and community homes within the wider community. Thirteen medication systems were reviewed at 13 houses in the estate and 2 community homes in Christchurch. Medicine allergies and or sensitivities are required to be identified and recorded. There are no residents who self medicate. Medication policy and procedures follow recognised standards and guidelines for safe medicine management practice. There are medication profiles/photographs used to identify residents. There is improvements identified around managing medications.

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

Audit Evidence

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

There is a medication management system implemented across the homes in the Brackenridge estate and community homes within the wider community. Thirteen medication systems were reviewed at 13 houses in the estate and 2 community homes in Christchurch. In all houses weekly blister pack medication system is used. There is photograph identification retained with all medication charts in each house. Medication is prescribed by the residents GP/Psychiatrist/specialist. Medication charts across all homes included signatures, clear instructions of dose, time, frequency etc.

Medications are stored in locked cupboards in all houses. In house one and two a locked room is available where medication required to be refrigerated is stored correctly, the fridge temp is monitored weekly and temperatures documented.

In house one & two there are a number of residents that receive medication through their PEG. There were clear instructions around management of this for each resident, clear labelling of syringes, and safe practices for enteric coated medication. Advised that only the registered nurse administers medication through the PEG.

For house three (permanent respite house), all families must ensure blister packs are provided to the house or the respite resident cannot stay over. There is a medication sign in process for all meds in house three and charts are audited regularly by the house supervisor to ensure reconciliation of charts. Regular letters/reminders are sent to families to ensure that medication charts are kept up to date and align with blister packs. There were currently two regular respite insulin-dependent residents in the house. The medication chart for one resident stated the number of units to be given, but also stated to be adjusted depending on BSL levels. There was no other instructions regarding this at the staff unsure. There was a procedure in the resident's file around management of insulin/diet and management of hypo's. Although, not dated or signed. Staff were competent in the management of his diabetes, advised that the diabetic nurse had provided training with the staff.

Staff responsible for medication administration are trained in medication administration and only if approved are staff authorised to administer medication. Support staff must complete level 1 medication education and level 1 competency in order to administer medication and this is provided through the regular training programme.

Discussions with staff confirm that general practitioner reviews of resident health occur (usually at least 3 monthly) and where relevant medication reviews occur.
All medication no longer required or past its expiry date is returned to the pharmacy. There is a pharmacy returned box in each home.
The service has a system for the reporting of medication errors and the use of PRN medication used to manage behaviour.

Finding Statement

a) Across all houses, not all medications charted included dates; b) Transcribing onto drug charts and a number of blister pack signing sheets (where the pharmacy had not computerised what meds were included on the signing sheet) was completed in the two high needs houses (1& 2) also house eight; c) Documentation around management of prn medication had not been fully completed by staff in majority of houses, designation of staff member not documented in all records; d) In house two only 1/6 prn forms completed identified who had made the request; e) house four, six, seven and eight included a number of different prn forms; f) In house eight there were three signing sheets for Lorazepam, a number of signing sheets in the drug chart for old creams (not currently being given). One prn chart for resperidone had expired tabs, a further 28 tabs were added to the prn register without the expired resperidone tabs returned to pharmacy; g) in the majority of houses medication folders included a number of obsolete procedures around the management of prn medication and h) Iroquois medication documentation includes a number of errors.

Corrective Action Required:
The service should review the medication folders in all houses to a) remove obsolete procedures, and drug charts that are not current, b) ensure prn medication forms being used are current and all staff are implementing as per policy, and c) complete a regular audit of medication folders in all houses.

Timeframe:
1 month

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

The service has medication administration policies and procedures includes medication administration. Policies and procedures identify medicine management responsibilities, and accountabilities for staff.
The service policies and procedures continue to detail (but are not limited to): a) policy, b) prescribing responsibilities and process (including the role of general practitioner and pharmacist), c) dispensing process, d) administration responsibilities (including in relation to the administration of PRN), d) staff education, e) storage, f) disposal, g) supporting an individual to self medicate, adverse medication/drug reaction, h) respite service medication process, i) prn medication - telephone request process flow chart, j) support staff procedure for approving prn request via phone, k) registered nurse procedure for approving prn request via phone, and l) respite medication process for entering the home.
There are information folders for casual staff and agency staff around medication management and responsibilities in the house.

Finding Statement
In house four an incident form identified that resperidone tabs had been lost in the van during transportation of a client. The policies and procedures do not include the management of transportation of medication for those clients that are transported daily to outside activities.

Corrective Action Required:
Develop a procedure around management transportation of medication

Timeframe:
3 months

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:**

Medication administration is completed by staff who have had competency training. Discussions with staff in all houses confirmed that they are aware of requirements to complete training and that level one medication education and level one competency assessment must be completed in order to administer medication.
Registered Nurses are required to authorise the administration of all PRN medication administration. The staff member requesting completed a prn form and the registered nurse completes a prn medication authorisation form at their end. There are set questions to clarify before the RN will authorise the medication.
The service has further developed their process around the management of prn medication, however documentation (as identified in 1.3.12.1) is still not fully completed.

The service holds regular training for medication management and level one and two competencies are completed annually.

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:**

Medicine allergies and or sensitivities are required to be identified and recorded. Allergies and sensitivities are identified by bright stickers on medication charts across all houses.
Allergies and sensitivities are identified for recording on medication administration documentation. Two client files reviewed included warning and management of potential for anaphylactic reaction.
There is an Adverse medication/drug reaction flowchart for staff. Medication incident forms are utilised as part of the incident reporting system. The monthly reporting to the general manager includes stats on medication errors.

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:**

There are no residents who self medicate. There is a 'supporting the individual to self medicate' policy.

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:**

Medication policy and procedures follow recognised standards and guidelines for safe medicine management practice. There are medication profiles/photographs used to identify residents.
The use of PRN medication is monitored and reports are provided at an individual level to management. PRN charting across all the houses includes clear instructions for use. There is a specific prn guidelines chart for each individual prn medication used for that specific client. There is a prn guidelines - medical and prn guidelines - behaviour.
A medication management audit is completed at all houses, corrective action are identified but little documented evidence that actions are followed through in all cases, as per # 1.2.3.6.

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.

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 food policies/procedures for food services and menu planning is appropriate for this type of service. Dietitian input has been obtained for clients' requiring specialised dietary needs. Each house operates as a normal household. Clients' food preferences are identified and this includes consideration of any particular dietary preferences or needs. Systems are in place to ensure safe food service and handling. Introductory training on safe food handling is provided. Colour coded chopping boards are available at the houses. Fridge/freezer temperatures are not recorded. Clients' are not weighed regularly on a monthly basis as per service policy. Food removed from freezer and stored in the fridge is not correctly stored, dated or labelled.

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:**

Staff are responsible for planning and cooking the meals at each house. Documentation supported the service provided a variety of interesting meals.

8 clients' said their meals are good. 3 family said meals are nicely presented.

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:** Moderate

On 8 files viewed, there is evidence of dietitian input into specialised menus and dietary requirements.
There is evidence of foods available for special/modified dietary needs.
Clients' that require special diets have these needs met and this is documented on their files.

Finding Statement

Fortisip (high energy, nutritionally complete drinks) with expired dates were found at house 2.

Corrective Action Required:
Ensure fortisip is not past expiry date.

Timeframe:
1 month

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:**

Twenty six client plans reviewed (2 at each house) included likes, dislikes and preferences.
Staff gather dietary information on admission and this is kept on the clients' file.

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:**

The service has established links to enable referrals for specialist assessment for equipment when required. Needs assessment can identify when specialised equipment is necessary. Feeding aids are currently used. Feeding aids are available as necessary.

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

Food in the houses storage areas are dated, labelled and are correctly rotated.
Staff said fridge and freezer temperatures are taken in the houses but there was no documentation of recordings available. The fridges in the houses had thermometers in them. The fridge in house one used for storing medications has the temperature taken and recorded.
Food in the fridges and freezers are stored correctly, covered and dated. Monthly internal audits at each house has the criteria for refrigerators to be clean outside/on top, clean inside and for the safe and appropriate storage of food but it does not record temperatures.
Staff spoken with (across the13 houses), were aware of their obligations to ensure all aspects around food management and procurement comply with current legislation, regulations and requirements. Colour coded chopping boards are available for use.
Policies are in place for food services and menu planning. Staff receive training at orientation.
Training on safe food handling level one (introductory) was provided in March, April, May and August 2010.
Each house is responsible for purchasing their food supplies on a weekly basis.

Finding Statement

Fridge/freezer temperatures are not recorded at the houses. Uncovered food is in the fridge of house four. Food in the fridge at house ten had been taken out of the freezer and stored in the same bags as purchased in. These bags had labels with the date of purchase and use by date. It presented as food being 3 weeks past the use by date.

Corrective Action Required:
Record and document fridge/freezer temperatures. To store, date and label food taken out of freezer. To keep food covered in the fridge.

Timeframe:
6 months

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.

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 service has waste management policies and procedures and guidelines for the safe disposal of waste and hazardous substances.

There is an incident reporting system that includes investigation of these types of incidents. Chemicals are labelled and stored safely. Appropriate protective clothing and equipment is not always available for staff or found in the designated areas at the houses.

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:**

A waste management policy and procedures is in place.
The service uses the Christchurch City Council kerbside collection of household waste with a 3 bin method of waste disposal.
A mini skip for the disposal of bulky items is available for other items.
A cardboard recycling crate is for the disposal of excess cardboard items.
An independent contractor may provide bins at some houses for general waste disposal.
Sharps policy and procedure identifies the correct disposal of sharps.
Household hazardous waste is defined with procedures listed for disposal.

Finding Statement

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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:**

The service has a hazards management policy and guidelines to ensure hazards are identified.
Hazard identification checklist audits are completed. Any incidents are recorded and variations and trends identified.
The manager said the service would promptly action and respond to the early management of any incidents involving waste and hazardous substances.
There are guidelines for the handling of infectious waste and dangerous rubbish.
A system for investigating, recording and reporting spills of biological material, needle stick injuries and similar blood/body substance exposures, and managing hazardous waste is in place.

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 policies and guidelines for the handling and dealing with infectious material and hazardous substances.
Policy states all incidents involving infectious material follow the process as outlined in the services policies including spills of biological material, needle stick injuries and blood / body substance exposure.
The service has emergency procedures to support its management of hazard incidents or accidents.

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:**

Staff receive training in the safe management of waste and hazardous substances in their orientation.
Health and safety training level one is documented on the learning and development training schedule for February, May, August and November 2010.

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 used at the thirteen houses were correctly labelled for identification.
These are the normal type of household cleaning products.
Policy and guidelines require staff to follow the instructions and information on the container.
Material Safety Data Sheets are available for these chemicals and hazardous substances.

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

Personal protective equipment (PPE) policy is included in the health and safety manual.
The policy states ' the service is committed to having systems and procedures in place to ensure a standard approach to the issuing and usage of PPE.
The coordinator is responsible to identify where the use of personal protective clothing is required, to ensure PPE is correctly stored at all times when not in use, regularly checked to guarantee it remains in good condition, that employees use the appropriate PPE when required, ensure employees are trained in the safe use of the PPE they are required to use'.
Protective clothing is provided to the staff as required: gloves, goggles, aprons and masks.
Discussions with eighteen staff identified the PPE was not always available for use. Often it was not found in the designated storage areas and staff have to look for the protective clothing.

Finding Statement
To provide PPE as per service policy. Protective aprons are not available in house 2. House four has one plastic apron.

Corrective Action Required:
To ensure personal protective clothing is available and stored in the designated areas at each house.

Timeframe:
3 months

STANDARD 1.4.2 Facility Specifications

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

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 service has a current building warrant of fitness for the eleven house certificate that expires on 1 October 2010. The Oakhampton house has a building warrant of fitness with an expiry date 1 March 2011. The building warrant of fitness for the Iroquois house was not available. Maintenance is carried out. Furniture and fittings are selected with consideration to clients' abilities and functioning. There is enough room throughout the service for residents to mobilise safely. Floor surfaces are appropriate and equipment is obtained as identified.

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

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

All applicable legislation codes, standards, and regulations are complied with.
Policies are linked to appropriate legislation and standards.
The service has a maintenance system to ensure the houses, plant and buildings are maintained.
There is an administration manager of support services.

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

The building warrant of fitness for the eleven houses audited on the estate have an expiry date 1 October 2010.
The Oakhampton house has an expiry date of 1 March 2011.

Finding Statement

The building warrant of fitness for the Iroquois house was not found at the time of the audit.

Corrective Action Required:

To obtain/produce the Iroquois house building warrant of fitness.

Timeframe:

3 months

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:**

Furniture and fittings in the thirteen houses are selected with consideration to the clients' abilities and level of functioning and to maximise their independence wherever possible. Identified links to appropriate professional agencies to provide advice and assessments for individual physical care and equipment requirements and needs are arranged as necessary. Clients assessed as requiring specialised equipment have this provided and includes hoists, shower trolleys, wheelchairs and standing frames, hydraulic beds and special mattresses for clients.
Wet areas in the bathrooms of the thirteen houses have non slip flooring.
An environmental building maintenance policy and procedures is in place.
The service operates a house maintenance programme to ensure the safety and comfort of the people living in the houses.
Each house has a budget for maintenance.

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 eleven houses on the estate have been purpose built to meet the needs of the differing client groups and to allow freedom of movement using mobility equipment or with assistance from staff. The Oakhampton house has a smaller dining/lounge area. Two staff interviewed said clients still could mobilise freely. The Iroquois house is larger and is appropriate to the client group.

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:

Clients' bedrooms at the thirteen houses visited, are personalised with furnishings, items, possessions and decorations, chosen with assistance from family and staff and selected to suit the individuals' personality.
This was evident in all the bedrooms.
Improvement Note:
Clients in house 6 lock their bedroom doors at night. The doors can be opened from the inside by turning the door knob. 1 staff was asked how would they enter the room in an emergency. They replied a key was available. They were asked to get the key. After 5 minutes and trial and error with several keys, the lock was undone.

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:

Each of the eleven houses on the estate have access to landscaped courtyard areas.
Adequate shade is available at each house. Outdoor seating is available at each house.
The grounds of the estate provide other areas of shade and areas of seating for clients.
The estate is fully fenced on the perimeter boundaries. An automatic gated entrance allows vehicles in and out of the grounds.
The 2 community houses have accessible private outdoor areas.

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:**

The client transportation policy and procedures is in place.
It includes regular servicing and to meet legislative requirements (WOF, motor vehicle registration).
Staff driving the service vehicles have a copy of their drivers licence held on their personnel file.
The policy states staff driver assessments will be conducted by a reputable driver instruction company.
The use of hoists, wheelchair loading procedure, accessing/exiting vehicles and driver responsibilities.
Each vehicle has a log book.
Staff report any faults, problems or damage to the administration manager of support services.
Information on what to do in the event of an accident is available and a page with list of checks required such as seat belts,
There is a checklist for maintenance and cleaning of vehicles. Includes oil, water, tyre pressure, check first aid kit, fire extinguisher. cleaning the vehicle - vacuum, clean and wash interior, wash exterior, add air fresher and a damage check.

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.

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

Toilets and showers/bathing facilities with access to a hand basin are adequate for the current groups in each of the thirteen houses.

Toilets and showers are easily identifiable. Hot water temperatures are monitored in the eleven houses on the estate. The 2 community houses have no documentation to support hot water temperatures are tested . Fixtures, fittings and floor and wall surfaces are made of acceptable materials for the environments in the thirteen houses.

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:**

The thirteen houses have adequate bathroom and toilet facilities. These are conveniently located and suitable for the needs of the client group of each house.

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

The hot water temperatures are tested and recorded by an independent contractor for the eleven houses being audited on the estate.
This is done on a 3 monthly basis. Each of the eleven houses have the bath, toilet, shower and kitchen temperatures recorded.
The last recorded hot water temperatures is dated 29 June 2010.

Finding Statement

The Oakhampton and Iroquois community houses have no documentation to support water temperatures are monitored.

Corrective Action Required:
To test and record hot water temperatures at the 2 community houses.

Timeframe:
3 months

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:**

In each of the thirteen houses hand wash basins and hand drying facilities are readily accessible to each of the toilet facilities.
They are of a design appropriate to the clients groups.

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:**

Fixtures, fittings and floor and wall surfaces are made of acceptable materials for this environment and to ensure hygiene and infection control practices can be met.
Floor surfaces are maintained in good order. Wet floor services are clearly identified.

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:**

The toilet and bathroom facilities in the thirteen houses have no identification signage.
This is appropriate for the clients living in the houses as the service is providing care in a home like situation.

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.

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

Clients' bedrooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids.

Transfer of clients between rooms is not necessary in the client's bed. Equipment can be transferred between rooms.

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:**

Clients' bedrooms have space allowing care to be provided and for the safe use and manoeuvring of mobility equipment and assistive aids.

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:**

Equipment can be transferred between rooms as required.
House 1 and 2 have doorways wide enough to accommodate beds should this be necessary.
Discussions with 2 staff from house 1 and 2 indicated this did not occur.

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.

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

Each of the thirteen houses has an open plan kitchen/dining/lounge area. In the eleven houses on the estate, a smaller communal room is available. Clients can access other areas for privacy if required. Furniture is appropriate to the setting and arranged allowing clients to be moved safely and to mobilise with frames, assistive aids and chairs. Seating can be repositioned to allow care giver access to clients if required.

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:**

Each of the thirteen houses have a spacious open plan kitchen/dining/lounge area.
Clients were observed using the areas.

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:**

The furniture in the houses is arranged to allow clients freedom of movement either using mobility aids or with staff assistance.
Emergency access routes were unobstructed and were identifiable.

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:**

Activities can occur in the lounge or dining area at each of the houses.
Thirteen staff interviewed (1 at each house) said the areas are used for their designated purpose and client privacy is not compromised.

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.

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 cleaning and disinfection policy is in place. Definitions for cleaning, disinfection and sterilisation are included. The procedures state each house has its own system for maintaining cleaning. under the guidance from an advanced practitioner, registered nurse and coordinator. The service has in place policies and procedures for the management of laundry and cleaning practices. Each house has a laundry facility with a commercial washing machine and dryer. Laundry and cleaning processes are monitored daily by staff for effectiveness. There are designated areas at each house for the storage of cleaning and laundry chemicals.

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:**

A policy and procedure for handling of laundry is in place.

A laundry care and procedures quick reference flip chart is available at each house.
Information included:
-poisons centre
-hazardous materials
-laundry equipment
-laundry procedure - soiled washing
-laundry procedure - non soiled washing
The laundry facility of each of the eleven houses on the estate contains the following:
-washing machine and dryer
-laundry tub/s including one tub designated for sluicing body matter off soiled items (if required)
-high pressure hose for sluicing
-clearly labelled laundry baskets
-material safety data sheets
-appropriately stored cleaning agents
-scrubbing brushes. One identified to remove faecal matter from soiled items and one for general items
-labelled buckets with lids for soaking laundry items -one for tea towels and dishcloths, one for items soiled with faecal matter and if required one for infectious items.
-personal protective equipment - disposable gloves, disposable aprons and protective eye wear.
There are procedures for items soiled with blood, body fluids, secretions or excretions. and additional precautions for handling of laundry and clothing of clients with MRSA.
A blood and body substance exposure policy defines the recipient, donor and procedures.
Body waste spillage policy and procedures in place. A Medlab flowchart for blood/body substance exposure is available.
Sharps policy and procedures.
The 2 community houses have smaller laundry facilities. They use the same policy and procedure for handling of laundry.
They use the laundry tub for sluice purposes. 2 staff interviewed said staff were aware of removing body excrements into the toilet prior to sluicing.

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 staff at each of the houses monitors the effectiveness for cleaning and the laundry of the house.
A monthly internal laundry and cleaning service audits is scheduled. This checks the correct labelling of the mops, buckets, cleanliness of floor and if the lint collector clean on the washing machine.
Corrective actions are identified and recorded.
On viewing the audits in the following months, the identified corrective actions recorded have not always been actioned.
Staff at each house, said they monitor cleaning and laundry processes on a daily basis.

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:**

Each of the thirteen houses has a designated laundry and cleaning equipment area. Each area has lockable cupboards for the safe storage of cleaning and laundry products. In the eleven houses on the estate this is found in the attached garage. The 2 community houses have smaller laundry areas.

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.

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 policy and procedure for contingency planning adverse weather plan procedure is in place. The plan aims to provide a standard practice to ensure continuation of services during any adverse weather conditions. It applies to all service areas and employees. Instructions for the automatic gated and how to open them in adverse weather condition is available. The service has policies, procedures and guidelines for emergency situations and civil defence. Staff are required to have a current first aid certificate and to complete an annual CPR refresher. Fire drills/evacuations are held. The service has an approved NZFS evacuation scheme for the eleven houses on the estate. An approved NZFS evacuation scheme could not be found at the 2 community houses. Emergency lighting and cooking is available in the houses in the event of a power failure. An emergency supply of water is stored in the houses apart from the Iroquois house. Civil defence kits are not fully stocked or up to date in ten houses. Iroquois house does not have a civil defence kit or water stored. Security procedures are established for the houses. The service requires personal security alarms for emergency situations to be worn by staff in the houses on the estate. Of eleven staff interviewed (1 in each house in the estate) only one staff wore the alarm. Clients care plans identify individual additional requirements or needs. A slide bolt lock is in a fire exit door.

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

The service has policies and procedures for civil defence and other emergencies.
Staff are informed of fire requirements at orientation.
Ongoing fire safety training is mandatory.
Fire and evacuation rules are accessible in all houses,
All houses on the estate are equipped with an effective sprinkler system.
All staff are required to attend at least one trial evacuation annually.
Regular staff training/education on fire and emergency procedures is available.
There is a policy and procedure for medical emergency.
Staff are required to maintain a first aid certificate and to complete and annual CPR course..
A flow chart is available for urgent medical, out of hours and emergency situations.
Fire safety level 1 is documented on the learning and development training schedule for February, April, June, July, August, September and November 2010.

Finding Statement

House 2 has a slide bolt lock on the door to the laundry. This is a fire exit door and if the lock is in use, the door cannot be opened from the outside.

Corrective Action Required:
Remove the slide bolt lock.

Timeframe:
1 month

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:**

The service is able to provide a level of first aid and emergency treatment appropriate for the degree of risk associated with the provision of the service.
A staff member is always available to administer basic first aid.
Each house has a staff appointed as the fire person..
A fire folder contents includes information of the responsibilities for the person and trial evacuation procedures.
A flow chart shows the steps for planning a trial emergency evacuation.
A quick reference flip chart for emergency procedures is available in the houses.
This information cover:
-hazardous material alert
-accessing casual pool staff
-flooding
-missing client
-personal alarm system

-fire discovery
-suspicious activity unauthorised visitor/media
-emergency medical assistance
-resident crisis management
-natural disaster.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

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

The service has evacuation schemes approved by the New Zealand Fire Service with the following dates:

House 1 - 30 June 2000
House 2- 30 June 2000
House 3 - 23 May 2010
House 4 - 23 May 2000
House 5 - 23 May 2000
House 6 - 22 August 2003
House 7 - 23 May 2000
House 8 - 23 May 2000
House 9 - 23 May 2000
House 10 - 23 May 2000
House 14 - 23 May 2000

All houses are required to hold 2 trial evacuations each year.
Dates of the last trial evacuations are recorded as :

House 1 - 21 March 2010
House 2 - 22 May 2010
House 3 - 21 June 2010
House 4 - 10 July 2010
House 5 - 15 April 2010
House 6 - 14 March 2010
House 7 - 14 August 2010
House 8 - 8 June 2010
House 9 - 21 June 2010
House 10 - 24 July 2010
House 14 - 6 March 2010

Oakhampton house and Iroquois house do not have the information available.

Finding Statement

Oakhampton house and Iroquois house do not have copies of approved evacuations by the New Zealand fire service available . Oakhampton house and Iroquois house do not have documentation with dates of the last trial evacuations available.

Corrective Action Required:
For the Oakhampton and Iroquois houses to have an approved NZFS evacuation scheme. To have trial evacuations as per service policy.

Timeframe:
3 months

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

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

The service policy requires emergency equipment to be available in each house.
This is identified as:
a first aid kit, torch, gas heater, gas bbq, emergency food supplies (civil defence emergency situation), and water supplies.
Each house is expected to have a supply of food in the pantry (for 3 days), torches/candles and a lighter, gas heater, gas bbq/gas cooking unit, a house cell phone and a transistor radio and batteries.
Emergency lighting is available for 1 hour to each of the eleven houses. Emergency lighting is checked on a monthly basis by an electrical company.
The eleven houses on the estate have civil defence kits stored in each of their garages.
House 9 and house 5 were the 2 houses that had maintained and restocked the civil defence kits and filled in the required checklist forms in the kits.
The civil defence kits at the other houses had not been maintained or checked for use by dates for food items.
Food items were found in the kits with expiry dates as far back as April 2008.
The Oakhampton house has a civil defence kit. This is being stocked as their housekeeping funds allow. Currently, there is an insufficient supply of items stored.
The Iroquois house does not have a civil defence kit available.
Each of the eleven houses has water stored in containers in their garages.
The service bases all their emergency supplies quantities on the civil Defence Requirements / guidelines
Each house has extra blankets available for warmth.
In the event of the mains supply failing, the houses have access to torches.
House 1 and house 2 have emergency power via a gas operated generator.
Sufficient supplies of food are stored in the pantries, fridges and freezers in each house for approximately 3 days.
Extra blankets are available for warmth and barbeques can be used for cooking/heating.

Finding Statement

Civil defence kits in ten of the thirteen houses are not checked as required by the service. Iroquois house does not have a civil defence kit or water stored.

Corrective Action Required:
To ensure civil defence kits are regularly checked in all houses.Iroquois house to include stored water

Timeframe:
3 months

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

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

Staff are available to assist clients' at each residential and community house when required.
The service provides personal security alarms for staff working at the onsite houses for use in an emergency situation.

Staff are required to wear the alarm receiver when on shift in the house to ensure they are prepared for any emergency/crisis situation and to maintain their safety.
This alarm system links to all the houses and staff from the other houses are available to assist if required.
The system is appropriate for the client group.
Over the audit period of 4 days, staff at house 6 were wearing the alarms.
The alarms are available in the other houses but not being worn. Staff knew where the alarms were but in discussions with staff, they said they felt they knew the clients and felt it was not always necessary to wear the alarms.

Finding Statement

Staff at the houses on the estate do not wear the personal security alarms (apart from house 6).

Corrective Action Required:
To wear the personal alarms as required by the service.

Timeframe:
3 months

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:**

The service has procedures for security and safety.
It states the external garage doors should remain locked at night, windows and doors secured at a reasonable hour, suspicious individuals to be reported to the coordinator, vehicles locked when not in use and preferably housed in the garage, vehicles should be secure and valuables should not be kept in vehicles, locking the house when unattended (for the day) and to ensure outside lights are operational.
A policy on visitors is in place. Visitors are welcome during normal waking hours and at other times by arrangement.
The service asks visitors to ring the houses first to ensure the client is at there.
In the houses providing care for clients with more complex and higher needs, prior notice of visiting is requested to ensure safety for all.
Contractors and other services visiting on site are required to sign in at the Main Office. A visitors pass is to be worn.

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:**

Clients requiring greater supervision have their support needs clearly identified in the care planning process.
Where additional needs are identified and required, the service endeavours to meet these needs and providing the level of support for clients requiring greater supervision - all clients staffing needs are met as per their funding level and staffing rosters. Should any client experience periods of increased support requirements due to physiological/ psychological / behavioural issues the service provides extra support as appropriate.
The service links with other agencies involved with clients.
The service has a policy and procedures for managing challenging behaviours.

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.

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 homes communal living and dining areas are appropriately heated and ventilated. Windows in clients' bedrooms provide natural light.

There is adequate external light in all communal areas. The whole service is smoke free apart from 2 clients who are permitted to smoke on a monitored programmes in designated external areas.

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:**

The houses on site and the 2 houses in the community have heating supplied by heat pumps.
On the 4 days of the audit, the communal living areas and bedrooms of the eleven houses and 2 community houses are comfortably heated.
Windows and doors can be opened to provide ventilation when required.
3 clients, twelve staff and 4 family members said the homes are kept warm.

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:**

The communal areas of the eleven residential houses and 2 community houses have adequate natural lighting provided from outside.
Clients bedrooms have external windows providing natural light during daylight hours.

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:**

The service has a smoke free policy. This applies 7 days a week, 24hours a day to employees, clients, visitors, volunteers, students, contractors and everyone using the service as a place of work.
Smoking is not permitted in any Brackenridge Estate property, buildings, grounds, vehicles and work environments or where Brackenridge conducts any business. Employees are not permitted to smoke when on shift, when supporting clients in community environments and when representing the service in an official capacity.
The service supports staff members to access to smoking cessation programmes and to support clients to stop smoking.
Currently 2 clients smoke. As it is their home, they are permitted to smoke in a designated outdoor area at their house. They are both on controlled smoking programmes monitored by the staff.

Finding Statement

Corrective Action Required:

Timeframe:

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

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.

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 restraint: policy & procedure that is aligned with the restraint minimisation and safe practice standard and appropriate for this type of environment. The purpose of the service restraint minimisation policy is to ensure that the implementation of any physical intervention is used safely, as a last resort after all de-escalation/redirection strategies have failed and in line with Non Violent Crisis Intervention (NVCI) best practice, with full regard and respect for the individual concerned and for all associated legal constraints. Extensive and comprehensive staff education in place – Non violent crisis intervention programme. The restraint policy includes management of equipment such as chair harnesses used as enablers. There is an Enabler consent form that includes a definition.

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:**

There is a restraint: policy & procedure that is aligned with the restraint minimisation and safe practice standard and appropriate for this type of environment. The policy includes an approval process and assessment process in place. Review Group meets quarterly.
The restraint policy state, 'Any restraint procedure at Brackenridge is guided by ethical principles that include acting for the individual's good, avoiding harm to the individual, avoiding harm to self and others and respecting the dignity of the individual and their human rights. Any restraint intervention is to be used safely, only as a last resort and only after all de- escalation / redirection strategies have been unsuccessful, and in line with Non Violent Crisis Intervention best practice, with full regard and respect for the individual concerned and for all associated legal constraints. ' The policy includes a definition of an enabler and assessment process.

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 purpose of the service restraint minimisation policy is to ensure that the implementation of any physical intervention is used safely, as a last resort after all de-escalation/redirection strategies have failed and in line with Non Violent Crisis Intervention (NVCI) best practice, with full regard and respect for the individual concerned and for all associated legal constraints.
There is a restraint intervention assessment form that identified (but not limited to); behaviour requiring physical restraint, possible triggers identified and what supports are used to de escalate or redirect and other strategies to be tried before physical intervention is used.
Physical restraint assessment forms were reviewed on three resident files (from house 2, 4 and 6). These linked to the resident risk management plan. All three files included a completed restraint management form for an episode of emergency restraint. This included the outcome/effectiveness. Incident forms were completed for the restraint event and forwarded to the restraint approval group for analysis.
There are two behavioural support coordinators at Brackenridge (trained by the Institute of applied behaviour analysis in America)

The service has a number of people who have behavioural support needs. There is a restraint register and there have been 10 episodes of NVCI and 7 episodes of Non NVCI episodes (such as arms held) included on the register between Jan and July 2010. All restraint is episodic and related to behavioural needs. There is good documentation for each event and all incidents are analysed for the appropriateness of the action.

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

There are currently 36 people requiring enablers (including respite) at Brackenridge. Advised that implementation of enablers requires a minimum at least of two hourly checks to ensure the individual's comfort and health and safety.

All equipment maintenance is the responsibility of support staff / coordinators with the exception of personal wheelchairs that are checked annually or more frequently as required by designated professionals i.e. wheelchair / seating specialist etc.
Each resident requiring enablers at Brackenridge is assessed as requiring these to maintain the residents independence and safety.
There is an enabler consent form that includes description of the enabler, monitoring and review dates and review criteria.
One resident in house 2 requiring an enabler in the form of a lap belt when on the commode was signed and risk management plan included safe and appropriate use.
There is evidence of input from OT and seating specialist for some residents in house 1 and 2 with physical disabilities.

Finding Statement

Two residents in house one with physical disabilities and enablers in wheelchairs did not include completed documentation.

Corrective Action Required:
Ensure documentation is completed for all residents that are utilising enablers for safety/independence

Timeframe:
3 months

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 enabler consent form is signed/consented by the resident or EPOA. The review process identifies; a) is the use of an enabler the best option, and b) is this the least restrictive option. Enabler use is reviewed through reviews of the risk management plan. Individual monthly review plan also reviews enabler use as required.

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:**

Training in Non-Violent Crisis Intervention (NVCI) is compulsory for all staff. Staff commence NVCI training with a two day (16 hours) introductory course. Within six months of completing the introductory course staff are required to complete a one day (8 hours) Refresher Course. Thereafter attendance at a one day (8 hours) annual NVCI Refresher Course is compulsory. A record of staff training in NVCI is kept on the Staff Education database.

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:**

Approval committee meets annually. Extensive and comprehensive staff education in place – Non violent crisis intervention programme. comprehensive support plans in place for identified individuals.

There are currently 22 clients identified on the restraint register, including 17 episodes of NVCI between Jan - July 2010. There is clear processes for management of restraint and emergency restraint to ensure it is only used for safety.

Types of restraint approved is: non violent physical crisis intervention - approved methods only as identified for each individual. Implemented only as a last resort and the least restrictive intervention using the least amount of force for the least amount of time.

There are currently 36 residents people requiring enablers (including respite).

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 2.2 SAFE RESTRAINT PRACTICE

Consumers receive services in a safe manner.

STANDARD 2.2.1 Restraint approval and processes

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

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 clearly documented roles and accountability for restraint. The Restraint Coordinator is responsible for maintaining the Restraint Register and providing relevant information to the Restraint Review Committee. The Restraint Review Committee reports annually to the Restraint Approval Group and the Manager of Brackenridge. The restraint policy and register include approved restraints. The Brackenridge Restraint Monitoring Committee reviews / evaluate all episodes of restraint Intervention on a quarterly basis.

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

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

[There are clearly documented roles and accountability for restraint and include;

Staff involved in the use of restraint intervention / are responsible for the completion of the following documentation: a) the individual's Daily Record Book, b) Brackenridge Accident / Incident Report Form and Physical Restraint Management Form which are then forwarded to the Service Co-ordinator

The Service Coordinator, Behaviour Support Coordinator and Manager both review and sign the Physical Restraint Management Form prior to forwarding it to the Restraint Coordinator.

The Restraint Coordinator is responsible for maintaining the Restraint Register and providing relevant information to the Restraint Review Committee.

The Restraint Review Committee reports annually to the Restraint Approval Group and the Manager of Brackenridge.

Discussions with 17 support staff were all familiar with responsibilities of documentation.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.1.2 Approved restraints will be documented, along with alternatives to restraint, and made known to service providers.

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

The restraint policy and register include approved restraints. The policy follows the protocol of NVCI , to ensure that any restraint intervention is used and perceived only as a non-aversive process and implemented as a Last Resort in line with the Non Violent Crisis Intervention philosophy and strategies and the Restraint Minimisation Standard NZS 8134. 2: 2008. All staff are trained in NVCI processes.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.1.3 The approval for each restraint type is reviewed regularly.

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

The Brackenridge Restraint Monitoring Committee reviews / evaluate all episodes of restraint Intervention on a quarterly basis, minutes sighted.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.2 Assessment

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

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

For any individual identified as requiring the implementation of restraint intervention during crisis periods a Brackenridge Restraint Assessment Form is required to be completed. Any restraint intervention is identified in appropriate Person Centred Plans and Support plans developed in conjunction with the individual and / or their family / whanau / advocate / guardian and / or clinician and supported by employee training;

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

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

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

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

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

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

(f) Maintaining culturally safe practice;

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

(h) Possible alternative intervention/strategies.

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

For any individual identified as requiring the implementation of restraint intervention during crisis periods a Brackenridge Restraint Assessment Form is required to be completed. The Restraint Assessment Form is to ensure, a) the reason for restraint is identified (risks versus benefits), b) alternatives to physical intervention / restraint are identified, c) the type of restraint intervention complies with the NVCI programme requirements and the Restraint Minimisation and Safe Practice Standard (NZS 8134.2:2008), d) the identified restraint intervention is the least restrictive, e) safe cultural practice is adhered to, and f) input from the individual or their representative is included as practical.
The Restraint Assessment Form was cited on four client files.
The policy also includes a procedure for using restraint intervention in emergency situations

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.2.2 In assessing whether restraint will be used, the consumer and/or the family/wh?nau is informed and their input sought as practical.

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

Any restraint intervention is identified in appropriate Person Centred Plans and Support plans developed in conjunction with the individual and / or their family / whanau / advocate / guardian and / or clinician and supported by employee training.
Initial risk management plan includes signed consent of the individual and / or their family, advocate, guardian or solicitor for the use of any specified restraint process.
All consents for restraint intervention processes are reviewed annually or more often as requested by the individual, their family / whanau / advocate / guardian or the restraint approval group. This is documented in the clients What You Need to Know About Me Plan and signed off by their family / whanau / advocate / guardian.
Restraint is reviewed annually or more frequently as required, as determined by the Approval Group and / or Review Committee / family / whanau / legal representative or medical practitioner.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.3 Safe Restraint Use

Services use restraint safely

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

Brackenridge evaluates /review the use of restraint. This is done initially by the Service Coordinator and Manager upon receipt of the Restraint Management Form during their review. The Restraint Review Coordinator also evaluates each restraint situation on the Restraint Management Form. Review of the assessment, approval and evaluation process and training of staff confirms that non NVCI is used as a last resort. Each episode of non NVCI is documented on incident/accident forms, the restraint register includes reason for restraint and outcome.

Criterion 2.2.3.1 The need for continued use of the restraint is continually monitored and regularly reviewed, to ensure it is applied for the minimum amount of time necessary.

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

The policy states that restraint is monitored no less than two hourly when non NVCI restraint is required for the individual to participate in a safe and fulfilling lifestyle implemented with the consent of the individual and / or their family / whanau / advocate / guardian or solicitor and medical practitioner

Using the NVCI principles of Care, Welfare, Safety and Security, support staff stated that they continue to evaluate theirs and others safety and to reassess the need for restraint intervention . Advised that then they try to re-establish therapeutic rapport and support the individual to return to normal activities as able.

Documentation includes a record of the length of time restraint implemented for.

Brackenridge evaluates /review the use of restraint. This is done initially by the Service Coordinator and Manager upon receipt of the Restraint Management Form during their review. The Restraint Review Coordinator also evaluates each restraint situation on the Restraint Management Form.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

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

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

Audit Evidence

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

Brackenridge undertakes to support employees, and to acknowledge legal constraints, by ensuring that any physical intervention / restraint practice is used only as a last resort and to the least degree respecting the dignity and rights of the individual, approved by the Brackenridge Restraint Approval Group and consistent with preventing harm to self or harm to others.
Review of the assessment, approval and evaluation process and training of staff confirms that non NVCI is used as a last resort.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.3.3 **The frequency and extent of monitoring of the consumer during restraint is determined by the risks associated with the consumer's needs and the type of restraint being used.**

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

The service restraint management procedures identify that monitoring should occur throughout the application of restraint and that the individuals care, welfare, safety and security and risk of harm is to be monitored. Monitoring is to be no less than 2 hourly when non-NVCI restraint is used.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

(d) The outcome of the restraint;

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

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

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

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

Monitoring is required to be fully documented and this requires the completion of accident and incident recording forms and the use of the service restraint management form. Each episode of non NVCI is documented on incident/accident forms, the restraint register includes reason for restraint and outcome..

Finding Statement

Corrective Action Required:

Timeframe:

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

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

There is a restraint register that is implemented and regularly reviewed that includes a record of all NVCI and non NVCI.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.3.6 Each service provider has an individual record of education and competency in relation to restraint minimisation and safe practice.

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

Training in Non-Violent Crisis Intervention (NVCI) is compulsory for all staff. Staff commence NVCI training with a two day (16 hours) introductory course. Within six months of completing the introductory course staff are required to complete a one day (8 hours) Refresher Course. Thereafter attendance at a one day (8 hours) annual NVCI Refresher Course is compulsory. A record of staff training in NVCI is kept on the Staff Education database.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.4 Evaluation

Services evaluate all episodes of restraint.

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 service continues to complete evaluations of restraint use and these are usually completed at plan reviews and also through the review committee.

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

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

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

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

(d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

The service continues to complete evaluations of restraint use and these are usually completed at plan reviews and also through the review committee.
The service restraint process aligns with the requirements of this criterion .

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The review committee reviews the restraint register and the episodes of restraint to determine correct management and the risks to clients and staff.

When an individual's behaviour meets the criteria for the emergency use of restraint intervention and other risk management / de escalation strategies have been used without sufficient effect, there is clear procedure for support staff to follow.
Brackenridge evaluates /review the use of restraint regularly as noted in meeting minutes and client files. This is done initially by the Service Coordinator and Manager upon receipt of the Restraint Management Form during their review. The Restraint Review Coordinator also evaluates each restraint situation on the Restraint Management Form.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.4.3 Following each episode of restraint or at defined intervals, the consumer and where appropriate their family/wh?nau, receives support to discuss their views on the restraint episode.

Audit Evidence

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

Advised that debriefing for the Individual/s concerned and employees involved may include access to:

- NVCI Postvention guidelines
- Peer Support Team Members
- Occupational Counselling Programme Services (OCP)
- Service Co-ordinators
- Family/Whanau
- Independent Advocacy Services
- Cultural Representative
- Spiritual advisor

Review of four files that includes episodes of non NVCI included debriefing and discussions with the client.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.5 Restraint Monitoring and Quality Review

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

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

Restraint has been reviewed by the service and records of this are maintained. Individual use of restraint continues to be reviewed through the use of incident reports and other documentation. Reports on the use and frequency of restraint are provided to the service board monthly.

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

The Brackenridge Restraint Monitoring Committee reviews / evaluate all episodes of Restraint Intervention on a quarterly basis and consider:
a) the type, volume, frequency and duration of physical intervention / restraint use, b) if all compliance requirements are met e.g. Standards / Approval Process / Policies and Procedures, c) if support plans identify alternative techniques / strategies to restraint, d) the impact the restraint had on those involved – individual concerned and staff, e) restraint has been reviewed by the service and records of this are maintained.
Individual use of restraint continues to be reviewed through the use of incident reports and other documentation. Reports on the use and frequency of restraint are provided to the service board monthly.

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.

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 Programme at Brackenridge consists of (but is not limited to): a) governance, review and reporting, b) role of the infection control officer and infection control committee, c) written policies and procedures, d) surveillance and analysis, e) education and training, and f) access to infection control expertise and reference material. The Infection Control coordinator has in place a monthly reporting process for collecting a broad range of infection data and reporting this to the committee. The programme is reviewed annually. The service links with med lab south and this includes annual training for staff. The IC quality and risk management policy includes external advice from med lab south and CDHB.

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 Infection Control Programme at Brackenridge consists of (but is not limited to): a) governance, review and reporting, b) role of the infection control officer and infection control committee, c) written policies and procedures, d) surveillance and analysis, e) education and training, and f) access to infection control expertise and reference material.

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 has in place a monthly reporting process for collecting a broad range of infection data and reporting this to the committee. Discussions with the Infection Control coordinator indicated that the service has and would take the necessary actions required to control a serious infection including too notify a serious incident of infection. Monthly registers from each house are reported to the IC Coordinator

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:**

The infection control policies and procedures were reviewed Dec 2008. The IC committee reviews the Infection Control Programme in conjunction with the Health and Safety Committee annually.

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 service has developed infection control policies and procedures in consultation with Alison Carter from Med Lab South. The IC quality and risk management policy includes external advice from med lab south and CDHB.
The service manager has approved the infection control programme and the Health and Safety Committee is responsible for reviewing the programme annually.
There is an Infection Control Officer and the responsibilities of the position are described. There is also an Infection Control Committee and the responsibilities are also defined. The IC committee meeting quarterly.

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 service links with med lab south and this includes annual training for staff. The IC quality and risk management policy includes external advice from med lab south and CDHB..

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 Brackenridge Quality Council meets monthly and consists of the Manager Organisational Development, the Client Services Manager, the Health Adviser Co-ordinator, a staff person from each home (as available) and where practicable a client representative. One of the Council's responsibilities is the monitoring of the Infection Control Programme for effectiveness. The team is appropriate for a service of this type and size.

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 committee continues to be clearly defined in the Governance Review and Reporting section of the Infection Control Programme and associated 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:**

The Infection Control Committee meets quarterly and considers policy and resourcing (as well as other infection control matters) relating to infection control. Extraordinary meetings may be called if required. Monthly Infection Control data is collected / documented in each home and forwarded to the Manager Organisational Development. Any issues / concerns are raised on a needs basis. Monthly infection control data is reported to the General Manager and the board of Brackenridge.

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:**

In discussion with the infection control officer and staff confirm that the service is capable of implementing policies and procedures to effectively manage and isolate residents who present an infection hazard. The service has experienced very few infectious outbreaks but where a infection is detected in the past the service has reacted quickly and effectively and this could be described by staff. The service has in place infection outbreak policies. Prevention and Management of infections policy includes staff health.

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.

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 Committee includes key management staff. The Infection Control Committee oversees the Infection Control Programme at Brackenridge and provides the Brackenridge Quality Council with reports on infection control surveillance data and management of any infection control issues that may arise. Annual Infection control training is provided to staff. The infection control officer has access to all resident records and this includes access to all relevant resident information to undertake surveillance, audits, investigation.

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 Committee includes key management staff. The service Infection Control Officer informs that the service consults with Alison Carter from Med Lab South as required. The IC Officer also belongs to the CDHB quality group.

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 programme details the role and responsibilities of the infection control team.
The Infection Control Committee oversees the Infection Control Programme at Brackenridge and provides the Brackenridge Quality Council with reports on infection control surveillance data and management of any infection control issues that may arise.
Responsibilities of the Infection Control Committee include (but are not necessarily limited to): a) developing policies, b) implementing policies, c) monitoring policies and d) evaluating the infection control programme on a quarterly basis.

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 policies and procedures are developed by the service and where relevant, external expertise has been involved (Alison Carter from Med Lab South). IC standards precautions and safe food handling training has been completed in 2010.

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:**

The infection control officer has access to all resident records and this includes access to all relevant resident information to undertake surveillance, audits, investigation. The policy requires that the infection control committee is to have access to the service individual's records and diagnostic results if required.

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.

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 Programme at Brackenridge consists of (but is not limited to): a) governance, review and reporting, b) role of the infection control officer and infection control committee, c) written policies and procedures, d) surveillance and analysis, e) education and training, and f) access to infection control expertise and reference material. The policies have been updated to reflect the Infection Control standards NZS 8134: 3 :2008.

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:**

The Infection Control Programme at Brackenridge consists of (but is not limited to): a) governance, review and reporting, b) role of the infection control officer and infection control committee, c) written policies and procedures, d) surveillance and analysis, e) education and training, and f) access to infection control expertise and reference material. The policies have been updated to reflect the Infection Control standards NZS 8134: 3 :2008.
Infection control policies and procedures include (but are not necessarily limited to): a) governance, review and reporting, b) surveillance and analysis, c) education and training, d) quality and risk management, e) hand hygiene, f) standard precautions, g) antimicrobial usage, h) blood and body substance exposure, i) transmission based precautions, j) outbreak management, k) notifiable diseases, l) single use/short life items, m) enteral feeding, n) sharps, o) prevention and management of infection in service providers, p) food safety management, q) specimen collection, storage and transportation, r) cleaning disinfection, s) body waste spillage, t) waste management, u) handling of laundry, and v) relevant references.

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:**

Infection control policies are relevant to the environment and include a) - i) in identified in this criterion.

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 policies and procedures are developed by the service and where relevant, external expertise has been involved (Alison Carter from Med Lab South).

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.

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 Officer continues to receive training and support by Med Lab South. Staff receive infection control training including standard precautions, and food handling as part of the orientation process and staff also receive regular training/information at staff meetings and IC training sessions at least annually. Records of infection control education are maintained and were sighted on sampled staff files.

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:**

The Infection Control Officer continues to receive training and support by IC Advisor Med Lab South.
Educational material is provided to homes in the form of fliers and memorandums. Videos and resources are available. Staff are provided with the minutes from the Infection Control Committee meetings.
Staff are provided with infection control training as part of their orientation process and on-going training is provided thereafter.

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:**

Staff receive infection control training including standard precautions, and food handling as part of the orientation process and staff also receive regular training/information at staff meetings and IC training sessions at least annually.

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 service implements a regular programme of education and training for staff. Where an area of need is identified by the Infection Control Officer or the Infection Control Committee additional training is provided.

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 infection control education are maintained and were sighted on sampled staff files. Training content/handouts is maintained

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:**

Records of infection control education are maintained and were sighted on sampled staff files. Discussions with a clients across the service described education sessions in house meetings such as food handling and hand washing.

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

There is an infection control surveillance and analysis policy which outlines the purpose and methodology for the surveillance of infections. Antibiotics prescribed are identified and linked with the infection control system and all infections including multi resistant organisms are included on the house IC registers. Infection control data continues to be collated monthly and reported to the infection control committee. The service infection control committee monitors and tracks infection trends. Internal audits are still inconsistently completed across all houses.

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 an infection control surveillance and analysis policy which outlines the purpose and methodology for the surveillance of infections. This is supported by a procedure for data collection which summarises the process of gathering and analysing infection information. Information from infection control data collection is used for data collation and analysis and staff confirm that this is reported (when relevant) at staff meetings.

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:**

Infection control data in relation to the use and effectiveness of antimicrobials continues to be collated monthly and included as part of the infection control committee monitoring function. Antibiotics prescribed are identified and linked with the infection control system and all infections including multi resistant organisms are included on the house IC registers

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:**

Infection control data continues to be collated monthly and reported to the infection control committee. The service infection control committee monitors and tracks infection trends.
There is an annual Infection Control Report that provides a comprehensive overview of the development, implementation, management, and monitoring of the infection control programme.
IC team members include staff across the organisation and include; Manager Organisational Development (Psychopaedic Nse / Quality Cert), Manager Client Services (Comprehensive Nse), Health Advisor (Psychopaedic Nse / Health Assessment for Adults, Careerforce Assessor Nat Cert Human Services), Person Centred Coordinator (RN), Nse Leader (House Ldr - Psychopaedic Nurse), Support Staff, Client Rep and Cultural Rep.
Internal audits are completed in all house and forwarded to the Manager organisational development

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:**

There are standardised definitions that align with the infection control register.

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:**

The type of surveillance undertaken across all the houses is appropriate of the size and type of service.

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:**

The infection control system continues to have a policy on surveillance. The policy requires that the following data is gathered: a) use of antibiotics, b) urinary tract infections, c) chest infection, d) skin infections d) eye infections requiring treatment, e) gastrointestinal infections, f) influenza and g) other infections. There is an infection control surveillance and analysis policy which outlines the purpose and methodology for the surveillance of infections.

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

Infection control data continues to be collated monthly and reported to the infection control committee. Trend data is analysed monthly and monthly data is graphed.
The service senior management are provided with monthly infection control information and trends are communicated to the board.
When internal audits are completed they include infection control criteria such as (but not limited to): a) safe food storage, b) fridge /freezer temperatures, c) general cleaning, d) toilet/bathroom cleaning, e) appropriate storage of cleaning materials, f) appropriate laundry infection management.

Finding Statement

Internal audits are still inconsistently completed across all houses.

Corrective Action Required:
Ensure all internal audits are completed in each house and the results are analysed through the IC Committee.

Timeframe:
6 months

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:**

Client files include progress notes on client infections, management and progress. Medical notes are included in files. In the permanent respite house, the support worker stated there is good communication with families and any infections/concerns are communicated.

Finding Statement

Corrective Action Required:

Timeframe: