Brackenridge Estate Limited

Surveillance audit, Audit Report

Audit Date: 12-Sep-11

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Brackenridge Estate Limited

Premise Name	Street Address	Suburb	City
Iroquois	5 Iroquois Place	Wigram	Christchurch
Oakhampton	71 Oakhampton Street	Hornby	Christchurch
House 1	150 Maddisons Road	Templeton	Christchurch
House 2	150 Maddisons Road	Templeton	Christchurch
House 4	150 Maddisons Road	Templeton	Christchurch

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

Type of Audit	Surveillance audit and (*if applicable*)	
Date(s) of Audit	**Start Date:** 12-Sep-11	**End Date:** 12-Sep-11
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	Jim DuRose	MBS, B.A., Dip Rehab, Lead Auditor Certificate	9.15	4.00	12-Sept-11
Auditor 1	Sharon Reilly	RN, auditor certificate	9.15	3.00	12-Sept-11
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	Lisa Cochrane			0.50	

Total Audit Hours on site	18.30	**Total Audit Hours off site** *(system generated)*	7.50	**Total Audit Hours**	25.80
Staff Records Reviewed	5 of 45	**Client Records Reviewed** *(numeric)*	5 of 30	**Number of Client Records Reviewed using Tracer Methodology**	1 of 5
Staff Interviewed	8 of 45	**Management Interviewed** *(numeric)*	2 of 2	**Relatives Interviewed** *(numeric)*	0
Consumers Interviewed	7 of 30	**Number of Medication Records Reviewed**	10 of 30	**GP's Interviewed (aged residential care and residential disability)** *(numeric)*	

Declaration

I, (full name of agent or employee of the company) Jim DuRose (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 19 day of October 2011

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

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

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

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

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

Services and Capacity

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit **	Number of Swing Beds for Aged Residen-tial Care	Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disabilit
Iroquois	5	4		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☐	☐
Oakhampton	5	5		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☐	☐
House 1	10	8		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☐	☐
House 2	10	8		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☐	☐
House 4	6	5		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐

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

Executive Summary of Audit

General Overview

Brackenridge continues to provide services for persons with intellectual and physical disabilities including high needs. They advised that three houses are in the orange zone from earthquake but none visited for certification. A sample of five houses was visited that have a total of 30 residents (35 beds). Iroquois with four persons, Oakhampton had five, Houses 1 and 2 had eight each and House 4 and five residents. There is a current strategic plan. The General manager has been with the service for the last 12 years and has a number of years experience in management, health and with CYF. He is completing the Mindful Leadership programme. There are human resource processes in place for recruitment and appointment.

The service has improved since the previous audit with; quality systems, the majority of support plan and medication documentation requirements, transportation of medication policies and procedures and food storage.

Improvement required as identified from this audit include; home agreements, follow-up of quality actions, documenting family involvement, goal setting and planning, documentation identified at Iroquois and infection surveillance.

1.1 Consumer Rights

An open disclosure policy is in place and information is available for residents and their family that includes consumer rights. An informed consent policy is in place that includes recording informed consent for routine situations. The service has an up to date register to maintain complaints. Improvement required for consistent home agreements on files.

1.2 Organisational Management

Quality data includes incidents, infection control, health and safety, hazards, complaints, internal audits, medication errors. There are monthly Quality / health and safety committee meetings and the data is collated quarterly for review and evaluation. The service has an established health and safety programme. ACC WSMP achieved November 2010. There continues to be a comprehensive annual training programme (Learning and development schedule) and competencies are implemented. There is policy for staffing levels and rosters for each house. Improvements required for further internal auditing sign off, incident report timely reviews, and for staff designation on records.

1.3 Continuum of Service Delivery

Five files were reviewed (one in each of five houses). 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 family / client (as appropriate) / Behaviour Support (as required) / Service Manager / other people as relevant i.e. specialist support. The service has developed person centred plans, care plans that are based on a social model of care and support. The service requires that they are developed and reviewed with the inclusion of relevant people such as the resident and were appropriate their family/whānau/guardian. The level of resources, expertise and equipment provided by the service for residents is appropriate to meet their care and support needs. They have experienced, trained and dedicated staff around behaviour support and vocational support. Improvements are required with regard to documentation of family involvement, timely reviews, documentation of Short term care plans, risks and resident goals.

There is a medication management system implemented across the homes. Management of prn medication has clear guidelines in place. Improvement required with documentation.

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.

1.4 Safe and Appropriate Environment

Personal protective equipment (PPE) policy is included in the health and safety manual. The main office had a WoF expiry 1st October 2012. The hot water temperatures are tested and recorded by an independent contractor for the five houses being audited on the estate. This is done on a monthly basis. The service has policies and procedures for civil defence and other emergencies. Civil defence kits are in place for each house and checked.

2 Restraint Minimisation and Safe Practice

There is a restraint: policy & procedure that is aligned with the restraint minimisation and safe practice standard and appropriate for this type of environment. There is an up to date enabler register and documentation is in place on resident files sampled. The enabler consent form is signed/consented by the resident or EPOA. Training in Non-Violent Crisis Intervention (NVCI) is compulsory for all staff. Improvement required to review the safety gate documentation at Iroquois.

3. Infection Prevention and Control

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.
An improvement is required around ensuring all infections surveillance reporting sheets are completed in each house and include all infections.

Summary of Attainment

1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery		0	0	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery		0	0	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect		0	0	0	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs		0	0	0	0	0	7
Standard 1.1.5	Recognition of Pacific values and beliefs		0	0	0	0	0	2
Standard 1.1.6	Recognition and respect of the individual's culture, values, and beliefs		0	0	0	0	0	2
Standard 1.1.7	Discrimination		0	0	0	0	0	5
Standard 1.1.8	Good practice		0	0	0	0	0	1
Standard 1.1.9	Communication		0	1	0	0	0	4
Standard 1.1.10	Informed consent		0	0	1	0	0	9
Standard 1.1.11	Advocacy and support		0	0	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources		0	0	0	0	0	2
Standard 1.1.13	Complaints management		0	1	0	0	0	3

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

1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance		0	1	0	0	0	3
Standard 1.2.2	Service Management		0	0	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems		0	4	1	0	0	9
Standard 1.2.4	Adverse event reporting		0	0	1	0	0	4
Standard 1.2.5	Consumer participation		0	0	0	0	0	5
Standard 1.2.6	Family/whānau participation		0	0	0	0	0	3
Standard 1.2.7	Human resource management		0	2	0	0	0	5
Standard 1.2.8	Service provider availability	Met	0	1	0	0	0	1
Standard 1.2.9	Consumer information management systems		0	0	1	0	0	10

Organisational Management Standards (of 9):			Met:1	Not Met:0	N/A: 0
Criteria (of 42):	CI:0	FA:8	PA:3	UA:0	NA: 0

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services		0	0	0	0	0	5
Standard 1.3.2	Declining referral/entry to services		0	0	0	0	0	2
Standard 1.3.3	Service provision requirements		0	1	2	0	0	6
Standard 1.3.4	Assessment		0	0	0	0	0	5
Standard 1.3.5	Planning		0	0	1	0	0	5
Standard 1.3.6	Service delivery / interventions		0	2	0	0	0	5
Standard 1.3.7	Planned activities		0	0	1	0	0	3
Standard 1.3.8	Evaluation		0	0	1	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)		0	0	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer		0	0	0	0	0	2
Standard 1.3.11	Use of electroconvulsive therapy (ECT)		0	0	0	0	0	4
Standard 1.3.12	Medicine management		0	4	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management		0	3	0	0	0	5

Continuum of Service Delivery Standards (of 13):		Met:0	Not Met:0	N/A: 0	
Criteria (of 55):	CI:0	FA:10	PA:6	UA:0	NA: 0

1.4 Safe and Appropriate Environment

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.4.1	Management of waste and hazardous substances		0	1	0	0	0	6
Standard 1.4.2	Facility specifications		0	1	0	0	0	7
Standard 1.4.3	Toilet, shower, and bathing facilities		0	1	0	0	0	5
Standard 1.4.4	Personal space/bed areas		0	0	0	0	0	2
Standard 1.4.5	Communal areas for entertainment, recreation, and dining		0	0	0	0	0	3
Standard 1.4.6	Cleaning and laundry services		0	0	0	0	0	3
Standard 1.4.7	Essential, emergency, and security systems		0	4	0	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating		0	0	0	0	0	3

Safe and Appropriate Environment Standards (of 8): Met:0 Not Met:0 N/A: 0

Criteria (of 36): CI:0 FA:7 PA:0 UA:0 NA: 0

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation		0	3	1	0	0	6
Standard 2.2.1	Restraint approval and processes		0	0	0	0	0	3
Standard 2.2.2	Assessment		0	0	0	0	0	2
Standard 2.2.3	Safe restraint use		0	0	0	0	0	6
Standard 2.2.4	Evaluation		0	0	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review		0	0	0	0	0	1
Standard 2.3.1	Safe seclusion use		0	0	0	0	0	5
Standard 2.3.2	Approved seclusion rooms		0	0	0	0	0	4

Restraint Minimisation and Safe Practice Standards (of 8):			Met:0	Not Met:0	N/A: 0
Criteria (of 30):	CI:0	FA:3	PA:1	UA:0	NA: 0

3 Infection Prevention and Control

		Attainment	CI	FA	PA	UA	NA	of
Standard 3.1	Infection control management		0	0	0	0	0	9
Standard 3.2	Implementing the infection control programme		0	0	0	0	0	4
Standard 3.3	Policies and procedures		0	0	0	0	0	3
Standard 3.4	Education		0	0	0	0	0	5
Standard 3.5	Surveillance		0	0	1	0	0	8
Standard 3.6	Antimicrobial usage		0	0	0	0	0	5

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

Criteria (of 34): CI:0 FA:0 PA:1 UA:0 NA: 0

Total Standards (of 57) **Met:** 1 **Not Met:** 0 **N/A:** 0

Total Criteria (of 247) **CI:** 0 **FA:** 30 **PA:** 12 **UA:** 0 **N/A:** 0

Corrective Action Requests (CAR) Report

Provider Name: Brackenridge Estate Limited
Type of Audit: Surveillance audit
Date(s) of Audit Report: Start Date:12-Sep-11 End Date: 12-Sep-11
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: Jim DuRose

Std	Criteria	Rating	Evidence	Timeframe
1.1.10	1.1.10.1	PA Low	**Finding:** Inconsistency of signed home agreements on resident files. **Action:** Check that home agreements are on all files.	3 months
1.2.3	1.2.3.8	PA Low	**Finding:** Internal audit system is not fully functioning for actions and sign off. Some staff house meetings do not fully show sign of actions. **Action:** Further review and implement internal audits, consistently document actions completed in staff meetings and continue to work through developing client surveys.	3 months
1.2.4	1.2.4.3	PA Moderate	**Finding:** Incident report reviews by the Behaviour or Service Area Manager are often greater than 5 days (not timely). **Action:** Complete incident reviews in a timely manner and better document improvements and follow through.	3 months
1.2.9	1.2.9.9	PA Low	**Finding:** Designation is not consistently evident in care plans, reviews or daily progress notes. **Action:** Staff to include designation when documenting records.	3 months
1.3.3	1.3.3.2	PA Low	**Finding:** One file in each house was reviewed; In house 2, and in Iroquois and Oakhampton there was no documented family involvement /sign off.	6 months

			Action: Ensure that family involvement if support plans is consistently documented.	
1.3.3	1.3.3.3	PA Low	**Finding:** One file was reviewed in each of five houses. Brackenridge house one , monthly reviews were in place, but not all completed, the care plan was signed but had no date or designation. Brackenridge house two, monthly reviews were in place, the care plan and reviews were signed but had no designation and just the month (no date) for reviews. Brackenridge house four, monthly reviews were in place, but not fully completed, the care plan was signed. Oakhampton, monthly reviews were not always monthly and not always signed, the care plan signature had no designation. For Iroquois, the plan reviewed was not reviewed monthly, was not signed or dated. The last review documented was Jan 2011. The support plan in place was not signed or dated. This remains a finding from the previous audit. **Action:** Ensure that reviews are in place according to policy, that they are dated and signed with designation. Ensure that care plans are dated and signed with designation.	6 months
1.3.5	1.3.5.1	PA Moderate	**Finding:** In the five files reviewed, goals were not well documented in house one and in Iroquois. The Iroquois resident file lacked information that allowed the carers to provide the specific care needed (noting that carers, due to their resident knowledge, provide the care needed). Resident risks were not well documented in Iroquois. **Action:** Both long and short term goals to be fully documented. Risks associated with resident support to be documented with strategies to minimise.	3 months
1.3.7	1.3.7.2	PA Low	**Finding:** The recreation plans for all client files reviewed had no documented goals. **Action:** Recreation plans should be goals oriented to assist the resident to work towards their social and or recreation goals.	6 months
1.3.8	1.3.8.3	PA Low	**Finding:** The service does not use short term support plans for short term and or acute conditions (infections for example). **Action:** Where the resident has an acute condition the service should put short term support plans in place to guide care givers.	6 months

1.3.12	1.3.12.1	PA Moderate	**Finding:** In Iroquois house the documentation around medication management was not well documented and unclear about returning to the pharmacy. **Action:** Medication stored should clearly document the reason (e.g. returns to pharmacy) and staff should be educated in this process. Medication audits and actions should be extended to Iroquois house.	1 month
2.1.1	2.1.1.6	PA Low	**Finding:** At the Iroquois residence there is a safety gate in place on one resident's door due to safety from another resident having access at certain times of day. This is described as monitored closely by staff. The aim is to keep the non mobile person safe while they have a period of time out of their wheelchair on their bed - safe and free from harm, risk, or injury. Documentation of this was not evident to determine if this is identified as an enabler, restraint or a risk management approach. **Action:** Review the safety gate situation at Iroquois to determine whether enabler or restraint and fully document assessment, risk management and monitoring.	1 month
3.5	3.5.7	PA Low	**Finding:** Surveillance data for infections are still inconsistently completed and reported across all five houses reviewed. Not all infections as noted from resident files were documented on the surveillance sheets. This remains an finding from the previous audit. **Action:** Ensure all infections surveillance reporting sheets are consistently completed in each house and include all infections. Also, opportunity to review that the data collection sheet documents when infections start and are resolved.	3 months

Continuous Improvement (CI) Report

Provider Name:	Brackenridge Estate Limited
Type of Audit:	Surveillance audit
Date(s) of Audit Report:	Start Date:12-Sep-11 End Date: 12-Sep-11
DAA:	Health and Disability Auditing New Zealand Limited
Lead Auditor:	Jim DuRose

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.9 Communication

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

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:**

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 and information is available for residents and their family that includes consumer rights.

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:**

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 that includes recording informed consent for routine situations. There are signed consent forms on file and this includes welfare guardians where they are in place with that resident.
This criterion was partially attained at the last audit.

Finding Statement

Inconsistency of signed home agreements on resident files.

Corrective Action Required:

Check that home agreements are on all files.

Timeframe:

3 months

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:**

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 an up to date register to maintain complaints. Complaints received include the dates and actions taken. There have been two complaints since the last audit, in April and May 2011. Both related to a late pick up of the client from day services.
Improvement Note: Opportunity to improve the register by including a summary of the complaint and actions rather than just Y / N.

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:**

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 General manager has been with the service for the last 12 years and has a number of years experience in management, health and with CYF. He is completing the Mindful Leadership programme. There is an organisational chart with managers in a variety of roles across the organisation that includes Manager training & quality, young persons, high needs (Clinical nurse leader, adult residential, and daily operations supervisor.

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:**

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

Audit Evidence

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

A restructure of senior staff has resulted in a changed management structure which is to provide an improved client services approach. Further change is to be implemented at house level with one outcome being that those clients who are able to participate in house meetings are encouraged to do so as they wish.
Client survey tool yet to be developed (refer to #1.2.3.8) though family surveys are completed. Family information meetings are provided during the year.
This criterion was partially attained at the last audit.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

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

Quality data includes incidents, infection control, health and safety, hazards, complaints, internal audits, medication errors. There are monthly Quality / health and safety committee meetings and the data is collated quarterly for review and evaluation.
This criterion was partially attained at the last audit.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

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

The service continues to have a process in place for measuring achievement against its quality and risk plans. This includes the monthly Quality / health and safety meetings, management meetings and house meetings. These meetings provide the means to measure progress with the quality / risk system. The general manager also 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.

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

Internal audits are completed by the daily operations supervisor and the houses then undertake the actions. House team meetings include: health & safety, quality, individual client reviews, active support, family / whanau contact, staff education, and house topics for discussion. Staff sign off for attendance. The house meeting minute book has been amended to include the review of previous meeting and outcomes of actions taken in the minute book format.
This criterion was partially attained at the last audit.

Finding Statement

Internal audit system is not fully functioning for actions and sign off. Some staff house meetings do not fully show sign of actions.

Corrective Action Required:

Further review and implement internal audits, consistently document actions completed in staff meetings and continue to work through developing client surveys.

Timeframe:

3 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. ACC WSMP achieved November 2010. Behaviour management is in place with clients as identified.

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:**

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.
This criterion was partially attained at the last audit.

Finding Statement

Incident report reviews by the Behaviour or Service Area Manager are often greater than 5 days (not timely).

Corrective Action Required:

Complete incident reviews in a timely manner and better document improvements and follow through.

Timeframe:

3 months

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:**

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

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

There are human resource processes in place for recruitment and appointment. Five staff files sampled and they include appointment information, qualifications, orientation, training and appraisals completed. New appraisal tool is developed and being rolled out with training to supervisors for annual appraisal from October.
This criterion was partially attained at the last audit.

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 continues to be a comprehensive annual training programme (Learning and development schedule) and competencies are implemented. The service maintains training records of training and education provided to staff. This year's raining includes: cultural, non violent crises intervention, health and safety, fire safety, manual handling, medication, infection control, epilepsy, positive behaviour support, autism, informed consent / advocacy, oral health and certification.

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 policy for staffing levels and rosters for each house.

Audit interviews as follows: House Manager interview at office, GM and Quality / Education manager, Iroquois = bureau staff interviewed, RN (Acting Service Manager), no clients home. House 1 = 1 SW and 2 clients observed in lounge. House 2 = 2 SWs and 3 clients. House 4 = 1 SW and no clients at home. Oakhampton = 1SW and 2 client interviewed.

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

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

There is policy for staffing levels and rosters for each house.
Iroquois: 7-3, 3 - 11, 11pm - 9am.
House 1: 7-3 (two SW + 1RN), 1-9, 2-10 (two) 3-11 (1SW and 1 RN)
House 2: 7 - 10 (two), 7-3, 7-2, 2-10, 4-9 (two), 3-11 (RN), 11-7 (aim for RN)
House 4: 7-1, 7-3, 2-10, 3-11, 11-7
Oakhampton: 7-3, 3-11, 4-9 (M, W, F), 11pm - 9am.
There is RN support across the houses.

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:**

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 are legible, signed and dated.
This criterion was partially attained at the last audit.

Finding Statement
Designation is not consistently evident in care plans, reviews or daily progress notes.

Corrective Action Required:
Staff to include designation when documenting records.

Timeframe:
3 months

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.3 Service Provision Requirements

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

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:**

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

The service has developed person centred plans, care plans that are based on a social model of care and support. The plans are entitled 'what you need to know about me'. The service requires that they are developed and reviewed with the inclusion of relevant people such as the resident and were appropriate their family/whānau/guardian.
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.
Brackenridge House one and four, One resident file was reviewed each house and support plan documented family involvement/ sign off.

Finding Statement
One file in each house was reviewed; In house 2, and in Iroquois and Oakhampton there was no documented family involvement /sign off.

Corrective Action Required:
Ensure that family involvement if support plans is consistently documented.

Timeframe:

6 months

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.

All resident files reviewed had monthly weighing charts and follow up for weight loss of gain. This is an improvement on the previous audit.

Finding Statement

One file was reviewed in each of five houses. Brackenridge house one , monthly reviews were in place, but not all completed, the care plan was signed but had no date or designation. Brackenridge house two, monthly reviews were in place, the care plan and reviews were signed but had no designation and just the month (no date) for reviews. Brackenridge house four, monthly reviews were in place, but not fully completed, the care plan was signed. Oakhampton, monthly reviews were not always monthly and not always signed, the care plan signature had no designation. For Iroquois, the plan reviewed was not reviewed monthly, was not signed or dated. The last review documented was Jan 2011. The support plan in place was not signed or dated. This remains a finding from the previous audit.

Corrective Action Required:

Ensure that reviews are in place according to policy, that they are dated and signed with designation. Ensure that care plans are dated and signed with designation.

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 five client files included correspondence from dieticians, occupational therapy, medical and CYF.

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:**

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 5 files 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. There is a well documented behaviour management plan for a resident in house four. Communication links with other health providers across all five files.

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

In the five files reviewed, goals were not well documented in house one and in Iroquois. The Iroquois resident file lacked information that allowed the carers to provide the specific care needed (noting that carers, due to their resident knowledge, provide the care needed). Resident risks were not well documented in Iroquois.

Corrective Action Required:

Both long and short term goals to be fully documented. Risks associated with resident support to be documented with strategies to minimise.

Timeframe:

3 months

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:**

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 strives to provide a home for residents and this is achieved in the small houses with staff that are demonstrably caring towards the residents. Community links are established for all residents with outside agencies such as Horizon, Westwood stables providing important aspects of the ' living a normal life'
Tracer;
A resident with challenging behaviour.
Incident forms document that behaviour for the resident is becoming more common and more difficult for the service to manage in the current environment.
This resident has a well documented behaviour management plan. the plan includes input from a behaviour specialist and the manager. This is not signed by the family (#1.3.3.2)
There are documented team meetings that discuss behaviour issues as there is a clear escalation of behaviour over the last two months.
The team meetings document that all staff have been able to discuss problems, and how they have managed the situation.
The service has commenced an ABC behaviour management plan to assist in the referral process to a higher level of care. and resident files document that the process has commenced.
The resident has an activities plan but as noted in # 1.3.7.2 this is not goal orientated.

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. They have experienced, trained and dedicated staff around behaviour support and vocational support. Person centred coordinators personalises the service received by clients.
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.

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:**

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

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.

Finding Statement

The recreation plans for all client files reviewed had no documented goals.

Corrective Action Required:
Recreation plans should be goals oriented to assist the resident to work towards their social and or recreation goals.

Timeframe:
6 months

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:**

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

Discussions with staff and a review of a sample of files identified that reviews and changes to support plans are in place for conditions such as challenging behaviour. But this is not the case for infections.

Finding Statement

The service does not use short term support plans for short term and or acute conditions (infections for example).

Corrective Action Required:

Where the resident has an acute condition the service should put short term support plans in place to guide care givers.

Timeframe:

6 months

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:**

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:** Moderate

There is a medication management system implemented across the homes in the Brackenridge estate and community homes within the wider community. Five medication systems were reviewed at five houses. 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.
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.
House one keeps controlled drugs for house one and two and these are stored and given according to policy. There are well documented guidelines across all houses for PRN medication where the RN on duty and any of the houses reviews the need and gives permission (or not) via PRN permission slip.
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.
For houses one, two, four and Oakhampton medication management has improved since the previous audit and previous findings addressed. Audits of medications are 3 monthly.

Finding Statement

In Iroquois house the documentation around medication management was not well documented and unclear about returning to the pharmacy.

Corrective Action Required:
Medication stored should clearly document the reason (e.g. returns to pharmacy) and staff should be educated in this process. Medication audits and actions should be extended to Iroquois house.

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

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.
Since the previous audit the service has implemented a policy on the transportation of medications for residents attending outside activities. This is an improvement on the previous audit.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.12.5 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.

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:**

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.
2 clients' at each house said their meals are good. The kitchens were clean, and well kept. Kitchens are maintained as a normal domestic kitchen to maintain the home like environment of the houses.

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:**

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

Corrective Action Required:

Timeframe:

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

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

Food in the houses storage areas are dated, labelled and are correctly rotated. Staff said fridge and freezer temperatures are taken in the houses. The fridges in the houses had thermometers in them. Temperatures are recorded monthly on the Monthly Data Recording sheet which is forwarded to the Service Manager then to the Manager Training and Quality Services. The fridge in house one used for storing medications has the temperature taken and recorded. Larders and fridges in five houses had no out of date food or fluid.
This is an improvement on the previous audit.

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

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:**

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

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

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 staff in each of the five houses identified the PPE was available for use. Gloves and aprons were sighted. This is an improvement on the previous audit.

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.2 Facility Specifications

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

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:**

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

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

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

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

The main office had a WoF expiry 1st October 2012.

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:**

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

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

The hot water temperatures are tested and recorded by an independent contractor for the five houses being audited on the estate.
This is done on a monthly basis. Oakhampton and Iroquois has their hot water temperatures monitored. This is an improvement on the previous audit

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:**

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

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

The service has policies and procedures for civil defence and other emergencies. Staff training/education on fire and emergency procedures is provided at orientation and ongoing. At the last audit House 2 was identified as having a slide bolt lock on the laundry and this has been removed.
This criterion was partially attained at the last audit.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The service ahs been advised by NZ Fire Service - as both Iroquois and Oakhampton houses have a fire alarm and sprinkler system connected to the Fire Service therefore a Fire Scheme is not required. Trial evacuations occur for all houses and are scheduled six monthly. For Iroquois and Oakhampton, Housing NZ is conducting trial evacuations and the service is working through the communication aspects for this.
This criterion was partially attained at the last audit.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Civil defence kits are in place for each house and checked. This includes sufficient stored water and, as identified at the last audit, for Iroquois House implemented from November 2010. There is emergency lighting an d torches. Barbeques are available for cooking. There are extra blankets available for warmth.
This criterion was partially attained at the last audit.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

There is 24 hour staffing at each house. Each house includes emergency contact numbers, emergency procedures and there is on call staff available. The service is determining whether it will continue with a policy for personal alarms as often staff do not use them and there are other arrangements in place for emergencies.
This criterion was partially attained at the last audit.

Finding Statement

Corrective Action Required:

Timeframe:

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

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

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:**

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

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

There is an up to date enabler register and documentation is in place on resident files sampled. There is an enabler consent form that includes description of the enabler, monitoring and review dates and review criteria.
This criterion was partially attained at the last audit.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The 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 as required with the enabler register maintained.

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 and this is followed by a one day (8 hours) Refresher Course. A record of staff training in NVCI is kept on the Staff Education database and this year's Learning and development schedule includes NVCI.

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

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.

Finding Statement

At the Iroquois residence there is a safety gate in place on one resident's door due to safety from another resident having access at certain times of day. This is described as monitored closely by staff. The aim is to keep the non mobile person safe while they have a period of time out of their wheelchair on their bed - safe and free from harm, risk, or injury. Documentation of this was not evident to determine if this is identified as an enabler, restraint or a risk management approach.

Corrective Action Required:
Review the safety gate situation at Iroquois to determine whether enabler or restraint and fully document assessment, risk management and monitoring.

Timeframe:
1 month

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

STANDARD 3.5 Surveillance

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

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

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

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
Surveillance data for infections are still inconsistently completed and reported across all five houses reviewed. Not all infections as noted from resident files were documented on the surveillance sheets. This remains an finding from the previous audit.

Corrective Action Required:

Ensure all infections surveillance reporting sheets are consistently completed in each house and include all infections. Also, opportunity to review that the data collection sheet documents when infections start and are resolved.

Timeframe:
3 months