Brackenridge Estate Limited

Certification Audit Report

Audit Date: 22-Aug-12

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Brackenridge Estate Limited

Premise Name	**Street Address**	**Suburb**	**City**
Brackenridge House 1	150 Maddisons Road	Templeton	Christchurch
Brackenridge House 10	150 Maddisons Road	Templeton	Christchurch
Brackenridge House 14	150 Maddisons Road	Templeton	Christchurch
Brackenridge House 8	150 Maddisons Road	Templeton	Christchurch
Brackenridge House 13	150 Maddisons Road	Templeton	Christchurch
Iroquois	5 Iroquois Place	Wigram	Christchurch

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

Type of Audit	Certification audit and (*if applicable*)	
Date(s) of Audit	**Start Date:** 22-Aug-12	**End Date:** 24-Aug-12
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	Tricia Dore	MBA MN B.ED Adv Dip Child and Family Health RGON Dip Tchg	24.00	12.00	22-Aug-12 to 24-Aug-12
Auditor 1					
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor	Rhonda Heather	8086, family member, experienced consumer auditor	24.00	8.00	22-Aug-12 to 24-Aug-12
Peer Review Auditor	Jim DuRose	Lead Auditor		1.00	

Total Audit Hours on site	48.00	**Total Audit Hours off site** *(system generated)*	21.00	**Total Audit Hours**	69.00
Staff Records Reviewed	10 of 56	**Client Records Reviewed** *(numeric)*	11 of 34	**Number of Client Records Reviewed using Tracer Methodology**	2 of 11
Staff Interviewed	15 of 56	**Management Interviewed** *(numeric)*	5 of 5	**Relatives Interviewed** *(numeric)*	7
Consumers Interviewed	4 of 34	**Number of Medication Records Reviewed**	15 of 34	**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 27 day of September 2012

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 Residential 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 Disability
Brackenridge House 1	10	8		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge House 10	6	6		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge House 14	6	5		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge House 8	6	6		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Brackenridge House 13	6	6		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
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: ““Supporting People To Create Great Lives”. Brackenridge has its head administrative base at 29 Birmingham Drive Middleton. They have a complex of homes at 150 Maddisons Rd Templeton where they have 14 houses and an administration building. They also operate other houses in the greater Christchurch area and they are actively engaged in support residents to move from the estate into community settings.

Six houses were included in the sample size including five at Maddisons Rd on the Brackenridge Estate and one in the greater Christchurch area. 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 their 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).

The organisation has been given a rating of continuous improvement in three areas: one for good practice with innovative and new models of service delivery provided, one around the use of quality data to improve service delivery and one in relation to the reduction of Restraint Implementation across the organisation.

Improvements are required to the following: home agreements, employee files, goal planning, and administration of medication.

1.1 Consumer Rights

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

Services are provided in a manner that is respectful of client rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs. Clients and family members interviewed stated their satisfaction with the service and that staff are providing appropriate care and treatment. There are systems in place to manage the complaints processes with a register is maintained.

The organisation has been given a rating of continuous improvement for good practice around the new implemented models of service delivery provided to give residents more independence and community engagement.

An improvement is required to home agreements.

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 and 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. There is evidence that improvements are made to service delivery as a result of analysis of data. Staff are employed in the homes as per a staffing policy and all stakeholders interviewed confirmed that staffing safely meets support needs of residents. The service has a well-developed orientation programme that includes relevant aspects of service delivery to support entry of new staff into the service and there is an comprehensive annual training programme and competencies implemented.

The organisation has been given a rating of continuous improvement for the use of quality data to improve service delivery.

Improvements are required to employee files.

1.3 Continuum of Service Delivery

Each resident has their own file with assessments and plan documented. There are behavioural plans documented when issues are noted and staff are supported to implement strategies with support from the behavioural specialists. Other plans are documented as per individual need e.g. for epilepsy, PEG feeds etc. Plans are reviewed six to twelve monthly. All long term residents are assessed by a needs assessment coordination service prior to entry to the service. 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. 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. Respite services are offered with information relevant to the resident well documented.

There is a medication management system implemented across the homes in the Brackenridge estate and community homes within the wider community. Management of PRN medication has clear guidelines in place and staff are appropriately trained to administer medications.

There are food policies/procedures for food services and menu planning is appropriate for this type of service. Dietician 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 are improvements required to goal planning and administration of medication.

1.4 Safe and Appropriate Environment

The estate was purpose built thirteen years ago and five of the houses being audited are part 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. One community house from the service is included in this audit. The

Iroquois house is in a cul de sac in the suburb of Wigram. All 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. All bedrooms are single and personalised with clients belongings. General living areas and resident bedrooms are appropriately heated and ventilated and residents have access to natural light in all rooms and there is adequate external light in communal areas of the houses.

2 *Restraint Minimisation and Safe Practice*

There is a restraint policy and 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 – Nonviolent 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 would be 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. The service has focused on reducing the episodes of restraint across the organisation of the past years and no restraint was used in the homes audited. Any use of an enabler is only for the safety of the resident e.g. ankle strap, seatbelt, tray. The organisation has been given a rating of continuous improvement for reduction of Restraint implementation.

3. *Infection Prevention and Control*

The Infection control coordinator is a registered nurse and has in place a monthly reporting process for collecting a broad range of infection data that is reported monthly to the health and safety and quality committee with a full review at the infection control meeting quarterly. The programme is reviewed annually. The service links with Medlab South and this includes annual training for staff. The Infection Control Committee includes key management staff. Annual Infection control training is provided to staff. Policies are currently being reviewed. There is an infection control surveillance and analysis policy which outlines the purpose and methodology for the surveillance of infections.

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	1	0	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:1	FA:40	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	1	8	0	0	0	9
Standard 1.2.4	Adverse event reporting	Met	0	4	0	0	0	4
Standard 1.2.5	Consumer participation	Not Applicable	0	0	0	0	5	5
Standard 1.2.6	Family/whānau participation	Not Applicable	0	0	0	0	3	3
Standard 1.2.7	Human resource management	Met	0	3	2	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	10	0	0	0	10

Organisational Management Standards (of 9):		Met:7	Not Met:0	N/A: 2	
Criteria (of 42):	CI:1	FA:31	PA:2	UA:0	NA: 8

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	5	0	0	1	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	2	1	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	5	1	0	1	7
Standard 1.3.13	Nutrition, safe food, and fluid management	Met	0	5	0	0	0	5

Continuum of Service Delivery Standards (of 13): Met:12 Not Met:0 N/A: 1

Criteria (of 55): CI:0 FA:40 PA:3 UA:0 NA: 12

1.4 Safe and Appropriate Environment

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

Safe and Appropriate Environment Standards (of 8):	Met:8	Not Met:0	N/A: 0		
Criteria (of 36):	CI:0	FA:36	PA:0	UA:0	NA: 0

2 Restraint Minimisation and Safe Practice

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

Restraint Minimisation and Safe Practice Standards (of 8):		Met:1	Not Met:0	N/A: 7
Criteria (of 30): CI:1	FA:5	PA:0	UA:0	NA: 24

3 Infection Prevention and Control

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

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

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

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

Total Criteria (of 247) **CI:** 3 **FA:** 181 **PA:** 6 **UA:** 0 **N/A:** 57

Corrective Action Requests (CAR) Report

Provider Name: Brackenridge Estate Limited
Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:22-Aug-12 End Date: 24-Aug-12
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: Tricia Dore

Std	Criteria	Rating	Evidence	Timeframe
1.1.10	1.1.10.1	PA Low	**Finding:** A home agreement has not been signed for two of the eight residents (excluding respite) as there are no family or welfare guardians involved and staff/managers have signed the agreement in two other instances where there are no family involved. In respite services, admission agreements have not been signed to date noting that the manager is aware of this and is beginning to get these completed. **Action:** Ensure that each resident has an appropriately signed home agreement. Service Agreements (in lieu of Home Agreements as the respite house is not the persons home) have been forwarded to all Families accessing Respite Support September 2012 - currently awaiting return of documents.	6 months
1.2.7	1.2.7.3	PA Low	**Finding:** i) The HR staff member states that reference checks are completed and that these are destroyed after completion. There is no evidence on record therefore that reference checks have been completed. ii) Two of 10 staff files do not include a contract. iii) One staff file has an expired work visa and another does not include a work visa that should. **Action:** i) Document evidence of reference checking. ii) Ensure that staff files include a contract. iii) Ensure that staff who require this have a current work visa.	6 months

1.2.7	1.2.7.5	PA Low	**Finding:** Five of 10 performance records are not current. **Action:** Ensure that all staff have a current performance appraisal.	6 months
1.3.5	1.3.5.2	PA Low	**Finding:** i) Goals for each resident are documented in a number of places as follows a) short and long term goals in the individual support plan for long term residents, b) goals in the my daily goals action plan, c) goals on the daily active support plan. The goals are not necessarily the same and some do not have interventions, accountabilities and responsibilities with evidence that they are actioned. ii) The respite service resident files do not indicate that goals have been well documented despite some residents coming two or three days a week with some having accessed the service for a number of years. iii) House 1 - a plan to address weight issues for one resident is not well documented. **Action:** i) Document goals for each resident that include interventions, accountabilities and responsibilities with evidence that they are actioned. ii) Document goals in the respite service. iii) House 1 - Document a plan to address weight issues for the resident identified.	3 months
1.3.12	1.3.12.1	PA Moderate	**Finding:** i) There is evidence of transcribing at house 13 (respite house) including on documentation of PRN guidelines. ii) The drug fridge temperatures in house one are identified as being higher than the norm and there is no evidence that these are adjusted. iii) House 10: A controlled drug register is used to record any medication that comes in from pharmacy but is not used to record balances after each administration. **Action:** i) Cease the practice of transcribing. ii) Ensure that all fridge temperatures are within normal range in house 1. iii) House 10: Document administration of controlled drugs on the relevant register each time these are administered. Prior to the final audit report, service advises that document of controlled drug administration in #10 in place as of 24th August 2012	3 months

Continuous Improvement (CI) Report

Provider Name: Brackenridge Estate Limited
Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:22-Aug-12 End Date: 24-Aug-12
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: Tricia Dore

Std	Criteria	Evidence
1.1.8	1.1.8.1	**Finding:** The service was set up following the closure of Templeton and continues to be funded by the Ministry of Health. Homes were established on the Templeton site and the management team has long since recognised the difficulties of continuing with the homes all on one site with an electronically controlled gate that affords residents restricted entry and exit. There has been significant discussion and planning in line with the disability MOH strategy to take the service to being community based. The strategic direction and plans indicate that the service has worked to implement the philosophy of Brackenridge which is to support people in ways relevant to the individual. Families have been engaged in the discussions around moves for the future through family meetings, family representation on the board, satisfaction surveys etc. Evidence to show that the service is implementing the strategy is as follows: a) There are documented plans and a policy around downsizing homes. b) There are now 68 residents at Brackenridge estate from the original 91 housed. There are now 52 residents living in the community. c) There are 14 homes on the estate with two now used for respite care. Five homes have been downsized by one or two residents. d) The service is working with two families so that they can purchase a home for their family member. e) The contracts sighted do not require a registered nurse to be on site on all shifts as occurs currently in houses one and two and this is gradually being reduced. There is a position paper outlining the move and family have been involved in the discussions to have registered nurse oversight and input as required. f) The CEO is continuing to have discussions with the CDHB and Housing NZ with regard to the use of the houses as these become vacant. There is a well implemented quality and risk management programme with a training programme implemented. The service has its own behavioural management team and there is evidence of well documented individual assessments that identify needs and strengths. The service uses a strengths based approach to service delivery. Seven family members interviewed were very positive about the service and the support provided. They stated that they were pleased with the service and staff excellent, could identify key positive outcomes, 'hands on staff were great', staff friendly, good variety of food with healthy eating, a nice environment etc.
1.2.3	1.2.3.6	**Finding:** The analysis of data and continued improvements have continued since the establishment of the organisation and indicate that

		there have been many changes to service delivery on the basis of analysis of data and subsequent implementation of recommendations. Examples include a comprehensive review of use of restraint which has seen use of restraint reduced from over 250 incidents to 30 incidents in 2011 with 22 planned for one resident to cut nails; identification of medication errors as an area of concerns in July 2012 with minutes at board and staff/manager level indicating that there is a planned approach to minimising these - a full critique of medication administration has already been completed to identify key areas for improvement; modifications to documentation for the respite service have continued as the respite services continue to be developed; support for residents to live in the community; review of differing levels of support for individual residents etc.
2.1.1	2.1.1.6	**Finding:** The training and quality manager is identified as the restraint coordinator (registered nurse). There has been considerable analysis of data around use of enablers and restraint with clear identification of enablers as those supports required for residents on a daily basis for safety e.g. lap belts, tray tables, bed rails etc. The use of restraint is identified as being for interim transport position, transport position or team control position. The number of incidents in 2004 was identified as being 269 and in 2011 as 30 with 22 for one resident who is required to be restrained when her nails are cut. The service provides all staff with nonviolent crisis intervention and there are two approved trainers on site. The service continues to discuss restraint use at the monthly health and safety and quality meetings. Monthly summaries of use of restraint and enablers is presented to the board with evidence in board meetings that they there is active monitoring of this. Quarterly summaries are provided to the health and safety and quality meeting with graphs and trends presented and discussed. The approval group continues to meet annually and as required and there is a continued focus on trying to minimise the use of restraint. Brackenridge has the following guidelines: guidelines for restraint assessment, restraint system flowchart 2011, restraint system responsibilities, restraint management form. The only holds used are the team control position and the transport position (confirmed by the restraint coordinator and a review of incident forms for restraint in the last year.

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
The residents are informed of their rights. The provider has a policy aligned with the legislation. The code of rights is incorporated into support provided to the residents.	

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 orientation/induction the staff receive an information pack which includes consumer rights, advocacy, how to make a complaint documentation. Training programmes for the staff is ongoing on consumer rights and obligations. The seven families and four residents interviewed were aware of their rights and had received information on rights in the admission pack. The 12 support staff interviewed confirmed they had received training and a copy of the code of rights - training around circles of safety including rights provided in Nov 2011. Staff are aware of their obligations to the residents and practice this by giving the residents choices in food preferences, annual goals and daily activities.		
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

In the homes where the residents can understand consumer rights, resident meetings are held where people are given the right to have their say on what is happening in their lives. Advocacy support is available if required.

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:**

The Code of Health and Disability posters are displayed in the main living areas of homes audited. Four of four residents interviewed were aware of their rights.

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:**

An information pack is given to the families and residents on entry to the service which includes information on the complaints process, advocacy and rights. A simple version of the rights is available. Some of the residents use pictures to understand their rights. The four residents interviewed confirmed they have an understanding of the Code and other rights. The seven families interviewed are aware of the code of rights.

The provider has a policy on cultural and interpreter services and a policy on consumer rights.

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 four residents interviewed confirmed the information regarding their rights was provided in a way they understand. Opportunities for discussion at residents meetings were documented as sighted in resident meeting minutes reviewed.

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:**

Information on the Health and Disability Advocacy services is included in the admission pack. The seven families interviewed confirmed they are aware of advocacy services.

The provider has a policy on advocacy and client advocacy.

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

The residents and their privacy are treated with respect. They have individual rooms. Staff are respectful of privacy and resident files are kept in secure areas away from public view.

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:**

The provider has a policy on consumer rights which states that the resident will be treated with dignity and as an individual, to be provided with personal and health care according to need, assured personal privacy, ensuring confidentiality with records, phone calls, mail, visitors and personal conversations, and to be addressed by preferred name. Staff interviewed described ways in which the residents privacy was respected including knocking on doors, having private spaces for discussions and care taken with personal belongings. The four residents interviewed felt their privacy was respected.

The provider has a policy on physical and personal privacy.

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:**

The residents support plans provides information on the residents cultural, spiritual and likes and dislikes. Residents are supported by staff to make choices, and enhance personal growth and staff were observed to encourage residents to make choices on the days of the audit. The service has access to links with a Maori cultural advisor, CDHB Maori Health, and the Maori community.

The service has a cultural policy that ensures cultural or ethnic values are responded to appropriately.

The service has a policy and procedures on death and dying.

The four residents interviewed confirmed they were receiving services appropriate to their needs.

Assessments and plans reviewed include reference to cultural, social, spiritual needs, values and beliefs.

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 support plan includes documentation of the residents preferred name. The staff interviewed stated that the residents were asked their preferred name and this was used. The four residents interviewed felt they were addressed respectfully. Staff were observed addressing residents 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:**

The residents are supported to participate in the spiritual care of their choice. The spiritual needs of the residents are recorded on entry. Several of the residents attend church every Sunday.

The provider has a spiritual care and beliefs policy.

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:**

The provider has a policy / guidelines on intimacy and sexuality developed for staff to consider on the sexual and personal relationships of people with disabilities. Information on sexuality and privacy is collected during assessment and recorded in the care plan. One resident has a friend from the opposite sex at house number eight and is supported by staff to have private time as needed.

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:**

Service support plans demonstrate interventions that encourage independence and reflect the wishes of the resident. Three of the six homes had residents who could make choices and were verbal and the other three homes had non-verbal residents. Staff in these homes were aware of the residents wishes through body language and gestures and good family support.

The four residents interviewed confirmed they had a choice of what to do with their day and have a right to refuse if they don't want to participate. The residents, where able, have choices on meals, activities, and patterns of daily living. The residents interviewed are involved in chores including helping to prepare meals, setting of tables, taking out rubbish and described some of the activities they attend in the community. Staff interviewed discussed promoting independence including providing transport for community activities. Two of the residents with very high needs were going to attend the 'Top Twins' concert in Christchurch and another two were flying to Auckland to see the " Mary Poppins " show all with staff support.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence	**Attainment:** FA	**Risk level for PA/UA:**
There is an abuse and neglect policy which defines the differing types of abuse and neglect. The policy states that abuse and neglect will be prevented by staff education, through in-service training , and orientation. There is a "procedure following the identification of abuse " policy which details the steps to take if abuse is identified. The staff interviewed were aware of abuse and neglect issues and had received training as part of the CareerForce ID strand training for support workers. Staff stated that abuse or neglect was not occurring. The residents interviewed did not disclose any instances of abuse and 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 residents who identify as Maori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. The provider recognises the specific needs that Maori residents may have and has policies and practices in place 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:**

There is a cultural safety policy in place which discusses cultural safety in practice. The needs of Maori residents are identified upon entry and other services will be contacted to ensure appropriate service delivery. The service has a Maori Health Plan which adopts key principles of New Zealand Maori Health Strategy, The Health and Disability Act, The New Zealand Disability Strategy and the contractual arrangements with the funding body of the Ministry of Health. One resident at Iroquois Place is a Maori but he does not identify with his culture as stated in the resident file.

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:**

The policies around cultural and Maori responsiveness detail appropriate contacts for Maori (including CDHB Maori Health, cultural advisor, Maori community consultation, whanau and iwi.) Staff interviewed were aware of these contacts and how to access them.

The service has access to information in te reo if required.

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 provider ensures Maori residents when required, receive the same level of support as non-Maori and safeguarding Maori concepts, values and practices, to encourage participation at all levels of service provision to contribute to service development.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

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

The service has a Treaty of Waitangi policy and all staff have received training which is compulsory. Maori residents have a right to practice their cultural beliefs and this will be facilitated by staff. Staff interviewed described that cultural needs and beliefs and iwi would be identified on admission and actioned in an appropriate manner.

The service has a Maori Protocols Policy and a Maori Health Plan.

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 admission document identifies iwi and relevant Maori representatives. The support plans identify cultural needs. The service recognises the importance of whanau and states that the residents will be supported to involve them when appropriate.

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:**

Linkages have been established between the Maori community providers, whanau, iwi, CDHB Maori health, cultural advisor. The service promotes the use of Maori language and ensures all Maori residents support plans have a cultural component. Maori staff are supported to attend Maori support groups and forums and encouraged to participate in leadership development and CareerForce courses. The service incorporates the use of Te Reo and Maori art into everyday life and supports Maori language week.

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

The service has a policy on cultural safety. The families and residents are consulted regarding their culture, values, beliefs on entry into the service and their preferences are supported. Families are involved and in support plans.

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:**

The residents are supported to access their individual culture and beliefs. The families interviewed (seven including two in house 1, one in house 8, two in house 10, two in house 13) stated they were involved in the support plans.

A residents satisfaction survey was completed in July 2012 with positive results. The residents culture and individual values and beliefs are documented in " My Support Plan " things you need to know about me document.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The families and residents are consulted during assessment and annual planning on individual values and beliefs. This is documented on personal files. The service reviews goals monthly. The service delivery plan evaluations include residents, family/whanau input. The four residents interviewed (one in house 10, two in house 14, one in house 8) confirmed their cultural values and beliefs are being met. A residents satisfaction survey was done in July 2012 with positive results.

The service has a Maori protocols plan.

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

Staff interviewed are aware of the requirement for residents to be free of discrimination The service has policies on discrimination and harassment, ethics and practice. The staff interviewed are aware of professional boundaries around acts or behaviours which could be at the expense of the resident and benefit the provider

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:**

The policies and procedures outline the safeguards to protect the residents from discrimination, coercion, harassment, and exploitation along with actions that will be taken if there is inappropriate or unlawful conduct and safety of the resident is compromised or put at risk. Policies include responsiveness to a complaint of any form of impropriety, management of the residents finances and personal accounts and safety and identification of the residents property. The complaints procedure encourages residents to report unacceptable behaviour. The residents and families interviewed stated that there was no coercion or harassment to their knowledge.

The service has a policy on managing individuals finances.

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 on gifts to staff and professional and personal boundaries. All staff interviewed are aware of professional boundaries around acts or behaviours which could be at the expense of the resident and benefit the provider.

Staff interviewed as part of the audit are: House 1 - two support workers, 1 registered nurse, 1 manager; Iroquois - 3 support workers, 1 manager; House 10 - 1 support worker, 1 manager; House 14 - 1 advanced practitioner, 1 support worker, 1 manager; House 8 - 2 support workers, 1 manager; House 13 (respite) - two support workers, 1 behavioural specialist, 1 manager. Total staff: 12 support workers, five managers, one registered nurse, CEO, one behavioural specialist.

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 for providing consistent and continuity of quality of care with ongoing training for staff. Reporting systems are linked to quality improvement processes which are well established. 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. 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 criteria has been given a rating of continuous improvement for the way in which they are using evidence and best practice along with MOH direction to change the way the service is delivered.

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

Audit Evidence **Attainment:** CI **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 which are well established.

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.

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.

Finding Statement

The service was set up following the closure of Templeton and continues to be funded by the Ministry of Health. Homes were established on the Templeton site and the management team has long since recognised the difficulties of continuing with the homes all on one site with an electronically controlled gate that affords residents restricted entry and exit. There has been significant discussion and planning in line with the disability MOH strategy to take the service to being community based. The strategic direction and plans indicate that the service has worked to implement the philosophy of Brackenridge which is to support people in ways relevant to the individual. Families have been engaged in the discussions around moves for the future through family meetings, family representation on the board, satisfaction surveys etc. Evidence to show that the service is implementing the strategy is as follows: a) There are documented plans and a policy around downsizing homes. b) There are now 68 residents at Brackenridge estate from the original 91 housed. There are now 52 residents living in the community. c) There are 14 homes on the estate with two now used for respite care. Five homes have been downsized by one or two residents. d) The service is working with two families so that they can purchase a home for their family member. e) The contracts sighted do not require a registered nurse to be on site on all shifts as occurs currently in houses one and two and this is gradually being reduced. There is a position paper outlining the move and family have been involved in the discussions to have registered nurse oversight and input as required. f) The CEO is continuing to have discussions with the CDHB and Housing NZ with regard to the use of the houses as these become vacant. There is a well implemented quality and risk management programme with a training programme implemented. The service has its own behavioural management team and there is evidence of well documented individual assessments that identify needs and strengths. The service uses a strengths based approach to service delivery. Seven family members interviewed were very positive about the service and the support provided. They stated that they were pleased with the service and staff excellent, could identify key positive outcomes, 'hands on staff were great', staff friendly, good variety of food with healthy eating, a nice environment etc.

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

Staff state they communicate with the residents where possible with information about their personal requirements and health needs in a private environment as required. The residents and families interviewed stated they were happy with communication from the service.

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:**

Families interviewed (seven including two in house 1, one in house 8, two in house 10, two in house 13) state they are well informed about anything that may affect them and their family member. Staff give information in the appropriate format for each person. e.g. pictorial if required. One to one discussions are held in private situation. The service has an open disclosure policy.

Each resident file includes a responsibilities for informing families record which identifies who to contact in the following situations: emergency hospitalisation, planned hospital treatment, changes in health status requiring specialist input/medical changes, incidents and accidents requiring medical doctors assistance, minor incidents/injuries requiring first aid, significant changes in daily routines and activities. There is also a family/whanau important person contact list. Both forms were well completed in all 11 resident files reviewed (one at house 1, one at Iroquois, two at house 10, three at house 14, one at house 8, three at house 13).

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:**

All the residents in homes one, eight, ten, thirteen, fourteen at 150 Maddisons Road, and 5 Iroquois Place have own bedrooms. Any personal discussions around a resident are held in a private place most appropriate for the particular person. Families interviewed stated they are given times for private discussions. The four residents interviewed confirmed that they are given time to talk about the care they are receiving.

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:**

The support plans identify the staff involved in the residents everyday living. In the homes a notice board in the main living area displays a photo of the staff on duty that day for the residents to observe. Staff are well known to the residents and any new staff are introduced when they begin employment.

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:**

No one requires this service but staff advised that they would have access to interpreters in the community if required. Visual pictures are available for a number of the residents to support communication and advise them of daily activities and menus.

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 has been attended by staff in June 2012. Routine situations for informed consent are identified and there is a signed consent for sharing of information. The service does not record advanced directives for their clients. This is appropriate for the service. If residents do not have engagement with family or a named welfare guardian, then a key staff member/manager signs. An improvement is required to the home agreement.

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 and consent to collect or disclose client information and/or involved students in support.

Eleven files were reviewed (one at house 1 (ID, physical disability and nonverbal), one at Iroquois (ID, nonverbal with self harm and can choke), three files at house 14 (ID - one new admission who is currently being reassessed for other placement and one with extremes of challenging behaviours), two at house 10 (one resident with bipolar and extreme challenging behaviours and one residents with ID/autism/mental health issues/HepB), ID, one file in house 8 (young person with difficulties with family engagement), three files in house 13 - respite.

Informed consent forms are being signed for by the family member or in cases for a resident who has not had family engagement in the past, by the manager training and quality or a key staff member.

One new admission in house 14 has had the consent form signed by the staff member with a note documented by the residential manager summarizing principles of informed consent and stating that the resident is considered unable to give informed consent. It also notes that the resident does not have an appointee, welfare guardian, named person, family who can sign for him.

Finding Statement

A home agreement has not been signed for two of the eight residents (excluding respite) as there are no family or welfare guardians involved and staff/managers have signed the agreement in two other instances where there are no family involved. In respite services, admission agreements have not been signed to date noting that the manager is aware of this and is beginning to get these completed.

Corrective Action Required:

Ensure that each resident has an appropriately signed home agreement. Service Agreements (in lieu of Home Agreements as the respite house is not the persons home) have been forwarded to all Families accessing Respite Support September 2012 – currently awaiting return of documents.

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.

There is a simplified version of the home agreement and one resident has signed this along with the guardian.

Residents interviewed state that they have input into their care.

Residents also have choice through picture cues as sighted in house 8 and in house 10 through routines which include choice of meals for the day, choice of bed linen etc.

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.

Support staff and managers interviewed said they try to give clients' information in a manner that they can understand and this was observed to occur during the audit.

Staff interviewed demonstrated an awareness of the differing communication needs of clients'.

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.

Eight individual resident files reviewed 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 2011 and 2012 identifies informed consent training was provided for staff in June 2011.

A record of names of staff attending is maintained.

Discussions with support staff across the six 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:**

Eight of eight files reviewed indicates that residents are supported to have choice.

Discussions with staff indicate that residents 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 description of likes, dislikes 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

The service acknowledges the residents right to an advocate and is able to assist the resident to access one. The service has policies on advocacy and client advocacy.

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:**

The families received information in the admission pack on the Health and Disability Advocacy Services, which included phone numbers. Two of the four residents interviewed confirmed they are aware of the external advocacy service (the other two interviewed were not able to say). Families interviewed are advocates for their family member. Staff interviewed stated they would support a resident to access an advocate if requested.

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 on advocacy and clients advocacy. The policies give the resident a right to involve others in their care.

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:**

Orientation / induction programmes for the staff includes training on advocacy which must be completed within the first twelve months of employment - orientation sighted as being completed for staff on 10 staff files reviewed. Staff interviewed confirmed they advised residents as to how to access an advocate.

Staff received training around advocacy services as part of the training around informed consent provided last in Jun 2012.

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 residents at Maddisons Road and Iroquois Place maintain links with their family and wider community. The families and residents confirmed this happened. The service has policies on " visitors" and " protection of individual personal safety."

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

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

Families interviewed stated they visit often and some of the residents go home on a regular basis. The service has a policy on visitors to ensure the safety of the residents . A system is in place to ensure the residents safety and well-being is not compromised by the visitors to the service. The four residents interviewed confirmed they can have visitors of their choice. There is an entry / exit signed visitors / contractors book in the reception area of the office at Maddisons Road.

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 residents have an activities programme which includes access to community groups. e.g. Westwood Riding stables, Zumba classes, movies, Delta disco club once a month, scrapbooking, singstars, Delta friendships day Programme, meals at cafes on a Saturday night, bike riding, meals on wheels, Woolston working men's club, special Olympics and crusader rugby. One resident is going on a cruise with her family. A resident from house number ten visits his mother in a rest home on a regular basis. The four residents interviewed confirmed they supported to have access to services within the community.

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 right to complain is understood and respected by staff and residents. The complaints process is fair and responsive. Families interviewed are aware of the complaints process.

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

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

The service has a complaints policy. The complaints procedure details the complaints process. There is a complaints register which was sighted and corrective action implemented in a timely manner and signed off. The residents and families interviewed confirmed their awareness of the complaint process for the facility and have been provided with information regarding making a complaint on entry into the service. A comments, suggestions, and complaint form is available to the residents and families.

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:**

Residents and families interviewed confirmed that they have been provided with the complaint process information in the Admission information pack. The staff interviewed were able to explain the complaint process. One resident interviewed had made a complaint and he was happy with the outcome. A comments, suggestions and complaints form is available from the office at Maddisons Road.

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:**

There is a complaints / compliments register which includes a complaints log form and complaints are responded to in a timely manner and the investigation and outcome and further actions are recorded and signed off.

The service has a complaints / compliments policy.

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: "Supporting People To Create Great Lives". There are strategic, business (annual) and risk plans. Statement of service objectives and performance measures include long and short term objectives. The annual plan July 2012 - June 2013 includes strategic goals and actions. There is a documented risk register with mitigation strategies. 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 the services. Brackenridge has its head administrative base at 29 Birmingham Drive and has a complex of 14 houses and an administration building at 150 Maddisons Rd Templeton. However they also provide support for an additional 52 people in the greater community. As part of the scope of the audit, five houses were included at Maddisons Rd and one house in the greater Christchurch area - Iroquois house.	

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: 'Supporting people to create great lives'.

There is a documented strategic plan and annual plan 2012-13 with strategic goals and actions.

Strategic, business (annual) and risk planning occurs.

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 (refer 1.1.8.1).

Brackenridge has its head administrative base at 29 Birmingham Drive and has a complex of 14 houses and an administration building at 150 Maddisons Rd Templeton. However they also provide support for an additional 52 people in the greater community. As part of the scope of the audit, five houses were included at Maddisons Rd and one house in the greater Christchurch area - Iroquois house.

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 CEO 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 health and safety and quality meeting occurs monthly and includes the managers, training and quality manager (chair), behaviour support representative, representative from vocational services and staff representatives. Meeting minutes are available at each house for all staff.

Quarterly reporting of high-level risks is monitored and reported to the board monthly meeting minutes sighted.

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 CEO has been with the service since 2001 and has a number of years' experience in management, health and with CYFs. He has a background in social work and a BA and Master of Arts Social Work (certificates displayed). There is an organisational chart and a number of managers in a variety of roles across the organisation with key responsibilities including the manager training and quality, manager high needs service (registered nurse) etc.

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). 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 high needs and the training and quality manager. There is also a senior management structure that is able to provide support as is the board.

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).

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) two behaviour support coordinator, b) manager training and quality, c) manager high needs, d) manager young persons, e) two manager adult residential services.

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 continues to comprehensively implement an organisational 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. 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 and quality meetings. A rating of continuous improvement has been given to the level of review with actions taken for quality improvement and risk management.

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.

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. Quality and risk processes are being implemented at an organisational level and at a 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:** FA **Risk level for PA/UA:**

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 developing a suitable client survey tool.

House meeting minutes were sighted in all houses audited with monthly meetings documented.

A relative survey has been sent out six weeks ago and advised that results will be collated and analysed on return.

There is an appointed family member on the board. The service runs annual family information evenings (at least three a year).

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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.

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 the high physical needs of clients in house 1.

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 management and staff meetings.

a) Incidents and accidents are reported at house level and forwarded to senior managers. There is an incident and accident register at each house that includes clients and staff. Event reporting is analysed at the quality/health and safety meeting.

b) Complaints are an agenda item at the quality/health and safety 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 quality/health and safety meeting. 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 quality/health and safety meeting 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/health and safety meeting 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: CI

Risk level for PA/UA:

The service continues to implement a comprehensive internal monitoring system and a computer based analysis system enables the aggregation of key data into performance measurement information.

Internal monitoring includes 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 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.

The quality system is well established with all houses having completed their required internal audits and action plans. Meeting folders in houses have completed meeting minutes and records/feedback on quality data.

Finding Statement

The analysis of data and continued improvements have continued since the establishment of the organisation and indicate that there have been many changes to service delivery on the basis of analysis of data and subsequent implementation of recommendations. Examples include a comprehensive review of use of restraint which has seen use of restraint reduced from over 250 incidents to 30 incidents in 2011 with 22 planned for one resident to cut nails; identification of medication errors as an area of concerns in July 2012 with minutes at board and staff/manager level indicating that there is a planned approach to minimising these - a full critique of medication administration has already been completed to identify key areas for improvement; modifications to documentation for the respite service have continued as the respite services continue to be developed; support for residents to live in the community; review of differing levels of support for individual residents etc.

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.

There is a current annual plan which is reviewed through the quality/health and safety meeting and at a board level.

The service also has included a risk management plan that is reviewed annually be the board.

The CEO 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 CEO reports to the board in relation to quality targets including 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.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

There is a comprehensive meetings structure that is used to communicate the results of monitoring data.

The meeting structure includes a) board meetings monthly, b) executive management meetings, c) management meetings, d) health and safety meetings as part of the health and safety and quality meetings monthly (note health and safety is reported quarterly and as required), e) house meetings.

Organisation meeting minutes are well structured. Minutes indicate that the service takes actions to address service delivery, quality, staffing and risk.

Meeting minutes at all the houses have consistently been completed including documentation of discussions, action plans and follow up.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

Audit Evidence

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

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. Health and safety meetings are held quarterly as part of the quality meetings with any issues tabled at other quality meetings if required and they include representation (where possible) from the homes. The health and safety committee minutes identifies action points.

Visitors to the service are required to be identified.

The service has implemented systems for security including electronic gates to the Maddisons address.

An organisation wide risk assessment has been developed and is approved by the CEO. 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 2012. Hazard forms are implemented and an annual hazard register is reviewed.

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 fully completed. The incident and accident register at each of the houses is kept up to date.

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.

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

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.

A review of 20 incident/accident report forms across all the houses identified that the forms were fully completed with sign off by the appropriate manager noting that behavioural specialists are involved if issues relate to challenging behaviour.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

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

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.

Staff have had training around open disclosure last in Aug 2012.

Incident forms reviewed (20) and file notes indicate that family are actively informed about any incidents.

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 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 implemented. An improvement is required to staff files including reference checking, inclusion of a contract and current work visa, and performance records.

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 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 a) statements of organisation mission and values, b) purpose of the position, and c) key tasks. Performance contracts are documented (refer 1.2.7.3).

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 1 there is a RN/EN duty list and guidelines for agency staff.

The service has a recruitment/employment procedure that requires 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.

Of the ten records sighted, eight had contracts.

Finding Statement

i) The HR staff member states that reference checks are completed and that these are destroyed after completion. There is no evidence on record therefore that reference checks have been completed. ii) Two of 10 staff files do not include a contract. iii) One staff file has an expired work visa and another does not include a work visa that should.

Corrective Action Required:
i) Document evidence of reference checking. ii) Ensure that staff files include a contract. iii) Ensure that staff who require this have a current work visa.

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.

Six of 10 files show completion of orientation. The four staff commenced employment with the organisation when it first opened and this was managed by a contracted HR agency – Sheffields. All employees selected via this process participated in an orientation programme managed by the then contracted HR agency - Sheffield and an independent contractor. At that time the organisation did not receive any data / information relating to the orientation programme. Records of subsequent orientation have been held and copies filed as appropriate on staff files.

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

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

Five of 10 performance records are not current.

Corrective Action Required:
Ensure that all staff have a current performance appraisal.

Timeframe:
6 months

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 and 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 that is implemented. 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 and 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 registered nurse/enrolled nurse per shift as well as two support staff and awake staff at night noting that residents have high physical needs. The registered nurse on duty also covers house 2 with an on call at night if the registered nurse leaves house 1. Weekends are staffed with extra staff to support residents to access activities.

Staffing varies with the number and abilities of the people being supported and in all homes audited was noted to be satisfactory for the needs of the residents. This was confirmed by seven families interviewed confirmed and four residents interviewed (one in house 10, two in house 14, one in house 8).

Staffing in the respite facility is appropriate to the needs of residents with extra staff in the weekends to support activities. Staff are rostered on earlier in the mornings to help residents get ready for school and the day.

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.

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 1.2.9.3 Where the service is responsible for NHI registration of consumers, the recording requirements specified by the NZHIS are met.

Audit Evidence

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

The service retains sufficient consumer information to manage the safety of residents which includes 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 1.2.9.4 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 keeps a current register of all clients and records of past clients. House 13 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 1.2.9.5 The service keeps a record of past and present consumers.

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 1.2.9.6 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:**

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 1.2.9.7 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:

Records across all houses (1, 10, 8, 14, 13 and Iroquois) were legible with documentation that was signed by the writer and dated.

Residents' personal records are appropriately managed in accordance with the: a) Health Information Privacy Code 1994, b) Privacy Act 1993, Health (Retention of Health Information) Regulations 1996 and the regulations are described in policy.

All records were locked away on the day of the audit.

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:**

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.

Resident records are up to date and reflect resident's current overall health and care status. Records are able to be accessed staff on any shift from the office and on the day of the audit, the auditors were able to view the diaries that go with the residents to the day programme.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Plans and records were legible and signed (and dated) by staff entering information. Changes to plans have been signed and dated.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Resident records support the effective provision of care services and are accessible to relevant staff.

Medical care interventions are recorded (and signed and dated).

Resident records are maintained in individual files that are located in the office.

Medication files are kept with the medication in a locked cupboard.

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

The service has an entry policy and procedures are in place. The procedures identify that all relevant paperwork is signed and this was visible in resident files reviewed. Information gathered at admission is retained in resident's records. Each resident has a needs assessment that determines their suitability and eligibility status as provided by the needs assessment service.

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. Records for reason for entry are kept and reviewed annually.

Relevant paperwork is signed and this was visible in resident files reviewed. Information gathered at admission is retained in resident's records.

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 open 24 hours per day, 365 days of the year as for residential services.

There is 24 hour staffing in the house when residents are located at home.

Doors are secured during hours of darkness and at Maddisons site, the electronic gate is secured.

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:**

Information is made available at prior to entry and is available in the client handbook. The service communicates to residents/family/whanau that interpreter services are available. 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.

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 a policy on entry to the service which identify the criteria for entering the service. Information gathered at admission is retained in resident's records. Each resident has a needs assessment that determines their suitability and eligibility status and this is on each resident file.

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 entry (or non-entry) policy provides guidelines on managing any declines. The service records the reason for declining service entry to residents and communicates this to residents/family/whānau and referrer.

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. The service records the reason for declining service entry to residents and communicates this to residents/family/whānau and referrer.

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 reason for declining service entry to residents is recorded and communicated to the resident/family/whānau. The manager described how the referring agency is advised when a resident is declined. There are clear policies and procedures providing guidelines on the declining entry process. The manager advised that the service would discuss with the assessor or referrer the reasons for declining entry to the service.

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

Plans are developed following assessments completed by the needs assessment service e.g. Lifelinks with input from residents, staff and family if this is appropriate. The residential manager and support workers liaise with the day programme. There is a communication book and handover is done at the end of the day with the day programme. Staff meetings are held monthly and these record progress and any issues for clients. Clients and family state that they are involved in development of goals and plans. 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. In house 1, 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.

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:**

Personal plans are developed with input from clients, staff and family where appropriate as stated by clients interviewed (four) and family interviewed (seven). Personal background information is documented in the personal plans and this is information is used to make plans relevant and appropriate to meet the needs of the clients. There are goals documented in all files reviewed with 11 files reviewed (one at house 1 (ID, physical disability and nonverbal), one at Iroquois (ID, nonverbal with self harm and can choke), three files at house 14 (ID - one new admission who is currently being reassessed for other placement and one with extremes of challenging behaviours), two at house 10 (one resident with bipolar and extreme challenging behaviours and one residents with ID/autism/mental health issues/HepB), ID, one file in house 8 (young person with difficulties with family engagement), three files in house 13 - respite).

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, 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.

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. The service has identified two skilled staff (behavioural support coordinators) to conduct the screening process.

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:**

Seven families interviewed confirmed that they are involved where it is appropriate in the initial assessment and development of personal plans, and are welcome to be involved in the review process.

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 11 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 (refer 1.1.10.1).

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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 11 resident files included correspondence from dietician, occupational therapy, medical and CYF as per the individual resident needs.

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.3.5 The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

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

Each resident has plans and other information contained in their records. This information includes links to specialists, dentists, psychologist etc as per individual needs. Other key services linked with are pharmacy, needs assessment services e.g. Lifelinks, churches, police.

Four residents interviewed and seven family state that they received a lot of information that meets their needs.

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.

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. There is an appropriate hand-over briefing between the day programme and shifts.

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:**

All equipment required is assessed on the initial assessment and as needed thereafter.

Needs are assessed in the initial assessment and the information gathered at assessment is used to set personal plans including goals.

Staff state that there are sufficient resources to support residents in each home and there is a good support for residents from the behavioural support specialists employed by the service.

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:**

Needs are assessed in the initial assessment by the needs assessment service and the information gathered at assessment is used to set plans and goals for clients.

Any individualised equipment required is assessed on admission.

Behavioural issues are identified and risk management strategies are well documented.

Support from the behavioural support specialists is accessed through Brackenridge.

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 11 resident files reviewed.

In House one, 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 resident and family. Assessments are completed in the home for each resident by the needs assessment service - Lifelinks who reassess residents as required. The assessments serve as a basis for planning. Seven family members state that the assessment occurred in a safe and appropriate environment.

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 and from and to day programmes. Discussion with 12 support workers from each house identified that they review individual goals with the residents on a regular basis.

11 files reviewed (one at house 1, one at Iroquois, three files at house 14, two at house 10, one file in house 8, three files in house 13 - respite show realistic goals with good interventions and appropriate timescales and responsibilities documented.

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

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. Resident files reviewed (across 13 houses) have individualised documentation as per policy. An improvement is required to planning.

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

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

The care being provided is consistent with the needs of clients as demonstrated on support plans.

A review of 11 files reviewed (one at house 1, one at Iroquois, three files at house 14, two at house 10, one file in house 8, three files in house 13 - respite identified that the residents 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.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

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

All people in the service are identified as having intellectual disability.

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 include management of Pegs, and other medical needs.

Risk management plans include 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

i) Goals for each resident are documented in a number of places as follows a) short and long term goals in the individual support plan for long term residents, b) goals in the my daily goals action plan, c) goals on the daily active support plan. The goals are not necessarily the same and some do not have interventions, accountabilities and responsibilities with evidence that they are actioned. ii) The respite service resident files do not indicate that goals have been well documented despite some residents coming two or three days a week with some having accessed the service for a number of years. iii) House 1 - a plan to address weight issues for one resident is not well documented.

Corrective Action Required:
i) Document goals for each resident that include interventions, accountabilities and responsibilities with evidence that they are actioned. ii) Document goals in the respite service. iii) House 1 - Document a plan to address weight issues for the resident identified.

Timeframe:
3 months

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

Audit Evidence

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

Records of other allied health services are maintained and retained in notes e.g. OT assessments, behavioural support etc.

The manager of the house provides oversight of care and the team links daily with the day programme.

A review of 11 resident files identify that plans and records are integrated. Plans and files include 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:**

All residents (and family when available) are involved in the planning process as stated by four residents and seven family members interviewed.

Staff are seen to spend a lot of time communicating to residents in a way that they can understand, acknowledging their intellectual disability and the need to provide information in a slow and careful manner.

Four residents interviewed state that staff talk with them about their activities and goals.

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 residents as demonstrated on the overview of the support plans, goals identified in the plans, discussion with family, residents, staff and management. Residents spoken to stated their support of the care being provided. 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 service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. In managing the referral process the service provides relevant information and where necessary follow-up occurs. Examples of services accessed include dental services, podiatrist etc. Residents spoken to (four) where happy with the support provided to them as were seven family members interviewed.

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 also introduced the 'circles of support'. There are other key roles such as vocational support service, and behavioural support coordinators.

Tracer methodology 1: A young person(14 years old) with ID including behavioural issues (absconding and other behaviours) and complex family dynamics.

One file was reviewed for a young person who has been admitted to the service in 2009. An assessment by Lifelinks is on file confirming that the placement is appropriate for the resident with intellectual disability. Key contacts including the grandparents who have brought the young person up till now are documented and the service works with another provider of services for people with intellectual disability for the resident to see her mother. Outcomes of a family group conference dated Aug 2011 were reviewed in May 2012 with clear parameters of engagement with the family documented.

The resident has a well-documented behavioural support plan (4 stage behaviour support plan with documentation of the behaviour i.e. what the behaviour looks like, rational to be supported to have a good day, anxiety/defensive with staff to be supportive and directive, acting out around keeping everyone safe and tension reduction including establishment of a therapeutic rapport. Stakeholders having input into the plan are documented as being the family member (grandparent), behaviour support service and manager as well as the client (limited) and key staff. All staff sign to say that they have read and understood the plan. The resident's bedroom is alarmed as she absconds. The resident has recently formed a friendship with a new resident to the home and staff state that they do activities together which has reduced the times the residents absconds. Her room indicated that she loves doing crafts and is engaged in fun activities. The risk management plan includes strategies around biting nails, assault to others, stranger danger and absconding.

the My Goals action plan includes goals relevant to the resident i.e. to dress independently, to cook a meal, to learn about stranger danger. Long and short term goals include actions, responsibilities and timeframes.

There is monthly review of health and wellbeing and the resident is weighed monthly as according to staff she eats everything.

The home agreement is on file and has been signed by the resident (simplified version) and by the legal guardian.

The resident attends school and progress notes indicate that she is well supported at all times.

The resident can understand photographs and very short sentences and nodded to say that she liked the service when interviewed.

personal plan 2011 includes client details, a summary of the history of the person, lifestyle goals (four) in the domains of special interest, health, work and self-improvement and a lifestyle plan with goals, interventions, responsibility and review date. The goals are well documented and reflect the persons individual interests.

The medication chart reviewed indicated that medication was prescribed, sign off appropriately on the administration sheet and allergies are documented including in the client file.

The resident was not able to be interviewed however she was observed in her own environment and appeared happy and well supported by staff. Activities were provided that she was engaged in.

Because of the difficult family dynamics, the family was not able to be interviewed.

Tracer methodology 2: Respite resident.

The resident has a diagnosis of intellectual disability with uncontrolled epilepsy and stays in the respite centre for three days a week. There is a well-documented seizure plan that is individualised. Instructions around administering of midazolam are documented. There is a fact sheet from Epilepsy New Zealand and the resident uses headgear when he is identified as being unsteady on his feet. An epilepsy management plan has been documented on 9/2/11 and approved by the specialist 7/9/11. There are also instructions for staff if the resident spikes a high temperature and strategies to manage a risk of the resident choking.

Staff are clear around who is being admitted on a daily basis to the respite house and are always prepared for the resident when he comes in (confirmed by the family member interviewed). All documentation is completed appropriately (refer 1.3.5.2).

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.

Residents and or their family/whanau are involved as appropriate when referral to another service occurs. In managing the referral process the service provider ensures: a) appropriate transfer of relevant information, b) where relevant a multi-disciplinary team approach is used, and c) follow-up occurs where appropriate. Documentation in resident files indicated that safety of the person had been well managed. Links include 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:**

All residents have a plan which focuses on goals identified by the client.

There is evidence of development of skills and goals that include access to the community etc with residents working in work programmes, school, activities programmes etc during weekdays.

Residents are encouraged to do as much for themselves as possible and are involved in activities of daily living.

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.

The service provides a) 'active support', b) Vocational/ Employment Service, c) respite service that includes policies and procedures, d) children's service that is supported by experienced psychopaedic nurses and e) there is wider community living options.

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

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

Each resident has a documented support plan. The families interviewed are invited to have input into the support plan, which is reviewed six monthly. All of the residents are encouraged to attend vocational programmes or work in the community but participation is voluntary. Social activities in the community are encouraged and supported by staff.

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

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

The residents support plans document activities " where I go during the week' with a weekly timetable plus details of what they need to take with them. This also includes a transport plan. The residents interests are documented plus details on how to communicate with the resident for community outings.

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:**

The residents plans show documented support for community outings to encourage an ordinary life. Some of the community activities the residences attend are; movies, chipmunks for home number one, willow bank animal farm, art classes, music therapy, Hamner springs picnics, library, model train rides, meals on wheels, paid work in the community , alpha programme, Westwood riding school paid employment. Several of the residents are still attending the local schools.

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:**

The preferences of the residents and families is documented in the support plan with goals set. Two of the residents from home number 14 are flying to Auckland with staff support to attend the ' Mary Poppins Show' which was a goal set to achieve . Another two residents from home number one were attending the ' Top Twins" concert which was a goal to attend concerts in the community. The Edie Low concert is always a popular concert for the residents to attend with staff support. The residents are also supported to do the food shopping weekly. Staff members interviewed at all of the homes support and assist the residents to access a number of activities in the community. Birthday celebrations are very important for all of the residents and families are invited to attend and staff make it a special occasion in all of the homes. Planned activities in the community are visiting cafes, movies, parks, bike riding, zumba, walks around the local parks and reserves.

The service has a policy for transporting residents to ensure safety of travel.

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 and lifestyle plans are evaluated by resident and staff (and family when appropriate) at least annually and usually six monthly or when changes to needs happen. Resident records provide evidence of coordinated care. There are links between support notes, service plans, and progress notes. Files reviewed indicated that plans had been reviewed as per timeframes. .

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 six-12 monthly review by the medical practitioner noting that residents in some homes such as house 1 where there are residents with significant physical needs attend GP appointments more regularly.

Progress are documented at each shift.

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.

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. Residents' and or their family/whanau 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.

In managing the referral process the service provides relevant information and where necessary follow-up occurs.

Examples of services accessed include dental services, psychologist.

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:**

In managing the referral process the service provider ensures: a) appropriate transfer of relevant information, b) where relevant a multi-disciplinary team approach is used, and c) follow-up occurs where appropriate. Documentation in resident files indicated that safety of the person had been well managed.

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 has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records.

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 an entry and exit policy and supporting procedures (form) to facilitate discharge and access to others services. Residents and or their family/whanau are involved as appropriate when referral to another service occurs.

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 has appropriate documentation and procedures to support the exit, discharge or transfer. While no discharge files were sighted at the audit, discussions with staff including five managers in the homes indicate that relevant information would be provided on discharge and that the service would be active in communicating with other providers when discharge occurs. **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
The service has a medication administration policy which defines dispensing, and administering, and the procedures for the management of medication for individual residents. There is a medication authority form whereby the key family member gives signed permission for the resident to access the doctor for medications. Staff are provided with training at orientation and induction this is recorded on the staff record. Medication profiles exist that record prescribed medications by clients' general	

practitioners. Medication administration charts that are pharmacy generated are retained in a medications administration folder. A medication sign off sheet is completed identifying staff in the folder. Improvement is required for consistent application of the medication system across the houses.

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

The service has a medication administration policy which defines dispensing, and administering, and the procedures for the management of medication for individual residents. There is a medication authority form whereby the key family member gives signed permission for the resident to access the doctor for medications. Staff are provided with training at orientation and induction this is recorded on the staff record. Medication profiles exist that record prescribed medications by clients' general practitioners. Medication administration charts that are pharmacy generated are retained in a medications administration folder for drugs that are blister packed. A medication sign off sheet is completed identifying staff in the folder.

15 medication files were for residents in the residential homes i.e. three in house 1, three in house 10, two in house 14, three at Iroquois, two at house 8 and two in house 13 respite. All files include a medication chart that is clearly and correctly documented and there is evidence of at least annual review of medication by the GP. PRN medication is charted appropriately. House 10 has Controlled drugs that are kept secure in the locked cupboard.

Controlled drugs were only sighed in house one and house 10 and these were correctly documented as being administered and checked.

Families of residents in the respite house are required to bring in the medication at each visit and this is appropriate to the service offered.

Finding Statement

i) There is evidence of transcribing at house 13 (respite house) including on documentation of PRN guidelines. ii) The drug fridge temperatures in house one are identified as being higher than the norm and there is no evidence that these are adjusted. iii) House 10: A controlled drug register is used to record any medication that comes in from pharmacy but is not used to record balances after each administration.

Corrective Action Required:
i) Cease the practice of transcribing. ii) Ensure that all fridge temperatures are within normal range in house 1. iii) House 10: Document administration of controlled drugs on the relevant register each time these are administered. Prior to the final audit report, service advises that document of controlled drug administration in #10 in place as of 24th August 2012

Timeframe:
3 months

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 a medication administration policy which defines dispensing, and administering, and the procedures for the management of medication for individual residents.

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:**

Records indicate staff comply with the service medicine management policies and procedures and there is training of relevant staff in relation to medicine management at orientation. 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 - documentation including training records sighted.

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:**

The service policy states that residents who are able to manage their own medications safely will self-medicate. The service chooses not to have anybody self-medicating as all residents require assistance and supervision.

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:** Met

The service has a food handling and waste handling policy for safe food and waste management. There are clear details for cooked food storage and meat storage. Staff have received training on choking and eating December 2011, drinking safely, health and safety quality May 2012 and safe food handling July 2012.

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 home with the residents supporting where they can. In the residents support plans their likes and dislikes of food are documented. The four residents interviewed confirmed that the meals were varied , good and tasty and that adequate food and fluids were provided. The families confirmed this. The menus are planned and reviewed at regular intervals with resident input where possible. The staff monitor the residents

weight monthly and this is recorded. The kitchens in all of the homes were clean and well kept. The kitchens are maintained as a normal domestic kitchen to maintain the home like environment of the houses. Some of the residents are peg fed and staff have received training in this area. Staff wear gloves for food preparation .

The service has policies on food handling and safe food management.

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 dietician input into specialised menus and dietary requirements.

There is evidence of foods available for special/modified dietary needs. The residents that require special diets have these needs met and this is documented on their files. The residents satisfaction survey confirmed that their individual preferences are catered for and special needs are being met. Some of the residents require peg feeding and staff have received training in this area. In the high needs homes there is sufficient staff support at meal times and appropriate utensils are provided.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

In the support plans of the residents their likes and dislikes are documented. In some of the homes where the residents are verbal discussions are held re choices for meal planning at the residents meetings and discussions around the dining table. The menu range is varied and appropriate to the individual resident. The four residents interviewed confirmed their nutritional needs are being met and their dignity is maintained whilst eating and drinking and that they have input into the range and choices of meals being provided where possible. Visual pictures of menus for the day are on the notice boards in the living areas of all of the homes.

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:**

Some of the residents require special equipment and staff support while eating meals. Special cutlery, high sided plates and non-slip table mats are some special equipment used. Some of the residents are peg fed. Staff have received training on peg feeding.

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 homes storage areas are dated, labelled and are correctly rotated. Fridge and freezer temperatures were checked monthly and documented on the monthly data recording sheet which is forwarded to the Service Manager. Some of the homes have separate fridges for storing medication and the temperature is checked monthly. The fridges and freezers in all of the homes had thermometers in them. Kitchen compliance audits are completed to ensure compliance against all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal and a visual inspection confirmed this occurred.

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:** Met

The service has an environmental building maintenance policy and a hazard management policy. A health and safety survey is carried out monthly. Staff receive on-going training on waste and hazardous substances. A health and safety officer visits weekly.

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:**

Documented policies and procedures are in place for the management of waste and hazardous substances which meet the requirements of legislation, local authorities and relevant standards. The responsibility for the health and safety is a shared one, with the employer having a primary role. The manager and co-ordinator have identified roles for safety. The health and safety manual includes policies on hazard, hazard notices, bottled gases - oxygen, bottled gases, chemical storage and use, fire risk, flammable goods, harassment, knife handling, hot water, laundry, violence in the workplace, dishwashing and storage, accident / incident and near miss reporting forms, induction for staff training and wellbeing.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

The service has a system that investigates, records, reports and responds in a timely manner to incidents through the hazard identification register. All homes have flip charts for emergency contacts involving incidents in hazardous material alert, crisis assistance, natural disasters, fire discovery, emergency medical assistance, flooding. The service has guidelines on body waste spillage and sharps guidelines.

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:**

All homes have flip charts for prompt action contact details for emergency situations. A documented system is in place to prevent waste and hazard incidents or accidents occurring in the form of health and safety policies, a risk management plan, hazard register, internal audit programme. The service has guidelines on single use / short life items, e.g. syringes, needles, scalpels, catheters, tube feeding, oxygen masks, gastrostomy feeding.

The recycling procedure for household waste meets city council regulations collected every two weeks identified by the red lid rubbish bin. The green lid rubbish bin is for organic food scraps collected weekly.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Training is provided to all staff at a level of detail appropriate to the risk involved to ensure the safe management of waste and hazardous substances. The staff interviewed confirmed training on management of waste and hazardous substances had occurred.

Training records confirm that staff have training last in Jul 2012 as part of the infection control training.

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:**

All hazardous substances are stored in a locked cupboard and are clearly labelled in line with legislation and are free from damage. Monitoring processes are in place to ensure compliance with the policies / procedures, legislation and local body requirements. A visual inspection of the facilities confirmed that hazardous substances are correctly labelled and stored in appropriate containers.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Protective clothing is provided to the staff as required; gloves, aprons, masks, goggles, footwear. These were sighted. Personal protective equipment is included in the health and safety manual. The service ensures that all protective equipment is stored correctly when not in use and is checked on a regular basis. The staff interviewed from the five homes confirmed that protective clothing was available for use.

The service has a policy on individual personal safety.

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:** Met

The service has a property maintenance policy. A Health and safety survey is carried out monthly with a full site inspection.

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

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

Policies are linked to appropriate legislation and standards. The service has a maintenance system to ensure the homes, plant and buildings are well maintained. The staff interviewed confirmed that the equipment is checked before use and they are competent to use the equipment. All homes have a list of external contactors and preferred suppliers.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

A current building warrant of fitness is dated 1.10.12 for all homes at Maddisons Road which is held in the office at Maddisons Road. Iroquois is not required to have a building warrant of fitness.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

A full site inspection is done monthly which includes the re-reporting of areas that have been identified as potential health and safety and building compliance risks. There is evidence that maintenance issues are being addressed promptly. Each home has a budget for maintenance. Staff are able to request and ensure immediate and long term maintenance. Requests for maintenance are fulfilled through the manager of support services. A visual inspection of all the homes evidenced that fixtures equipment and furniture meet infection control requirements and are easy to clean and maintain. Non - slip surfaces are a safe effective means to minimise slipping which are provided in the bathroom areas and other areas exposed to moisture.

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:**

There is a hazard identification register and actions taken. Hazard forms are available to all homes. Inspection of all the homes evidenced wide corridors to allow the residents to pass each other safely, safety rails are installed where appropriate, equipment does not clutter passageways, floor surfaces are maintained in good order and are appropriate for the resident group and setting. The four residents interviewed confirmed they live in a safe environment and are able to move around freely.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

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

All the residents have their own rooms which are personalised with possessions and familiar belongings. Most of the residents have a T.V. in their bedrooms.

In the home number 13 where a respite service is delivered the lounge / living area was furnished in bright colours and was very welcoming . Educational toys were available for the residents.

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:**

All homes have safe fenced external areas with shade. All homes have attractive garden areas and outdoor garden furniture and BBQ. The service has ramps allowing access to outdoor areas. The gates that lead to the main road have a safety feature for cars only to drive over to open. The four residents interviewed advised that they live in a safe environment. The families interviewed confirmed this. The homes are safely maintained and are appropriate to the resident group setting.

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 service has a transportation policy to minimise any risks. The service has mobility vans for transportation and the use of hoists. Sealed bags are used for transportation of medication when delivering the residents to their vocational programmes. The staff interviewed are aware of their responsibilities when transporting the residents and the procedures for boarding the residents into the vans, using safety straps and seat belts . All mobility vans have current WOF, current registration and are covered with full insurance.

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

All of the homes for the residents were clean, warm, safe, well-maintained, homelike and a comfortable environment that respects the residents privacy, individuality and promotes their wellbeing. Hot water temperatures are checked monthly and recorded for each home.

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 homes all have adequate communal toilet and bathroom facilities which are conveniently located and suitable for the needs and abilities of the residents. For staff and visitors there are designated toilets. The families interviewed (seven) advised that the homes were adequate, attractive, homely and warm.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Hot water temperatures are checked in every home on a monthly basis and temperatures are documented. Documentation was viewed supporting this occurred and showed temperatures were safe and appropriate for the residential group. The last documented recordings indicated all of the homes water temperatures were 44 to 45 degrees Celsius.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Hand wash basins, liquid soap, and hand drying facilities are readily accessible to each of the toilet facilities and are of a design appropriate to the resident group. Paper towels were available in the communal toilets. These facilities promote good infection control practices.

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 appear to be of acceptable materials and ensure that hygiene and infection control practices can be met. In home number 10 all electrical, T.V. light switches, heat pumps, are protected by covers because of the behaviour of one of the residents. The heating panels in the bedrooms are located in the ceiling for safety. Floor surfaces likely to be slippery when wet are clearly identified with a ' wet floor hazard sign'. The ramps meet the safety requirements.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Communal toilets and showers are identifiable and have locks to ensure privacy. The locks can be opened if required. Shower trolley beds are required in the bathrooms in some of the homes to support the high needs residents for bathing / showering.

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

The residents rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids.

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

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

The four residents interviewed advised they were happy with the size of their bedrooms. Some residents require staff support from transfer from wheelchair to bed and hoists, slings are used for safety. Staff interviewed have received training on correct procedures on transfers of residents and that there is adequate space provided in the bedroom and bathroom areas.

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:**

A visual inspection of the homes , especially in home number one, there is evidence that where residents if required are to be transferred between rooms in their beds there is space to accommodate the bed or other equipment.

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

All homes visited had attractive large living / kitchen / dining areas to accommodate the resident's needs. Furniture is appropriate to the settings and arranged allowing the residents to safely move around. The residents are able to access other areas for privacy 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:**

The four residents interviewed confirmed their living and bedroom areas were adequate, warm and attractive. Most of the homes had an open plan lounge, dining kitchen areas which were of a good standard and attractive.

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 all of the homes was arranged to allow the residents freedom of movement either independently or by using mobility aids or with staff support. Emergency access routes were unobstructed and were clearly identified. Furniture, fixtures and fittings were safe and maintained.

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:**

Staff interviewed advised that activities can occur in the lounge and or dining areas, and the outside areas of each of the homes as required. The residents have their own bedrooms for privacy. Most of the residents have their own T.V in their bedrooms and can make choices on where they watch their favourite T.V. programmes.

All of the homes have flat external areas for entertainment and BBQ's. The families interviewed advised that they can have private time with their family member if required and staff respect their privacy. Families are invited to meals, BBQs and birthday parties.

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

Policy and procedures clearly identify the responsibility of the staff for best practice standards of laundry and cleaning practices. Laundry and cleaning processes are monitored by internal audits for effectiveness. There are designated areas for the storage of cleaning and laundry products which were locked.

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:**

The service has training for staff for hazardous substance and laundry chemicals done on orientation to the service through the health and safety plan. The objective is to provide effective cleaning of the homes which maintains a high standard of disinfection, general cleanliness and at the same time good appearance, taking in to account the resident's needs, bathroom and toilet areas, hand basins, showers, equipment and machinery, chemical safety and storage areas related to cleaning. The laundry objective covers the laundry design, infection control, separation of clean and dry laundry, sorting, soaking, infectious and badly soiled linen, bed changing days, equipment, chemicals used, work injuries, staff practices and infection issues. Coloured baskets are labelled and used for laundry identification and use. A commercial washing machine and dryer is used.

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:**

Staff interviewed have received training on chemical safety and the correct use of the chemicals. Training is ongoing. The four residents interviewed confirmed their satisfaction with the cleaning and laundry services. The service monitors the effectiveness and compliance with their policies and procedures with internal laundry and cleaning service audits. Any corrective actions are identified and reported to the manager for improvements to be implemented.

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:**

Safe and secure storage areas are available in all of the homes and the chemicals are labelled and stored within these areas. Chemical safety data sheets are available. Sluice tubs are identified and are available for the disposal of soiled water and waste. Hygiene standards are maintained in the storage areas. The staff interviewed take care to minimise damage to the personal clothing of the residents laundry.

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 gates 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 homes on the estate. Emergency lighting and cooking is available in the houses in the event of a power failure. Emergency supply of water is stored in the houses. Civil defence kits are stocked or up to date in all houses.

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 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 (training records sighted confirm that this occurs).

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.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

House 1 - 30 June 2000

House 8 - 23 May 2000

House 10 - 23 May 2000

House 13 - 30 June 2013

House 14 - 23 May 2000

5 Iroquois - not required.

All houses are required to hold 2 trial evacuations each year with staff attending one at least annually.

Dates of the last trial evacuations are recorded as :

House 1 - 25/9/11, 1/4/12

House 8 - 15/11/11, 25/4/12

House 10 - 8/8/11, 14/1/12, 14/7/12

House 13 - Vacant in April when last due 30/6/12

House 14 - 14/8/11, 18/2/12

5 Iroquois - 13/4/11, August / 12

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:

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 houses on the estate have civil defence kits stored in each of their garages and these are maintained and restocked.

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 has emergency power via a gas operated generator.

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:**

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.

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

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

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:**

Residents 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

All of the homes are well heated with heatpumps and appropriately ventilated. Windows in the residents bedrooms provide natural light and there is external lights in all communal areas. Smoking is only permitted in a designated area. The residents are encouraged not to smoke through the healthy eating and living plan.

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:**

A visual inspection of all of the homes evidenced adequately ventilated areas, plenty of heat pumps and in some of the homes heat panels on the ceilings in the bedrooms for safety reasons. The four residents interviewed confirmed their homes were warm and comfortable in the winter. Families interviewed were satisfied with the heating and ventilation of the homes. The residents satisfaction survey confirmed the homes were heated appropriately. On the day of the audit the communal living areas and bedrooms were appropriately heated and the homes were warm and well ventilated.

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 all of the homes have adequate natural lighting from the outside. The residents bedrooms have external windows providing natural light during daylight hours. The residents with visual impairments hall have good light bedrooms with bright coloured furnishings.

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 with no smoking permitted within any of the homes. There are designated outdoor areas for smoking. The service encourages the residents not to smoke through a healthy living and eating programme. The homes are all clean, warm, safe and well-maintained and promote a homelike environment that respects the residents wellbeing, privacy and individuality.

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

A comprehensive restraint policy out lines all the requirements of the standard and any associated codes. This policy links to the policy on managing challenging behaviour and there are clear strategies in resident files around management of behaviours that do not include the use of restraint. There is a restraint register however the service has a policy of using as little restraint as possible and there is no one using restraint in the homes sampled. Enablers are used in the service. Any use of restraint is documented using an incident form and there are robust processes in place to manage any incident of restraint. The service has received a rating of continuous improvement for the focus on improving quality of life for residents around the use of restraint.

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

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

(i) The service's philosophy on restraint

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

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

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

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

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

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

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

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

The 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 deescalate or redirect and other strategies to be tried before physical intervention is used.

Non-use of restraint was noted in the homes reviewed.

There are two behavioural support coordinators at Brackenridge (trained by the Institute of applied behaviour analysis in America) who support staff to manage behaviour.

The service has a number of people who have behavioural support needs. There are 44 clients using enablers i.e. lap belts, ankle straps, bed rails and trays. All are identified as enablers and not restraint as they are used for resident safety while in chairs.

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:**

Each resident file that requires it has a behavioural plan that includes risk management strategies that do not include the use of restraint.

Staff are able to talk about the assessment process which occurs every as part of the review process of plans.

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Enablers are used in the service. The restraint policy describes what enablers are and all staff in the homes are familiar with the term, use and monitoring of these.

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:**

Staff state that any enablers are used for safety of the resident only and only while they are in chairs etc that require them to be in a certain position e.g. seatbelt, ankle strap etc.

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:**

All staff interviewed were able to describe restraint and enablers and all stated that restraint is not used in the service. If any restraint is used it is with holds learned in the NVCI course. Staff have had training around nonviolent crisis intervention in 2012 (training records sighted).

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

There is a restraint register and there have been 24 episodes of NVCI with 18 for one resident who requires being held while fingers and toe nails are cut in 2012 to date. Staff state that she now moves into the position voluntarily. There is good documentation for each event and all incidents are analysed for the appropriateness of the action. in the homes sampled for the audit, there are no residents using restraint.

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 12 support staff were all familiar with responsibilities of documentation.

Finding Statement

The training and quality manager is identified as the restraint coordinator (registered nurse). There has been considerable analysis of data around use of enablers and restraint with clear identification of enablers as those supports required for residents on a daily basis for safety e.g. lap belts, tray tables, bed rails etc. The use of restraint is identified as being for interim transport position, transport position or team control position. The number of incidents in 2004 was identified as being 269 and in 2011 as 30 with 22 for one resident who is required to be restrained when her nails are cut. The service provides all staff with nonviolent crisis intervention and there are two approved trainers on site. The service continues to discuss restraint use at the monthly health and safety and quality meetings. Monthly summaries of use of restraint and enablers is presented to the board with evidence in board meetings that they there is active monitoring of this. Quarterly summaries are provided to the health and safety and quality meeting with graphs and trends presented and discussed. The approval group continues to meet annually and as required and there is a continued focus on trying to minimise the use of restraint.

Brackenridge has the following guidelines: guidelines for restraint assessment, restraint system flowchart 2011, restraint system responsibilities, restraint management form.

The only holds used are the team control position and the transport position (confirmed by the restraint coordinator and a review of incident forms for restraint in the last year.

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 responsibility is clearly defined with clear lines of responsibility though the infection control policies. There is a well-developed infection control programme which has been developed in consultation with relevant specialists (GP) and stakeholders. Infection control advise is available to the facility and there is an infection control committee (health and safety meeting monthly). There is also an Infection Control Committee and the responsibilities are also defined. The IC committee meeting quarterly. The infection control coordinator is the training and quality coordinator (registered nurse). Each resident is seen by a GP when needed and annually and support can be obtained through the general practitioner.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.2 **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:**

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.4 **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:**

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:**

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:**

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:**

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:**

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 **Implementing the infection control programme**

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

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 team includes all staff and the overall manager with the training and quality manager identified as the infection control coordinator (registered nurse). The infection control coordinator consults with the general practitioner when further advice is needed and is able to access Alison Carter if required. The roles and responsibilities of the infection control coordinator are well described in the infection control policy. Infection control training was last provided to staff in July 2012. Staff have access to lab reports and GP summaries whenever the resident has been seen. These are filed in resident records. The general practitioner, who manages the treatment of all clients with infections, receives diagnostic results of residents. If there is a significant issue the general practitioner will inform the staff of the service.

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:**

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:**

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:**

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:**

S

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 service has well developed policies and procedures for the management of infections which are appropriate to the type and size of the service. There are supporting policies and procedures around service delivery such as laundry, food services etc. Policies focus on hand washing and standard precautions. 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 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. Policies have last been reviewed in Dec 2009 with updates made in response to changes in practice. The 2012 review of the policies has already commenced.

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:**

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:**

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:**

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. The infection control coordinator has last had formal infection control training in Nov 2009 from Alison Carter and training around PEG feeds with an infection control component in June 2012.

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

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

Criterion 3.4.2 **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:**
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:**

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:**

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.5 **Surveillance**

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

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

How is achievement of this standard met or not met? **Attainment:** 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 infection control registers. Infection control data continues to be collated monthly and reported to the infection control committee and to the monthly health and safety and quality meetings monthly. The service infection control committee monitors and tracks infection trends. Internal audits are consistently completed across all houses with corrective actions indicating that information is used to improve services. There are standardised definitions that align with the infection control register. The type of surveillance undertaken across all the houses is appropriate of the size and type of service. Reports are provided to the board monthly.

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

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

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

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

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:**

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:**
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:**
Finding Statement		
Corrective Action Required:		
Timeframe: 6 months		

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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:**

Finding Statement

Corrective Action Required:

Timeframe: