**North Waikato Care of the Aged Trust Board**

**Current Status:** **18-Jul-13**

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

**General overview**

Kimihia Home and Hospital provides rest home, dementia and hospital level care with a maximum capacity of 77 beds. On the day of this unannounced surveillance audit there are 25 hospital level care residents, 35 rest home level care residents and 11 residents in two secure units on site.

There have been changes to the size of services delivered since the previous certification audit in December 2011. A verification audit was carried out in October 2012 to consider the impact of increasing service capacity by 16 beds. This unannounced audit verified that the areas for improvement identified at the verification audit (e.g. staffing levels, completion of external areas and approval of the fire evacuation scheme) are all resolved.

There are three areas for improvement required as a result of this audit. One of these is related to development of initial care plans within the required time frame. This matter is an ongoing area of improvement which was identified at the certification audit in 2011. There is a requirement to ensure all residents' care plans are accurate and contain details about current needs and cares. Improvements required in medicine management are related to the details included in medicine standing orders and prescribers complying with current best practice for documenting prescribed medicines.

**Audit Summary AS AT** **18-Jul-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  18-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit  18-Jul-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  18-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |
| **Safe and Appropriate Environment** | Day of Audit  18-Jul-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  18-Jul-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  18-Jul-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Kimihia Home and Hospital**

North Waikato Care of the Aged Trust Board

Surveillance audit - Audit Report

Audit Date: 18-Jul-13

**Audit Report**

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | North Waikato Care of the Aged Trust Board |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Kimihia Home and Hospital | 67 Rosser Street |  | Huntly |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 18-Jul-13 **End Date:** 18-Jul-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

**Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXXXX | NZRPN  Lead Auditor NZQA 8086  Dip Mgment  BSocSci | 8.00 | 6.00 | 18-Jul-13 |
| Auditor 1 | XXXXXXXXX | RN,Lead Auditor  NZQA 8086 | 8.00 | 5.00 | 18-Jul-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXXX | RN,MBA  NZQA 8086 |  | 2.00 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 13.00 | **Total Audit Hours** | 29.00 |
| **Staff Records Reviewed** | 5 of 65 | **Client Records Reviewed** *(numeric)* | 7 of 77 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 7 |
| **Staff Interviewed** | 10 of 65 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 4 |
| **Consumers Interviewed** | 5 of 77 | **Number of Medication Records Reviewed** | 14 of 77 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 2 |

**Declaration**

I, (full name of agent or employee of the company) XXXXXXXXX (occupation) Director of (place) Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofThe DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that The DAA Group Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 2 day of August 2013

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

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

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

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

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

**Services and Capacity**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Kimihia Home and Hospital | 77 | 71 | 32 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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**Executive Summary of Audit**

*General Overview*

Kimihia Home and Hospital provides rest home, dementia and hospital level care with a maximum capacity of 77 beds. On the day of this unannounced surveillance audit there are 25 hospital level care residents, 34 rest home level care residents and 11 residents in two secure units on site. There is one resident under the age of 65 years and three respite (short stay) residents.

There have been no known complaints to the Office of the Health and Disability Commissioner, no issues based audits, or coroners inquests. There have been changes to the size of services delivered since the previous certification audit in December 2011. A verification audit was carried out in October 2012 to consider the impact of increasing service capacity by 16 beds. This unannounced audit verified that the areas for improvement identified at the verification audit (eg, staffing levels, completion of external areas and approval of the fire evacuation scheme) are all resolved.

There are three areas for improvement required as a result of this audit. One of these is related to development of initial care plans within the required time frame. This matter is an ongoing area of improvement which was identified at the certification audit in 2011. There is a requirement to ensure all residents' care plans are accurate and contain details about current needs and cares. Improvements required in medicine management are related to the detail included in medicine standing orders and prescribers complying with current best practice for documenting prescribed medicines.

*1.1 Consumer Rights*

Residents and relatives are advised on entry to the facility of the complaint process and demonstrate a good understanding of this process. There is evidence that all expressed concerns and/or formal complaints are taken seriously and acknowledged by the service, and then investigated and managed in ways that facilitate resolution between affected parties

The service adheres to the principles and practices of open disclosure in regards to complaints and adverse events. .

*1.2 Organisational Management*

Quality and Risk management systems are well established and are being maintained by the service provider. The scope, direction and goals of the service are documented, monitored and reported against. All areas of service delivery and organisational management are overseen by the facility manager who is a registered nurse with extensive back ground in aged care.

Quality and risk indicators are identified and quality data (incident/accidents, complaints, infections, restraint activity, resident and relative feedback) is collected and analysed to improve service delivery. Quality improvements are also monitored through extensive and regular internal audits. Quality monitoring results are shared with all staff.

The organisation has joined with seven other age care facilities, that are charitable trusts, to share resources and maximise their purchasing power. This has resulted in significant cost savings.

The adverse event reporting system is a planned and co-ordinated process. Staff clearly and reliably report and/or document adverse, unplanned or untoward events. Review of incident and accident reports show that all falls, skin tears, 'wandering', challenging behaviour and medicine errors are reported, analysed and reviewed and then ways to reduce or prevent future incidents are discussed with staff. There is evidence families and other affected parties (eg, general practitioners) are notified of incidents where necessary, in a timely manner.

The human resources management system provides for the implementation of appropriate employment of staff and on-going training processes. All staff are supported and encouraged to attend regular education and engage in professional development. There is a clearly documented rationale for determining staff levels and skill mix in order to provide safe service delivery. Rosters and interviews demonstrate that staff are allocated according to residents' needs and that staffing meets contract requirements. There is at least one registered nurse on site 24 hours a day seven days a week and an appropriate number of care staff and auxiliary staff are employed for all shifts. There is a low staff turnover.

*1.3 Continuum of Service Delivery*

Care and support needs required are identified, co-ordinated and planned in participation with the resident. All residents' files sampled provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and their family, where appropriate. There is an improvement required to ensure that all the required interventions are included in the care planning process and a previously identified improvement regarding the time frame for completing long term care plans remains in place.

An active activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents. Residents participate in events organised by the diversional therapist. Adequate activities are provided in the rest home, hospital and dementia areas.

Well defined medicine management policies guide practice, however an improvement is required to ensure that all medications have been individually prescribed and reflect current guidelines. There are no issues of concern regarding medicine recording processes and the administration processes. All staff involved in medication management are assessed for competency and medicine records show that medicine reviews for residents are occurring every three months.

Menus are reviewed by a dietitian and prepared by suitably trained kitchen staff. Any special dietary requirements and needs for feeding assistance or modified equipment are recorded and being met. Residents are weighed regularly to ensure nutrition is adequate. Residents interviewed are satisfied with the food service provided.

*1.4 Safe and Appropriate Environment*

There have been no structural changes to the building since the previous verification audit in October 2012. There is a current building warrant of fitness. There is evidence that corrective actions identified at the verification audit in October 2012 are now resolved. There is an amended and approved evacuation scheme for the new buildings, fire suppression systems are monitored and checked regularly and the external recreational areas are safe and appropriate for use by older confused people.

*2 Restraint Minimisation and Safe Practice*

There are 14 residents who currently require bed rails and lap belts to be used intermittently for safety reasons. There is an area for improvement related to documentation of restraint interventions in service delivery plans, as already mentioned in section 1.3 above. Staff training in safe restraint practices and avoiding the use of restraint is ongoing.

*3. Infection Prevention and Control*

The infection surveillance programme is appropriate for the facility and the level of care provided. Surveillance requirements are implemented as required including collation and analysis of data.

**Summary of Attainment**

* 1. ***Consumer Rights***

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

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:4 PA:0 UA:0 NA: 0 |

* 1. ***Organisational Management***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:17 PA:0 UA:0 NA: 0 |

* 1. ***Continuum of Service Delivery***

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

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 3 PA Neg: 0 PA Low: 2 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:11 PA:3 UA:0 NA: 0 |

* 1. ***Safe and Appropriate Environment***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 2 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 1 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:6 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:3 PA:0 UA:0 NA: 0 |

1. ***Restraint Minimisation and Safe Practice***

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

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 5 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:0 FA:1 PA:0 UA:0 NA: 0 |

1. ***Infection Prevention and Control***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |  | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 33 **CI:** 0 **FA:** 14 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 38 **PA:** 3 **UA:** 0 **N/A:** 0 |

**Corrective Action Requests (CAR) Report**

Provider Name: North Waikato Care of the Aged Trust Board

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:18-Jul-13 End Date: 18-Jul-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.3 | 1.3.3.3 | PA  Low | **Finding:**  Three of six long term care plans sampled have not been developed within the stated time frame of three weeks.  **Action:**  Provide evidence that all long term care plans are developed within the required three week time frame, including internal transfers when the level of care has changed. | 6 months. |
| 1.3.6 | 1.3.6.1 | PA  Moderate | **Finding:**  Four of the seven care plans sighted do not accurately and clearly describe all current needs and interventions.  **Action:**  Review and amend care plans to reflect current needs and interventions. | 3 months |
| 1.3.12 | 1.3.12.1 | PA  Low | **Finding:**  The standing order process has not been amended to include the number of doses which can be given. Four medication charts in the sample of 12 have medications prescribed which have not been individually signed for by the GP (these are bracketed).  **Action:**  1) Amend the standing orders to include the number of doses that can be given. 2) Discontinue bracketing prescriptions and ensure each medication is individually signed for by the GP. | 6 months |

**Continuous Improvement (CI) Report**

Provider Name: North Waikato Care of the Aged Trust Board

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:18-Jul-13 End Date: 18-Jul-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXXX

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.9 Communication**

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

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

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

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

There is evidence that the service adheres to the practices of open disclosure. An interview with four relatives and two GPs confirm that staff are open about adverse events that impact residents and maintain communication with those residents and their significant others. Review of incident/accident reports for 2012 and 2013 contain evidence that family and/or GPs are notified when appropriate, and in a timely manner of any change in a resident's health status. All residents interviewed are able to identify staff involved in their care.

Access to interpreter services is available but there are no residents in the home who do not speak English. The residential agreement contains clear descriptions of all funded and unfunded services.

The service complies with ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii;D16.4b; D16.5e.iii; D20.3.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has appropriate systems in place to manage the complaints processes and a register is maintained (confirmed by review of 2013 register and electronic records of complaints received and investigated for 2012, interview with the facility manager and a family member who submitted a complaint in February 2013).

Residents and their families are advised about how to raise concerns or complaints on entry to the facility (confirmed by interview with one new resident and two family members). As per the requirement in ARC D13.3 h, complaints procedures are included in the admission agreement. There have been no external complaints to the Health and Disability Commissioner. There have been 20 complaints received and investigated since the certification audit in December 2011.

Five residents (three hospital and two rest home level care) demonstrate understanding about the complaint processes. A family member interviewed by telephone who submitted a complaint this year, spoke very highly about the way the complaint the was received and handled which included bringing in an advocate from the Nationwide Advocacy Service. All other ARRC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

Service marketing documents, the 2013 business plan and the current quality and risk management plan clearly define the scope, direction and goals of the organisation. These are monitored for implementation by the facility manager (FM) and the trust board (confirmed by interview with FM and review of a sample of manager’s reports to the trust board for 2012-2013).

The full time FM (who is also an RN with a current APC) has total oversight and responsibility for organisational performance and service delivery, including the day to day running of business and financial administration, quality and risk systems and human resources. There is also a Clinical Nurse Manager (CNM) and a Clinical Administrations Manager (CAM) who are both RNs with different roles and responsibilities for clinical care and staff education. All nursing managers attend regular ongoing professional development relevant to their roles (confirmed by interview with FM and review of staff training records).

The FM has been in her post for five years, holds tertiary management qualifications and maintains nursing portfolio with at least eight hours per annum of suitable on-going training and education as required in the ARCC. There are sound financial management systems and procedures and the requirements of the Age Related Residential Care Contract A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; & E2.1 are met.

**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:**

**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:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

Quality and risk management systems are well established and effectively maintained. Quality activities are clearly linked with the business plan. Outcomes from quality and risk monitoring are reported to the Board monthly (confirmed by review of a sample of board meeting minutes for 2012-2013 and the FMs reports to the board). Interviews with four caregivers, two RNs, auxiliary staff and the FM confirm their understanding and involvement in quality and risk systems.

Control of documents and records (eg, document control, review, storage and management of obsolete documents) is managed by the FM and administrative staff with input from clinical managers for reviewing clinical policies and procedures. Care staffs interviewed confirm that they are kept informed about changes to policies, procedures and guidelines.

Quality data (complaints, infections, health and safety/near miss/hazard reporting and restraint and event reporting eg, incidents/accidents, skin tears, pressure areas, bruises, behaviours, medicine errors, staff illness and injury) are collected, analysed and compared month by month and then reported to all levels of staff at monthly staff meetings, the monthly Quality & RN meetings and the monthly Health and Safety & Infection Control meetings. (Confirmed by review of a sample of these meeting minutes for 2012 and 2013). Where appropriate, outcomes from service delivery monitoring are also reported to residents and their families at monthly residents meetings or via newsletters (interview with diversional therapist, review of meeting minutes and newsletters).

There is a comprehensive internal audit schedule and results of audits are communicated to staff and the board (evidenced in sample of board reports and confirmed in interview with 10 of 10 staff from different disciplines and shifts). Corrective actions (typically identified as a result of internal audits, adverse event reporting, and feedback from staff, residents and relatives) are documented as quality improvements and are monitored for progress by the FM.

Hazards are recorded on the hazard register which is updated when new hazards are identified. Risks and hazards are monitored by the health and safety team and through the internal audit programme (interview with the health and safety officer and review of internal audits related to safe environment hazards and other risks sighted).

Each resident is risk assessed using a range of assessment tools (eg, falls assessment, continence, skin integrity, nutrition and depression inventories where applicable-sighted in a sample of seven resident care records).

The service complies with ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

There are well known policies and procedures for managing adverse, unplanned or untoward events. Staff clearly and reliably report and/or document adverse, unplanned or untoward events (confirmed by sample of incident and accidents for June 2012- April 2013 and the collated reports of these). Trends show an average 20 falls and an average three medicine errors a month. All other incidents, such as skin tears, wandering, challenging behaviours, staff injury, near miss and security events are documented and reported. The sighted reports document that families and other affected parties (eg general practitioners) are notified where necessary, in a timely manner.

The service complies with ARC D19.3a.vi.; D19.3b; D19.3c by recording and reporting of incidents and accidents, complaints and suggestions, environmental hazards and others, as indicated by statute, regulation or professional practice standards.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

There are effective human resources management systems implemented before commencement of employment and on-going staff training to facilitate safe and effective practice. The FM validates professional qualifications and holds copies of each RNs and ENs current practising certificates and ensures local GPs, who are used by the service, have current registration with the NZ Medical Council and that allied health staff (eg, physiotherapist) have relevant practising certificates. (Interview with FM and review of records)

New staff orientation/induction occurs as per the requirements of ARC 17.6. Orientation covers the essential components of the service provided (eg, quality and risk systems, policies and procedures, health and safety requirements, including emergency procedures, authority and responsibility and key tasks of individual positions, knowledge of care delivery and standards and the organisation’s vision and values). Interviews with FM and a recently employed caregiver demonstrate that new staff are overseen by the CNM and are assigned a preceptor and a buddy on shifts if required. Assessments of competence is conducted by senior RNs and then an overall performance appraisal is conducted annually by either the CNM or CAM or the relevant supervisor depending on the position as required in ARC 17.7.

Registered Nurses are peer assessed and must demonstrate competency prior to carrying out tasks, procedures or treatments (evidence of annual medicine and restraint competency is sighted in three RNs' personnel records). RNs are on site 24 hours a day, seven days a week (24/7) for advice and support.

There is an on-going programme of staff development as required in ARC 17.8. The sighted staff education programme for 2013 is being implemented and covers subjects specific to care of the older person (confirmed by interview with FM, two RNs and four care givers).

All care staff have completed or are in the process of completing the core ACE training series and the dementia series, for those staff who work in the secure units. The CNM is an ACE moderator who oversees the self-directed education programme. In-service and external courses and the self-directed ACE training provide all care staff at least eight hours of training annually. There are individual written records of staff attendance at education sessions and the staff files sampled show care staff (from all shifts) have attended at least eight hours as required in the ARC 17.8.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

Adequate staffing for the increase in service delivery was not able to be verified at the October 2012 audit. There is evidence the organisation meets the requirements of the ARC 17.3. There are sufficient registered nurses on site and others available on call 24/7 to carry out duties as per clauses 17.3 b,c,e,f,and g. (confirmed by review of rosters from the previous month and forward planned rosters for July to August and interview with three of four family members and five residents).

The rostering protocol clearly describes how staffing numbers are determined (eg, resident numbers and acuity), which staff are allocated to each area, and for how many hours, and what to do when workload related to resident acuity increases.

Rest home staff allocation (for 34 residents) is as follows:

Morning shifts 7am to 3pm are staffed by a part time RN, and three care givers/ENs

Afternoon shift 3pm to 11pm are staffed by three care givers

Night shift 11pm to 7am is covered by two care givers (and one RN is available on site)

Hospital wing staff allocation (for 22 residents) is as follows:

Morning shifts 7am to 3pm are staffed by one RN, and four caregivers/ENs

Afternoon shift 3pm to 11pm are staffed by one RN, and four caregivers/ENs

Night shift 11pm to 7am is covered by one caregiver and an RN.

There is capacity to bring in an additional caregiver for a short shift from 9am to 1pm and again from 5pm to 9pm when resident acuity increases (confirmed by manager interview).

Two secure units staff allocation (one unit with five residents and one with six residents) are as follows:

One care giver in each wing at all times with relief and assistance from others as required and allocated hours from the RN and diversional therapist. Only care staff who have completed or are in the process of completing qualifications in dementia care are rostered to work in the dementia wing (confirmed by staff and manager interview and review of rosters). There are 20 care staff that have completed the dementia series and all RNs have completed these.

The Facility Manager/RN is on site Monday to Friday 8am - 4.30pm. The Clinical Nurse Manager is on site Mon-Fri 7am - 3.30pm or 8.30am - 3pm and on call evenings and weekends as is the Clinical Administrative Manager/RN

Auxiliary staff - There are always two cooks on site seven days a week who work 10 hour shifts, two cleaners Monday to Friday 5.30 am - 2pm and one on the weekend. A dedicated laundry person seven days a week 7am-3pm. Two diversional therapists are employed (one is part time) the other works Monday to Friday 8am-4pm. The service contracts a physiotherapist to be on site Monday, Wednesday and Fridays for flexible hours as required. A service is contracted to provide maintenance personnel who are also on call and grounds staff. A sufficient number of administration staff are also employed (eg, accountant, receptionist and accounts administrator).

Five residents (two rest home and three hospital) and three relatives were asked specifically about staff availability. They perceive there are enough staff on all shifts to attend to their needs in a timely way.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

Residents' and staff files sampled confirm that each stage of service provision is completed by a suitably qualified person. Assessments and care plans are developed and reviewed by a registered nurse and staff have the required competencies. Daily interventions and support with activities of daily living are implemented with the help of trained healthcare staff and assistants.

Timeframes for service delivery are defined. An assessment and initial care plan is developed on admission by the nurse and a medical assessment conducted by the GP within 48 hours. Short term care plans are available for use as and when required. Care plan reviews are completed (at a minimum) every six months, with a comprehensive multidisciplinary review completed annually. The previous required improvement regarding timeframes for the completion of long term care plans has yet to be addressed, as two out of six records sampled could not evidence the long term care plans had been developed within three weeks of admission. GP reviews are completed every three months. The two GPs interviewed confirm their involvement in specialist referrals and medication reviews and state they are always contacted regarding any concerns in a timely and proficient manner.

Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement. For example, GP entries and visits from allied health providers are sighted. Residents' files are integrated and contain a section for allied health reporting. Daily handovers also ensure continuity. During the audit one handover is observed and confirms accurate and comprehensive information is communicated amongst staff.

The relevant ARC requirements are met. Residents are assessed by their GP either prior to admission or on entry. Responsibilities for the provision of daily care are identified during the handover reports. Care plans include physical, spiritual and cultural abilities, deficits and expected outcomes.

Tracer methodology hospital resident:

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

Tracer methodology rest home resident.

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

Dementia tracer.

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

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

The previous improvement required regarding timeframes for the development of care plans has yet to be addressed. Two out of six care plans do not evidence that the long term care plan has been developed within three weeks of admission. One of these involved an internal transfer, with full assessments and care plans previously documented, thus (according to the risk matrix) the risk level remains low. The Facility Manager states that a new care plan, and review of assessments is expected with internal transfers if the level of service has changed. For example one resident was transferred from the dementia wing to the hospital wing. The transfer was conducted on the 2 May, and the new long term care plan was not completed until the 7 July.

**Finding Statement**

Three of six long term care plans sampled have not been developed within the stated time frame of three weeks.

**Corrective Action Required:**

Provide evidence that all long term care plans are developed within the required three week time frame, including internal transfers when the level of care has changed.

**Timeframe:**

6 months.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

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

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

All current interventions are required to be documented within each domain of the care plan. The majority of interventions sighted are commensurate with the nursing diagnosis and desired goals and are detailed and documented clearly to guide staff. However, an improvement is required to ensure that interventions reflect the current health needs of the resident and are updated when changes occur.

Short term care plans are required when a specific problem is identified and the required interventions are documented. The short term care plans sighted are well documented and monitored.

Additional care plans, and the required interventions, are documented. Examples sighted include a plan of care developed by the diabetic nurse, physiotherapy activities, wound care interventions and interventions required for the management and cleaning of hearing aids. Both GPs interviewed are satisfied that the required interventions and related monitoring is implemented.

Residents are encouraged to be involved in developing realistic and optimal levels of functioning to meet their own everyday living needs/goals and to maintain independence.

The ARC requirements are met.

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

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

Not all care plans sighted included the required interventions. For example the long term care plan for one hospital resident did not include specific interventions for pressure care, monitoring blood glucose (although this is documented in the diabetic nurse care plan) and the management of urinary incontinence. The long term care plan of one rest home resident does not accurately reflect the change in the level of care from hospital to rest home. Another example includes the required interventions for monitoring the behaviour of one dementia resident. The behaviour chart is not updated when a behaviour incident (requiring prn medication) has occurred.

The use of lap belt and bedrails or the risks associated with these are not clearly documented in the long term care plan of one resident with dementia.

**Finding Statement**

Four of the seven care plans sighted do not accurately and clearly describe all current needs and interventions.

**Corrective Action Required:**

Review and amend care plans to reflect current needs and interventions.

**Timeframe:**

3 months

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The activities programme is appropriate and reflects that independence is encouraged and choices are offered. The activities offered meet the residents' needs and are appropriate to the acuity of the residents. Daily activities are provided in the hospital, rest home and dementia areas. The activities assessments and plans (sighted in six of six residents' files) include the resident’s preferences, social history, and past and present interests. Each resident has activities preferences form with a resident centred goal. The activities plans sighted evidence they are updated or reviewed at least six monthly.

The rest home activities co-ordinator is interviewed and states there is normally an activities coordinator in both the rest home and hospital Monday to Friday (on the day of the audit the hospital activities coordinator is on leave). Dementia residents attend the activities conducted in the rest home (as able and was observed) and the secure dementia areas have spaces inside and out that allow maximum freedom of movement, while promoting safety for residents to pace.

The activities co-ordinator states feedback is sought from residents during and after activities and informally. The goals are developed with the resident and their family, where appropriate. Residents interviewed speak highly regarding the variety of activities and outings that are provided. Individual activity records sampled confirm a satisfactory level of attendance at activities.

The relevant ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Six monthly care plan evaluations occur, or more often if required. All care plans sampled have been evaluated with the required time frames, with a multidisciplinary (MDT) review annually. The MDT review includes input from the Manager, GP, diversional therapist, physiotherapist and family. Day to day response to care needs is documented in daily progress notes which are completed per shift. Three monthly GP reviews are also evident. Residents interviewed and two family members state they are involved in the care planning and review process. A required improvement has been documented in criterion 1.1.3.6 to ensure long term care plans are updated with current interventions (as needs change).

The relevant ARC requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements and safe practice; however an improvement is required to the standing orders process to ensure it meets the 2012 standing orders guidelines. A robotics medication system is implemented. The service has five regular visiting GP's and all medicines are prescribed by the GP using the pharmacy generated medication chart. An improvement is required to the prescribing process to ensure all medications are individually signed for by the GP.

All medication charts include photo identification and allergies. Three monthly GP reviews are evident in all records sampled. Administration records are maintained and specimen signatures current.

Medications are safely stored in a locked medication cabinet in the treatment room and administered from a secure medication trolley. Medication fridge temperatures confirm the fridge is maintained at the required temperature. Controlled drugs are secure and the required controlled drug checks are maintained.

There is a range of stocked medication for the hospital residents. This is limited and includes a range of antibiotics and pain medication. Stored medication is checked regularly for expiry dates and it's use monitored. All regular non-packaged medications are individually labelled. The use of 'as required' (PRN) medication is monitored during the three monthly GP review. This includes the use of PRN medication for behaviour management in the dementia wings.

Medications are administered by staff who have complete medication competencies. Competencies for medication management are monitored by the senior clinicians. Records are sighted to verify the process. A lunch time medication round in the hospital is observed and confirms administration is safely maintained and the administration record is accurately documented.

Medication errors are reported and investigated. There were very few medication errors in the past year.

There are three rest home residents who self-medicate. The required competency assessments have been conducted and GP approval obtained. Self-medication is also included in their long term care plan/interventions.

The remaining ARC requirements are met. Policies comply with the Medicines Act 1981 and residents' medication is reviewed on entry to the facility. This includes medication reconciliation.

**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:** Low

Twelve medication charts are sampled. This includes four hospital, four rest home and four dementia. Four medication charts in the sample have medications prescribed which have not been individually signed for by the GP (bracketed).

The standing order process has not been amended to include the number of doses which can be given. Likelihood and consequence of an adverse outcome to the resident as a result of the above (using the risk matrix) determines a low risk.

**Finding Statement**

The standing order process has not been amended to include the number of doses which can be given. Four medication charts in the sample of 12 have medications prescribed which have not been individually signed for by the GP (these are bracketed).

**Corrective Action Required:**

1) Amend the standing orders to include the number of doses that can be given. 2) Discontinue bracketing prescriptions and ensure each medication is individually signed for by the GP.

**Timeframe:**

6 months

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

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

**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:**

**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:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

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

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

Residents are provided with a well-balanced diet which meets their nutritional needs. The menus have previously been reviewed by a registered dietician and confirm they are appropriate for the needs of the older person. Nutritional assessments are completed on entry. Special dietary needs are identified and the cook confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident. Adequate special equipment is also provided.

Residents are weighed monthly, or more regularly if required. There are three hospital residents receiving regular nutritional supplements. The GP monitors health needs at each review. Residents interviewed are very satisfied with the food. Residents also state that they can ask for an alternative if they do not like what is on the menu. Lunch time is observed in all parts of the facility (eg, secure units, rest home and hospital. There is adequate staff to ensure those needing assistance are supported as required. There is food available 24 hours a day, specifically for residents in the secure units who have increased physical activity and wandering requires additional calories.

The nutrition and safe food management guidelines define the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers and records of temperature monitoring are maintained. Guidance is provided for staff on defrosting, environmental cleaning, storage, minimising risk of contamination and food hygiene principals. All kitchen staff have the required food safety qualifications. The kitchen staff at Kimihia also provide meals on wheels.

The ARC requirement is met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

There is a current building warrant of fitness which expires in March 2014. There was an area for improvement related to safe and suitable external areas in the new secure unit. Visual inspection of the external garden area demonstrates a secure area with safe walking paths, suitable furniture and no hazards.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

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

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

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

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

This was an area of non-compliance at the verification audit in October 2012. Approval for the fire approval scheme is notified on 8 November 2012 and this matter is resolved..

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

There are 14 residents with restraints and enablers (confirmed by review of current enabler/restraint register and interview with FM). All are bed rails and there is one resident in a secure unit who requires intermittent use of a lap belt to prevent falls.

The resident is listed in the restraints register as requiring use of bed rails and a lap belt to prevent harm from falls. Interview with two caregivers confirm that the resident sleeps with the bed lowered to the floor and bed rails up, and that a lap belt is used intermittently when caregivers are not within close proximity to discourage impulsive standing and subsequent falls. Staff demonstrate a thorough understanding of the risks associated with the resident. The long term care plan which was reviewed in March 2013 does not describe the safe use of the lap belt and there are no risks identified associated with the use of the lap belt or the bed rails. There is a corrective action related to this in criterion 1.3.6.1. Review of restraint monitoring records reveal that the bed rails are used every evening and that the lap belt has been used six times in the past 18 days. The time the belt is put on and taken off is recorded and staff demonstrate knowledge and understanding that the belt must be released at least every two hours. Staff training in safe restraint practices and avoiding the use of restraint is ongoing.(training plan and attendance records sighted)

**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:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 Surveillance**

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

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

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

The infection surveillance programme is appropriate for the facility and the level of care provided. Use of antibiotics is monitored and infection rates are monitored for quality improvement purposes. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Clinical staff interviewed report they are made aware of any infections of individual residents by way of feedback from the infection control team, infection reports and at staff meetings. Collated results and trends are also displayed. The December 2012, April and March 2013 collated reports and analysis is sighted. This includes proposed actions. Doctors are informed if their resident has an infection.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**