**Presbyterian Support Central - Huntleigh**

**Current Status:** **19-Sep-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**

Presbyterian Support Central (PSC) Huntleigh provides rest home and hospital level care for up to 71 residents with 64 occupied on the day of the audit.

PSC Huntleigh has a manager who is responsible for operational management of the service. She is supported by two care managers who are registered nurses, and a regional manager.

There is a quality and risk management programme that includes analysis of incidents, complaints and an implemented internal audit schedule. There is a schedule of meetings that provide an opportunity for all staff and residents to be engaged in analysis and discussion of issues.

Residents and family members interviewed spoke positively of the services provided at PSC Huntleigh.

The service has addressed the following shortfalls identified at their certification audit; complaints documentation, employee files, aspects of care plan documentation and medication management, recreation hours, preventative maintenance and environmental checks, civil defence monitoring. However improvement continues to be required around documentation to reflect enabler/restraint monitoring.

This surveillance audit identified further improvements required around aspects of medication management, use of clinical risk assessment tools and wound care.

**Audit Summary AS AT** **19-Sep-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 Audit19-Sep-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 Audit19-Sep-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 Audit19-Sep-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** |

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| **Safe and Appropriate Environment** | Day of Audit19-Sep-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 Audit19-Sep-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Infection Prevention and Control** | Day of Audit19-Sep-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** |

**Huntleigh Home**

Presbyterian Support Central

Surveillance audit - Audit Report

Audit Date: 19-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Presbyterian Support Central  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Huntleigh Home | 221 Karori Road | Karori | Wellington |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 19-Sep-13 **End Date:** 19-Sep-13 |
| **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 | XXXXXXXXX | RN, Auditor certificate | 8.00 | 6.00 | 19-Sept-13 |
| Auditor 1 | XXXXXXXXX | RN, Auditor certificate | 8.00 | 5.00 | 19-Sept-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXXXX |       |       | 1.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 28.00 |
| **Staff Records Reviewed** | 8 of 65 | **Client Records Reviewed** *(numeric)* | 8 of 64 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 8 |
| **Staff Interviewed** | 10 of 65 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 8 of 64 | **Number of Medication Records Reviewed** | 16 of 64 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXXXX (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 Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 22 day of October 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

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| --- | --- | --- | --- | --- |
|  |  |  |  | **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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Huntleigh Home | 71 | 64 | 42 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Presbyterian Support Central (PSC) Huntleigh provides rest home and hospital level care for up to 71 residents with 64 occupied on the day of the audit.

PSC Huntleigh has a manager who is responsible for operational management of the service. She is supported by two care managers who are registered nurses, and a regional manager .

There is a quality and risk management programme that includes analysis of incidents, complaints and an implemented internal audit schedule. There is a schedule of meetings that provide an opportunity for all staff and residents to be engaged in analysis and discussion of issues.

Residents and family members interviewed spoke positively of the services provided at PSC Huntleigh.

The service has addressed the following shortfalls identified at their certification audit; complaints documentation, employee files, aspects of care plan documentation and medication management, recreation hours, preventative maintenance and environmental checks, civil defence monitoring. However improvement continues to be required around documentation to reflect enabler/restraint monitoring.

This surveillance audit identified further improvements required around aspects of medication management, use of clinical risk assessment tools and wound care.

1.1 Consumer Rights

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service continually and as required. Information about services provided is readily available to residents and families. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents' and/or their family/whānau. Residents and family interviewed spoke very positively about care provided at PSC Huntleigh. Complaints processes are implemented and complaints and concerns are managed.

1.2 Organisational Management

Huntleigh is part of the Presbyterian Support Central organisation. The facility provides rest home and hospital level care for up to 71 residents. Occupancy was 64 residents on the day of audit. There were 22 rest home and 42 hospital level care beds occupied at the time of audit. The service has a manager (non clinical) who is responsible for the operational management and she is supported by two care managers (registered nurses).

Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and QPS benchmarking programme that is being implemented at PSC Huntleigh. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. There is a monthly quality committee meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings, resident meetings and six monthly family meetings.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff state that there are sufficient staff on duty at all times.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

1.3 Continuum of Service Delivery

The Registered nurses are responsible for each stage of service provision. The assessments and support plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The residents' needs, objectives/goals have been identified in the long-term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the records reviewed the resident and/or family/whanau and multidisciplinary team have input into the three monthly reviews. There is an improvement required around the review of pain assessments, monitoring of pain management and ensuring wounds/pressure areas are linked to the care plans. Resident files are integrated and include notes by the GP and allied health professionals.

The Diversional therapist and recreational officer plan an activity programme for the residents in the rest home and hospital units. The programme is varied, interesting and meets the recreational, physical, cognitive, cultural and spiritual needs and preferences of the consumer group.

Medication practice aligns with medication management policy and procedures. Education and medicines competencies are completed by the registered nurses and health care assistants responsible for administration of medicines. The medicines records reviewed include photo identification, documentation of allergies and sensitivities. General practitioner prescribing meets legislative requirements. There is an improvement required around GP review of medication charts for those residents who are self-administering their medications. Food services and all meals are provided on site. Residents individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene.

1.4 Safe and Appropriate Environment

The building has a current building warrant of fitness that expires 27-Nov-13. There is fire service evacuation approval. Fire safety equipment checks are current. There is adequate equipment for the safe delivery of care. All equipment has been electrically tested and tagged. There is a weekly, monthly, three monthly and six monthly maintenance schedule. Emergency plans have been updated since previous certification audit. The facility has two large water storage tanks which are located in the car park for use in an emergency. Civil defence kits are checked six monthly to ensure items stored remain within their expiry dates.

2 Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. Resident files sampled have detailed plans around the management of behaviours that challenge. There are currently ten residents using enablers. There are improvements required around documentation of enablers in care plans and the frequency of monitoring of enablers when in use being documented in progress notes.

3. Infection Prevention and Control

Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (a registered nurse) take overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations. The service uses the QPS benchmarking programme for infection control.

All surveillance activities are the responsibility of the infection control coordinator with assistance from the quality committee through the monthly quality meeting. There is an online infection register in which all infections are documented monthly.

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: 0Criteria (of 48): CI:0 FA:4 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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|  |  | **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: 0Criteria (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 | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | PA Moderate | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Low | 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:5 CI:0 FA: 4 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: 0Criteria (of 51): CI:0 FA:12 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 | 3 | 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: 0Criteria (of 36): CI:0 FA:4 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 | PA Moderate | 0 | 0 | 1 | 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: 0 PA Neg: 0 PA Low: 0 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:0 PA:1 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: 0Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 32 **CI:** 0 **FA:** 14 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 2 **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:** 39 **PA:** 4 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Presbyterian Support Central

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:19-Sep-13 End Date: 19-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.4 | 1.3.4.2 | PAModerate | **Finding:**There is no pain assessment for one hospital resident with pain following a fall. The same resident does not have a pain assessment completed on return to the facility following a surgical procedure. There is inconsistent monitoring of the effectiveness of pain relief. Two hospital level residents have not had a review of pain assessment for the last 18 months. One has been commenced on a controlled drug for pain relief. The other resident is on regular and prn pain relief.     **Action:**Ensure pain assessments are completed for all episodes of pain. Ensure the effectiveness of pain relief is monitored.  | 1 month |
| 1.3.6 | 1.3.6.1 | PALow | **Finding:**One chronic wound for a rest home resident is not linked to the long term support plan. There is no short term care plan with interventions documented for the management of a pressure area (painful heel). **Action:**Ensure chronic wounds and pressure area management is linked to care plans. | 3 months |
| 1.3.12 | 1.3.12.5 | PALow | **Finding:**The medication chart for one self-medicating resident has not been reviewed since Oct. 2012. **Action:**Ensure the medication chart for self-medicating residents are reviewed at least three monthly.  | 3 months |
| 2.1.1 | 2.1.1.4 | PAModerate | **Finding:**One care plan reviewed stated that the resident used a safety harness when the consent form was for a lap belt. Discussion with the health care assistants and care manager confirmed that the resident used a lap belt and not a safety harness. Care plans document the frequency of monitoring of enablers when in use, however the frequency of monitoring occurring was not evidenced to be consistently documented in the progress notes in three resident files reviewed. This was a finding at certification audit which has not been resolved.**Action:**(i) Ensure care plans document the enabler in use. (ii) Ensure frequency of monitoring required (as described in care plans) is reflected in progress notes. | 1 month |

# Continuous Improvement (CI) Report

Provider Name: Presbyterian Support Central

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:19-Sep-13 End Date: 19-Sep-13

DAA: Health and Disability Auditing New Zealand 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

Discussions with eight residents (four hospital and four rest home) and three family members all stated they were welcomed on entry and were given time and explanation about services. Resident meetings occur monthly and relatives meetings occur three monthly. (Minutes of meetings sighted). The Manager and has an open-door policy.

A review of incident forms from September 2013 identified that relatives are informed in all cases where appropriate.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Three relatives stated that they are always informed when their family members health status changes.

D 13.3 Eight files reviewed included completed admission agreements.

Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry.

D11.3 The information pack is available in large print and advised that this can be read to residents.

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs.

There is a Chinese resident who speaks Cantonese and very little English. Health care assistants and care manager interviewed described that the resident understands English but does not speak English. The care manager stated that the resident’s next of kin is involved in care planning and GP medical reviews so that the resident is informed of any changes and can also inform staff of any improvements required. The resident is supported to phone family if a block to communication/understanding has occurred so that this can be addressed. Family visit the resident frequently and the resident is supported to maintain links with family and community.

There are cue cards available to promote communication.

The residents and relatives survey conducted in 2012 evidenced overall resident satisfaction is 87.92%. Areas for improvement identified from the resident survey have been implemented and evaluated.

**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 a clearly documented process for making complaints and this is communicated to residents/family/whānau. There is a copy of the process documented in a notice-board in the service and a suggestions/complaints box.

Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with eight residents and three relatives confirmed they were provided with information on complaints and complaints forms and one family member described having a concern addressed and resolution of the complaint has been achieved. Complaint forms were visible for residents/relatives in various places around the facility.

D13.3h. A complaints procedure is provided to residents within the information pack at entry.

There is a complaints folder and register that includes complaints verbal and written and includes sign-off. All complaints formal and informal are included on the complaints register and the PSC templates are used. The complaints folder and register has been kept up to date and all complaints are included on the register with evidence of follow up and resolution. The June 2012 certification audit identified that the record of action taken was not consistently included on the complaints register. This finding has been addressed. There were nine complaints received in 2012 and to date in 2013 five complaints have been received. Four written complaints for 2012-13 were reviewed. All complaints were well documented including investigation, follow up, feedback (verbal, letter) and resolution. A letter from HDC dated 18-Jun-13 regarding one complaint was sighted which stated that the complainant no longer which to proceed with complaint and that no further action was required.

**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

Huntleigh is part of the Presbyterian Support Central organisation. The facility provides rest home, medical and hospital level care for up to 71 residents. There were 42 hospital and 22 rest home level care beds occupied at the time of audit. There were no residents receiving care under medical contract. The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director.

PSC Huntleigh has a documented mission statement, vision, values, corporate commitment and older person’s services goals.

There is a local risk management plan for 2013.

There is an Enliven PSC Huntleigh business plan that provides a mission, vision and values and goals. An action plan has been implemented to meet those goals.

The service has a structure that supports the continuity of management and quality of care and support (including staff management).

The manager is non-clinical and is supported by two care managers (RNs)

PSC provides care manager orientation training and support at least every two months across the organisation. Enliven also provides a two day education seminar annually for all care managers to ensure that all care managers receive at least eight hours annual professional development activities related to overseeing clinical care.

ARC,D17.3di (rest home), D17.4b (hospital), the manager and care managers have maintained at least eight hours annually of professional development activities related to managing a hospital.

**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

The service has a current business and a quality and risk management plan for 2013 -14.

The service has continued implementing their quality and risk management system since previous certification and a number of quality improvements have occurred to address shortcomings in previous certification audit.

Presbyterian Support Services Central has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and QPS benchmarking programme that is being implemented at PSC Huntleigh. There has been a review of the Quality Monitoring Programme with new draft audit templates introduced. The new templates have been in use since January 2013.

The manager provides a balanced scorecard report to central office.

All staff are involved in quality improvements. The quality committee includes key staff from all areas of the service. Quality reports are provided to the committee by members of the quality committee and include (but not limited to); a) quality coordinators report, b) kitchen monthly report, c) health & safety monthly report, d) laundry monthly report, e) IC monthly report, f) restraint monthly report, g) clinical monthly report, h) managers monthly report, i) chaplains monthly report, j) activities monthly report, k) education monthly report, l) Eden monthly report, m) domestic/cleaning monthly report and n) administrative monthly report.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement.

The service completes quarterly reports of the IC programme and the H&S programme to PSC Quality Coordinator.

The internal audit schedule has been combined to include QMP and QPS monitoring.

Policies and procedures cross-reference other policies and appropriate standards.

There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is a comprehensive IC Manual. Restraint policy and Health &Safety policy/procedures.

There is an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance and content has improved and sessions evaluated.

There is a policy review date schedule, and terms of reference for the policy review group.

New/updated policies/procedures are included in the "What’s New" manual for staff.

a) Monthly accident/incident/near miss reports are completed by the health and safety officer for each site that breaks down the data collected across the facility and staff incidents and accidents. These are also compared with the last month. The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents. There is a new online database for recording accidents and incidents with medication errors reported separately.

Incidents and accidents are also reported to PSC clinical director monthly.

b) The service has linked the complaints process with its quality management system. This occurs through the QPS benchmarking programme and the identification of complaints against a benchmark of the service peers. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Monthly manager reports include compliments and complaints.

c) There is an IC register in which all infections are documented monthly. A monthly IC report is completed and provided to quality meeting. The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. Infections are also being documented on the newly introduced electronic database.

QPS data analysis includes: Competency testing for IC, Wound Infection Rate, skin infection rate, Infection rate, UTI’s, Respiratory Tract Infections, ENT rates and GI rates graphed quarterly. A benchmarking report from the 3 month data is prepared for staff and displayed on notice boards. Internal infection control audits are planned and undertaken during the year.

d) Health and safety monthly reports are completed for each service and presented to the quality committee and a quarterly health and safety report is also completed. The report includes identification of hazards and accident/incident reporting and trends are identified.

e) The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. PSC Huntleigh is currently restraint free.

The service completes an internal audit for each area which results in a report that identifies criteria covered and achievement, a general summary of the audit results, key issues for improvement and an action plan for resolution. Meeting minutes and reports provided to the quality meeting have improved to the quality committee, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.

The service benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

A hazard register is established for each site that includes a hazard register for all areas of the facilities. There is also an implemented hazard monitoring form that is implemented for environmental inspections.

Civil defence procedures are in place and supported by staff training.

Preventative maintenance audit is completed annually. There is a facility risk management plan 2013

The service documents risk or areas of concern and remedial action is identified as a result.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident an hazard management

D19.2g Falls prevention strategies are in place such as falls risk assessment, physiotherapy assessment, low-low beds, sensor mats, landing mats, exercise classes to promote balance and range of movement and walking aids.

**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

The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services.

Thirteen incident forms for September 2013 were reviewed. All show the form has been fully completed and reviewed by a registered nurse.

All have on-going review and where appropriate actions to prevent recurrence completed by the care manager. Clinical meetings evidenced discussion around falls management and preventative measures to be implemented.

Quality meeting minutes include a comprehensive analysis of incident and accident data and analysis. A monthly incident accident report is completed which includes an analysis of data collected.

The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents.

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

**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

The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity.

A copy of practising certificates including RNs, EN's, pharmacists, the dietitian, the physiotherapist and GPs are kept.

There is a physiotherapist contracted to work 4 hours per fortnight.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (one recreation officer, one cook, two registered nurses, one care manager and four health care assistants). Each folder had a file checklist and documentation arranged under personal information, correspondence, agreement, education and appraisals.

The previous certification audit identified that an improvement was required around the completion of the orientation books. A quality improvement implemented following this finding was to improve the working environment for staff which included a dedicated focus towards a formal and informal socialisation process for employees with the intent to improve work place culture and team work approach, engagement, retention, issues and performance and changes to induction programme and handover.

A comprehensive orientation programme is now in place that provides new staff with relevant information for safe work practice. This was described by staff and records are kept. A buddy system supports new staff.

There are two comprehensive orientation books that include checklists for completion in files reviewed. There is an implemented specific RN orientation book. Registered nurses complete a four week orientation programme and health care assistants are buddied up with a more senior health care assistant for one week’s orientation. One HCA interviewed described that she identified that a new HCA she had been buddying needed a longer orientation period and that this had been arranged.

Agency staff (HCAs) were observed on duty during the audit. Agency staff complete and orientation.

The manager advised that the agency staff were covering for staff sickness. There are HCA vacancies currently being advertised and recruited,

There is a documented in-service programme for education and a specific staff educator. Competencies are identified and completed.

Health care assistants are encouraged and supported to undertake external education. Career force training is supported. The organisations policy is that after three months of employment all caregivers must be enrolled in Career force. There has been an increase in staff uptake of the career force education programme since June 2012. D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for health care assistants/caregivers. PSC Huntleigh has provided health care assistant and RN/EN compulsory training according to the framework.

There is one new graduate nurse who is part of the NetP programme.

Monthly reporting of training completed and percentages of staff attending is reported to the regional manager and clinical director monthly.

**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

Staff requirements are determined using an organisation service level/skill mix process and documented. Staffing levels are benchmarked against other PSC facilities. Staff levels/skill mix are meeting contract and industry norm requirements.

New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. Advised that the roster is able to be changed in response to resident acuity. The QPS benchmarking quarterly report states that staff hours remain consistently above the mean.

There are two care managers, one for the hospital and rest home.

Staff and residents interviewed reported that staffing levels were sufficient. There are currently two vacancies for healthcare assistants which are being advertised. Agency staff were observed on duty on the day of audit and confirmed they had received an orientation.

**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:** FA

D16.2, 3, 4: The eight files reviewed (three rest home and five hospital), identified that in all eight files an assessment was completed within 24 hours and all eight files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed by a RN and amended when current health changes. All eight care plans evidenced evaluations completed at least six monthly. There is evidence of the resident/family/whanau participation in the development and review of care plans. Family communication regarding any changes to health, GP visits, care plan reviews, MDT meetings are documented in the next of kin contact sheet.

D16.5e: Eight resident files (three rest home and five hospital) reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly. The clinical manager (interviewed) state residents may retain their own GP however they do have a home GP. The home GP visits Mondays and Fridays for half days. Three monthly reviews are carried out and any RN residents’ concerns are discussed in consultation with the GP, resident and family member (if appropriate). A locum is planned in advance for the weekly clinics to cover the house GP leave. The GP/locum is available after hours.

 A range of assessment tools where completed on admission in eight of eight resident files sampled including (but not limited to);

a) hygiene assessment b) nutritional and fluid assessment b) falls risk c) moving and handling assessment. d) Braden pressure area risk assessment, e) continence and bowel assessment f) pain assessment g) emotional wellbeing assessment h) wound assessment. Risk assessments have been reviewed at least six monthly in six of eight resident files sampled.

There is a physiotherapist contracted once a fortnight to follow up any RN/GP referrals and conducts falls/moving and handling assessments. A podiatrist visits regularly to provide foot and nail care. The clinical manager and RN's have ready access to nurse specialists including continence, wound care, speech language therapist, physiotherapist, palliative nurse, metal health services for the older person and the Care Coordination team. The GP and family are informed of any nurse specialist referrals. All referrals to other Specialists are made by the GP.

There is a handover period with the oncoming shift that includes a written handover form and verbal handover. The handover procedure (observed) ensure all significant resident information and health changes are known by the oncoming shift. This is an improvement from the previous audit.

Three rest home resident files sampled are as follows: 1) resident recently admitted with a chronic wound 2) resident under 65 with chronic fatigue syndrome 3) resident with challenging behaviour and falls

Five hospital level residents files sampled are as follows: 1) resident on controlled drugs for pain management 2) resident with challenging behaviour and on controlled drugs for pain management 3) resident with chronic wound 4) resident with complex medical problems and weight loss 5) resident with depression/anxiety

Tracer Methodology: Rest home resident

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

Tracer Methodology: Hospital level resident

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

**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:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

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

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

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to);

a) hygiene assessment b) nutritional and fluid assessment b) falls risk c) moving and handling assessment. d) Braden pressure area risk assessment, e) continence and bowel assessment f) pain assessment g) emotional wellbeing assessment h) wound assessment. There are pain monitoring charts available to be used in conjunction with the pain assessment tool. The partial attainment in the previous audit regarding pain assessments and lack of the monitoring of pain relief remains.

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

A range of assessment tools were evidenced completed in resident files reviewed.

**Finding Statement**

There is no pain assessment for one hospital resident with pain following a fall. The same resident does not have a pain assessment completed on return to the facility following a surgical procedure. There is inconsistent monitoring of the effectiveness of pain relief. Two hospital level residents have not had a review of pain assessment for the last 18 months. One has been commenced on a controlled drug for pain relief. The other resident is on regular and prn pain relief.

**Corrective Action Required:**

Ensure pain assessments are completed for all episodes of pain. Ensure the effectiveness of pain relief is monitored.

**Timeframe:**

1 month

**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 Low

Residents' support plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist nurse consultation. The CM, 2 RN's and seven HCA's interviewed stated that they have all the equipment referred to in support plans necessary to provide care, including hoists, chair scales, pressure relieving cushions and mattresses, shower chairs, transfer belts, slidy sams, wheelchairs, gloves, aprons and masks. Residents (four rest home) state their needs are being met. Relatives (one rest home and four hospital) state their relative receives the required support and their needs are being met.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services have been provided.

Complex or chronic wound assessment includes contributing health factors, allergies, nutritional status, length of time wound present, blood supply, any infection/systemic infection, malignancy, smoker, sleep disturbance and any diabetes. Wound progress notes and chronic wound support plans are in place for chronic wounds and pressure areas. Short term assessment and support plans are used for minor abrasions and skin tears. The RN assesses all wounds and documents dressing changes and evaluations for the rest home and hospital. The total number of wounds for the rest home are; one chronic hip fistula and two chronic leg ulcers. One chronic wound for a rest home resident is not linked to the long term support plan. There are six minor wounds, one skin tear and a chronic pressure area of sacral and buttocks in the hospital. Photographs are taken of chronic wounds to monitor healing progress. There is no short term care plan with interventions documented for the management of a painful heel. There is access to wound care nurses and specialists as required. There is evidence of dietitian advice for chronic wounds. Wound care education has been provided.

Residents are weighed monthly and there is a company dietitian available as needed for any dietary or weight loss concerns. Nutritional screening is completed for at risk residents.

**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:** Low

Complex or chronic wound assessment includes contributing health factors, allergies, nutritional status, length of time wound present, blood supply, any infection and pressure areas. Three chronic wounds in rest home; seven minor wounds/abrasions and three chronic wounds (one resident) in the hospital identified wound support plans in place

**Finding Statement**

One chronic wound for a rest home resident is not linked to the long term support plan. There is no short term care plan with interventions documented for the management of a pressure area (painful heel).

**Corrective Action Required:**

Ensure chronic wounds and pressure area management is linked to care plans.

**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

There is a registered diversional therapist (DT) employed full-time and a recreational officer works 20 hours a week. There has been an increase in activity hours since the previous audit. The DT is an Eden Champion and the recreational officer is an Eden associate. The DT attends the Wellington DT support group meetings, receives magazine and other information, attended conference and is support by the Enliven peer group quarterly meetings. The activity team meet monthly to plan the activity programmes for the rest home and hospital. There are combined activities for all residents such as bowls, bingo and entertainment. Other activities include newspaper reading, crafts, exercises, baking and happy hours, quizzes and games that meet the physical and cognitive abilities of the resident group. There are plans for a men's group to commence. Residents also receive one on one time as evidenced in the individual progress notes and resident interviews. There is a wheelchair van for outings. The DT has a current first aid certificate. Residents enjoy theme months, concerts, canine friend’s visits, speakers, community interaction such as visits to the kindergarten, fashion parades and shopping. Volunteers associated with the home assist with outings and activities on site. There is a student who comes in to play music. Music and entertainment is often arranged for the weekends. There are church services weekly. Church visitors and the chaplain visit regularly. Life reviews are completed on admission and recreation care plans are evaluated at least six monthly

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

**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

There are three monthly written reviews that include the residents general recordings and weight, review of risk assessment tools, any issues to be discussed with the GP. There is RN input, resident/family input, and any other allied health professionals involved in the residents care. The long term support plan is evaluated at least six monthly and changes made as required. The family/whanau communication form has written evidence of discussion held with families regarding care plan reviews. Short term care plans are used for short term or acute needs and are evaluated regularly. The GP examines the residents three monthly and reviews the medication chart.

Monitoring charts such as food and fluid intake charts, blood sugar level monitoring, weight and behaviour monitoring charts were evidenced in use.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated

D16.3c: All initial care plans were evaluated by the RN within three weeks of admission

**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 policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals and collects the returns. The facility use a blister packed medication system. Medications are checked and signed by the RN on duty. Any discrepancies are fed back to the pharmacy. All medication competent persons receive annual education and undergo an annual medication competency. The RN's have completed syringe driver training and refreshers through Mary Potter Hospice. There is a 2013 medication competent signature list. All medications are stored safely in locked medication rooms in the rest home and hospital wings. The hospital level has home stock. There are no standing orders in the rest home. Verbal orders are taken by RN's only. There are weekly controlled drugs checks and a six monthly pharmacy audit of controlled drugs. The administration of controlled drugs is signed by two medication persons on signing sheet. There are no gaps in the administration signing sheets. This is an improvement from the previous audit. All medication signing sheets are correct and prn medications have the time medication is given. Any changes of medications is written onto a yellow medication alert form with the medication chart.

Medication fridge temperatures are recorded weekly in both medication rooms. All prescription medications and drink supplements are within expiry dates. There are two residents who self-administer medications in the rest home. The residents have a self-medication competency assessment carried it by the RN. Medication persons monitor the self-medicating residents (signing sheets sighted). The medication chart for one self-medicating resident has not been reviewed since October 2012.

Sixteen medication charts sampled (six rest home and 10 hospital) have photo identification and allergies or nil known documented. PRN medications are prescribed with the indication for use.

D16.5.e.i.2; 15 of 16 medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed.

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

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

**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:**

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

There are two self-medicating residents in the rest home. The residents have a self-medication competency assessment carried it by the RN. Medication competent staff monitor the self-medicating residents (signing sheets sighted).

**Finding Statement**

The medication chart for one self-medicating resident has not been reviewed since Oct. 2012.

**Corrective Action Required:**

Ensure the medication chart for self-medicating residents are reviewed at least three monthly.

**Timeframe:**

3 months

**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

The kitchen is located within the hospital wing. The cook is commencing N.Z.Q.A. units. All kitchen staff have attended food safety and hygiene education. The cook attends PCS peer support group meetings and two monthly teleconferences. All meals, home baking and snacks are prepared on site. The PSC national menu for winter and summer is followed. The cook has ready access to the company dietitian if required. Resident dietary profiles are forwarded to kitchen staff and resident likes and dislikes are known. The cook is notified if there are any changes. Special and modified diets are accommodated. Alternative food choices are offered. The meals are delivered in a bain marie to the rest home dining room and served from the kitchen bain marie to the hospital dining room. Hot food temperatures are taken at each meal. Fridge, freezer and chiller temperatures are taken twice daily. Perishable foods in the chiller and fridges are date labelled. The RN has key access to the kitchen after hours for additional foods/snacks required. All staff are observed wearing protective clothing. Ecolab provide the chemicals used, safety data sheets and provide education as required. Quality control checks on the dishwasher are carried out monthly. Equipment has been checked and tagged June 13.

The cook attends Quality and staff meetings. One of the kitchen hands is a Health & Safety representative. Feedback is received from residents meetings and direct verbal feedback from residents.

D19.2 staff have been trained in safe food handling.

**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

The building has a current building warrant of fitness that expires 27-Nov-13. There is fire service evacuation approval. Fire safety equipment checks are current. There is adequate equipment for the safe delivery of care. There is a preventative maintenance plan in place. This is an improvement from the previous audit. All equipment has been electrically tested and tagged. Clinical equipment have had functional/calibration checks. There is a weekly, monthly, three monthly and six monthly maintenance schedule.

**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 1.4.2.4 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:**

**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

The previous audit found that the facility were not checking the civil defence kits to ensure that items were not past their expiry date; that they were unable to clarify how much water was stored; and that the civil defence policy required to be updated. This finding has been addressed

The facility now has two large commercial water storage tanks placed in a corner of the car park for use in emergencies. There are also stores of bottled water kept in civil defence kits available on each floor and in both lifts. Civil defence kits are checked six monthly to ensure items have not expired. The facility evidences: information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency flip charts were observed throughout the facility. Generators have been purchased for use in an emergency. There are gas bottles/burners for alternative heating and cooking and emergency food supplies sufficient for three days are kept in each kitchen. At least three days stock of other products such as incontinence products and PPE are kept. D19.6 there are emergency management plans in place to ensure health, civil defence and other emergencies are included and these have been updated.

**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:**

**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:** PA Moderate

There is a restraint minimisation and safe practice policy that is applicable to the service. This includes a restraint protocol for the steps from assessment, approval and into the support plan. The aim of the policy and protocol is to minimise the use of restraint and any associated risks.

The service currently has a restraint free environment. There are currently ten residents using enablers. The enablers in use include six bed rails, three lap belts and one resident uses both a bed rails and a lap belt. Three enabler files reviewed have appropriate consents indicating the enabler use is voluntary and assessments and reviews have been conducted. Three residents interviewed who use enablers confirmed their use was voluntary and at their request.

Care plans document the enabler in use, however there is a finding around ensuring that this is documented correctly.

Care plans document the frequency of monitoring of enablers when in use. Progress notes document the monitoring of enablers when in use however there is an improvement required around the documentation of frequency of monitoring of enablers. There is a restraint approval group at an organisation level that reviews restraint across all services.

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0

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

Two of three resident files reviewed requiring the use of an enabler documented the enabler that was in use in the care plan. Progress notes reviewed document monitoring of enablers when in use.

**Finding Statement**

One care plan reviewed stated that the resident used a safety harness when the consent form was for a lap belt. Discussion with the health care assistants and care manager confirmed that the resident used a lap belt and not a safety harness. Care plans document the frequency of monitoring of enablers when in use, however the frequency of monitoring occurring was not evidenced to be consistently documented in the progress notes in three resident files reviewed. This was a finding at certification audit which has not been resolved.

**Corrective Action Required:**

(i) Ensure care plans document the enabler in use. (ii) Ensure frequency of monitoring required (as described in care plans) is reflected in progress notes.

**Timeframe:**

1 month

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

**STANDARD 3.5 Surveillance**

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

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

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

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and Med lab that advise and provide feedback /information to the service.

The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. The quality coordinator also conducts benchmarking against their own infection rates from previous years by identifying K.P.I's. Systems in place are appropriate to the size and complexity of the facility.

Infection control data is collated monthly and reported to the monthly quality meeting. The meetings include the monthly infection control report and QPS quarterly results as available.

All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. One file of a resident with a diagnosis of ESBL +ve was reviewed. The care plan contained preventative infection control interventions to be implemented by staff. Health care assistants interviewed were able to describe the infection control measures that were required to be carried out by staff when caring for the resident.

**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:**