# Bima Health Limited

## Current Status: 12 August 2014

**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 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Bima Health Ltd operates Sunhaven Rest Home and Private Hospital (Sunhaven), a 37 bed psychogeriatric and dementia level care facility in Bell Block, New Plymouth. This event is a second, unannounced surveillance audit.

While previous areas for improvement have largely been addressed, seven areas requiring improvement are identified during this audit. These relate to the development of care plans in a timely way; interventions which describe the required support and meets assessed needs; a documented plan for activities; evaluation of care plans with changes made to interventions when needed; three aspects of medicine management are outside of accepted good practice and there has been no surveillance of infections since October 2013. The area for improvement relating to the lack of surveillance of infections, is rated as a high risk.

## Audit Summary as at 12 August 2014

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 |

### Consumer Rights as at 12 August 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Organisational Management as at 12 August 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Continuum of Service Delivery as at 12 August 2014

|  |  |  |
| --- | --- | --- |
| 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 as at 12 August 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Restraint Minimisation and Safe Practice as at 12 August 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Infection Prevention and Control as at 12 August 2014

|  |  |  |
| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Bima Health Limited |
| **Certificate name:** | Bima Health Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | The DAA Group Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Sunhaven Rest Home & Private Hospital |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care |
| **Dates of audit:** | **Start date:** | 12 August 2014 | **End date:** | 13 August 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 34 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 10 | Total audit hours | 34 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 3 | Number of staff interviewed | 5 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 36 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | The DAA Group Limited has provided all the information that is relevant to the audit | Yes |
| h) | The DAA Group Limited has finished editing the document. | Yes |

Dated Wednesday, 27 August 2014

## **Executive Summary of Audit**

**General Overview**

Bima Health Ltd operates Sunhaven Rest Home and Private Hospital (Sunhaven), a 37 bed psychogeriatric and dementia level care facility in Bell Block, New Plymouth. This event is a second, unannounced surveillance audit.

While previous areas for improvement have largely been addressed, seven areas requiring improvement are identified during this event. These relate to the development of care plans in a timely way; with interventions which describe support; and all support meets assessed needs; although activities are occurring there is not a documented plan; a new care plan has been implemented so that there has not recently been evaluation of plans; with changes made to interventions when needed; three aspects of medicine management are identified as being outside of accepted good practice and there has been no surveillance of infections since October 2013. The area for improvement relating to the lack of surveillance of infections is rated as a high risk.

**Outcome 1.1: Consumer Rights**

There is open disclosure to families/whanau when incidents occur and this is recorded on incident report forms and in residents’ files.

Formal complaints are managed following the organisation’s processes which meet the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code of Rights).

**Outcome 1.2: Organisational Management**

The organisation has a documented business plan which describes the mission, values and purpose of the facility. This is reviewed annually. There are quality goals within the plan and strategies for achieving these goals. There is a system for quality management which the owner and facility manager report is consistent with the size and scope of the facility and organisation. Quality improvement data is reported, collected, analysed and evaluated. Results are shared with staff at their regular staff meetings and at the quarterly continuous quality improvement (CQI) meeting. The risk register is monitored through the management and CQI meetings.

There are appropriate processes for the recruitment, appointment and management of staff at Sunhaven. There is evidence of a safe recruitment process to select and appoint staff members with appropriate skills, knowledge and training to meet the needs of residents. There is a wide range of training available to all staff members, from the induction and orientation of new staff to on-going training and in-service education for all staff members. There are effective procedures for performance appraisals of all staff and managers.

There is a documented process for ensuring the facility is rostered to maintain safe levels to meet residents’ needs. The rosters meet the required levels of staff numbers and ratios of staff members for the numbers of residents.

**Outcome 1.3: Continuum of Service Delivery**

Sunhaven specialises in caring for residents assessed as requiring Stage III dementia care or specialist hospital care (psychogeriatric). An experienced registered nurse (RN) care manager leads the clinical care team. Registered nurses are always on duty and help guide the practice of the caregiving team.

Four family members, two residents and the general practitioner all spoke highly of the services provided at Sunhaven. During the audit visit, residents were observed to be treated with dignity and respect, with staff particularly sensitive to early indicators that a resident’s behaviour might be escalating, and intervening promptly to address these situations.

The care manager has developed a range of new documentation to improve assessment, planning and evaluation of residents’ needs, but the service is still in the early phases of implementing these new systems, and much of the existing documentation is undated and/or incomplete. It is therefore difficult to evaluate whether each stage of service provision is being provided within timeframes to safely meet the needs of residents. Service delivery plans do not describe the current support required by residents and there is little evidence of evaluations being undertaken of resident achievement towards identified goals. All the previous required improvements related to these criteria remain as areas for improvement. When resident progress is different from expected, or new needs are identified, such as a chest infection, or immobility subsequent to a fall, the service does not respond by initiating changes to the service delivery plan, and this is identified as a new area requiring improvement.

Activities staff are not currently involved in the assessment, planning and evaluation of each resident’s activity needs, and activity schedules are not developed. These are identified as areas requiring improvement.

Medication management is generally consistent with legislative, contractual and best practice requirements. Three new areas requiring improvement related to medication management have been identified: the dating of medications when they are first opened, such as eye drops and ointments; the removal and replacement of medications that are past their expiry date; and ensuring that the specimen signatures of all staff administering medications are recorded.

**Outcome 1.4: Safe and Appropriate Environment**

There is a current building warrant of fitness at Sunhaven. The environment is suitable for the residents and promotes safety. There are appropriate arrangements and systems for emergencies and security.

**Outcome 2: Restraint Minimisation and Safe Practice**

The only restraints in use at Sunhaven are the environmental restraints for a secure facility. There are no other restraints in use. There are enablers used to allow residents to be safe and/or mobile with the minimum of restriction and intrusiveness.

**Outcome 3: Infection Prevention and Control**

The infection control policy includes a surveillance template which is to be completed monthly. The template includes details of the types of infections that should be included as part of the surveillance process. The last completed surveillance report sighted is for November 2013. Until that point, data was reported monthly and graphed across the year. A surveillance report is sighted for April 2014 (11 infections) but the analysis of the April data is incomplete. The care manager reports that monthly surveillance reports have been completed for the past four months, but is unable to locate the other reports during the audit visit. Processes associated with collecting, acting on, and reporting surveillance data are identified as areas for improvement.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 11 | 0 | 2 | 4 | 1 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 5 | 1 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 32 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 53 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | 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. | PA Moderate |  |  |  |
| HDS(C)S.2008 | 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. | PA Moderate | There is little evidence of service provision being provided within timeframes that safely meet the needs of residents.  | Provide evidence that all stages of service provision are provided within timeframes that safely meet the needs of residents.  | 90 |
| HDS(C)S.2008 | Standard 1.3.5: Planning  | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Service delivery plans do not describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.  | Provide evidence that service delivery plans describe the required support and/or intervention to achieve the desired resident outcomes.  | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | 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. | PA Moderate | The incomplete nature of resident documentation, including the absence of current documentation in all seven residents’ records reviewed means that is limited evidence of the provision of services being consistent with residents’ needs and desired outcomes. In addition, short term care plans are not being developed for residents in response to identified acute health problems, such as chest infections, or pain/immobility following a fall.  | Provide evidence that the provision of services is consistent with residents’ needs and desired outcomes.  | 90 |
| HDS(C)S.2008 | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | 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. | PA Low | 1. Although a range of activities are organised for residents and residents express their enjoyment of the activities being provided, there is no planned schedule for activities. 2. Diversional therapy staff are not involved in the assessment of residents’ activity needs and the evaluation of the outcomes of their activity plans.  | 1. Provide evidence of a planned schedule for resident activities. 2. Provide evidence that diversional therapy staff are involved in the assessment of residents’ activity needs, and the evaluation of their activity plans.  | 180 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation  | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | 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. | PA Moderate | There is no evidence that evaluations of resident progress towards meeting desired outcomes are undertaken in a timely, systematic and comprehensive manner.  | Provide evidence that evaluation of resident achievement towards meeting desired outcomes is undertaken in a timely and comprehensive manner.  | 90 |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | When resident progress is different from expected, the service does not respond by initiating changes to the service delivery plan.  | Provide evidence that when progress is different from expected, the service responds by initiating changes to the service delivery plan.  | 90 |
| HDS(C)S.2008 | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | 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. | PA Low | 1. The specimen signatures of staff administered medications are incomplete in the administration record.2. Eye drops and eye ointments, currently in use, do not have the date of first use recorded on them.3. There are expired medications in the medication trolley and in the medicines stock trolley.  | Provide evidence that the medicines management system complies with legislation, protocols and safe practice guidelines.  | 180 |
| HDS(IPC)S.2008 | 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. | PA High |  |  |  |
| HDS(IPC)S.2008 | 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. | PA High | There is no evidence that surveillance data is being collected on a monthly basis, analysed, evaluated, acted on and reported to staff and management.  | Provide evidence that surveillance data is being collected on a monthly basis, analysed, evaluated, acted on and reported to staff and management. | 30 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

# NZS 8134.1:2008: 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 **(**HDS(C)S.2008:1.1.9)

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

**Attainment and Risk:** FA

**Evidence:**

Open communication is evident at Sunhaven through the records associated with incident / accident reports and other adverse events. The incident report form includes a section which notes whether family/whanau have been advised of the event. A sampling of incident reports from recent months (June and July 2014) demonstrates that this section is used to record family/whanau notifications.

At interview with staff members (five), the facility manager (FM), and care manager (CM), they report that family/whanau are notified as they have requested to be notified about events.

At interview with family/whanau (four) they confirm receiving information about incidents which have occurred in a timely way and are satisfied with communication.

Interpreter services are used whenever needed. The facility has appropriate procedures for accessing interpreter services within their documented quality management system.

ARC and ARHSS contract requirements are met.

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.1.13: Complaints Management  **(**HDS(C)S.2008:1.1.13)

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

**Attainment and Risk:** FA

**Evidence:**

There is a complaints process within Sunhaven’s documented quality management system. It is included in the induction information and staff members interviewed (four of four specifically asked about complaints) report that they know there is a process in place. They describe the process appropriately when asked and give adequate explanations of how to support a resident of family/whanau member to make a complaint.

There is a complaint register which is maintained by the facility manager (FM). Since the last onsite audit there have been no new formal complaints made. At interview with the FM and owner they describe two instances of families discussing concerns with them and resolving the issues informally.

The training provided over the past 12 months within the facility includes a session on the Code of Rights run by the Nationwide Health and Disability Services advocate on 4 August 2014, which 16 staff members attended.

ARC and ARHSS contract requirements are met.

##### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **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 **(**HDS(C)S.2008:1.2.1)

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

**Attainment and Risk:** FA

**Evidence:**

There is an annual business plan which includes the purpose, values, scope, direction and goals of the organisation. These are reviewed annually with the business plan’s goals and objectives. The business plan is sighted and current to 31 March 2015.

The Sunhaven management team includes the owner, the FM and clinical manager (CM). The FM has worked at the facility for almost nine years and knows the residents and staff well. She is primarily responsible for the financial management of the facility, payroll, staff recruitment, appointment, leave approval and related systems, and the laundry and cleaning staff members.

The CM is an experienced registered nurse (RN) both here and in the United Kingdom. She commenced work at Sunhaven in November 2013. The CM is primarily responsible for all care delivery and the performance of the RNs and caregivers. She has a current annual practising certificate and her scope of practice is appropriate for the provision of services at Sunhaven.

ARC and ARHSS contract requirements are met.

##### **Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.2: Service Management  **(**HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

**Attainment and Risk:** Not Audited

**Evidence:**

##### **Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)**

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

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

**Attainment and Risk:** FA

**Evidence:**

There is a documented quality management system which is consistent with the size and scope of the facility. It is based on continuous quality improvement principles although the system itself is limited in its scope and complexity. Sunhaven current uses its business plan which has quality goals and objectives within the plan’s deliverables as its method of managing quality. The risk management plan which has been developed since the last certification audit in 2012 is monitored through the monthly management team meetings, and like the quality planning system, meets the minimum requirements of this standard.

Document control and management is handled by the FM and CM. While policies and procedures are available to staff in hard copy within the facility, there are electronic ‘master’ versions of all documents maintained. When updated, an obsolete version of a document is archived and the current version only is available electronically. The FM, CM and owner have access to these electronic versions of documents. A range of documents, policies and procedures, forms and letters are sighted during the audit. All are current and include document control and management information.

A range of events are documented, including incidents/accidents, complaints, medication errors and infections. The health and safety coordinator (not on duty during the days of the audit) and the CM collate the data from all types of incidents and accidents, medication errors and complaints and present this data to staff at the six weekly staff meetings and at the three monthly CQI meetings. Individual events and summarised data is also discussed at management team meetings. Meeting minutes for all meetings are maintained by the FM and meetings for all of 2014 are sampled. This includes the six weekly staff meetings; monthly management meetings; and three monthly CQI meetings. All minutes have standard agendas, are consistent and recorded to a level of detail which enables understanding of discussions, decisions and trends over time. Both the FM and the CM are interviewed during the audit and describe the process of collating incident data (excluding infections – see standard 3.5), graphing the data and comparing the frequency of events over each shift, types of event across the month, and frequency of types of event year to date. These graphs are on display in the staff room from the time of the staff meeting where they are discussed along with any associated corrective action plan developed in response to the analysis of events.

The meeting minutes throughout the year record the progress made against the quality objectives from the business plan. The most recent CQI meeting minutes (14 May 2014) record progress against some of the quality objectives, as do the management team meeting minutes through June and July 2014.

Corrective action plans are developed on Sunhaven’s own corrective action plan form and the incident / accident report form includes a section for planning / taking corrective action in response to the event being reported.

The risk register was developed in 2013 in response to an area for improvement identified at certification in 2012. It is in use, although review of the individual risks has not been formally recorded on the plan itself, as it has been designed to be used. The FM states that risks are reviewed during the management and CQI meetings and the minutes record the review. The minutes reflect ‘Risk’ as a standing agenda item and there are discussions at each meeting. The recorded discussions are about resident related risks as much as the business risks identified on the risk management plan, and how these risks and issues are being managed. This is appropriate activity for both the management and CQI meetings. Criterion 1.2.3.9, requires that the risks themselves and the strategies for managing each one be reviewed. This has not yet occurred and needs to be part of the next review of risks and the risk management plan.

ARC and ARHSS contract requirements are met.

##### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.4: Adverse Event Reporting  **(**HDS(C)S.2008:1.2.4)

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

**Attainment and Risk:** FA

**Evidence:**

The infection control and health and safety policies and procedures both include sections on essential notification appropriate to an aged care facility. There is a list of communicable diseases and the facility’s general practitioner (GP) is responsible for reporting these to Public Health. The health and safety procedures also includes a definition of serious harm accidents which require notification to Occupational Safety and Health.

There are procedures for reporting and recording a range of adverse events, including incidents / accidents / complaints / medication errors, and for categorising incidents and accidents.

The health and safety representative and the CM collate the monthly adverse event data and prepare graphs (as described in standard 1.2.3) to illustrate the frequency of each category of incident type. The six weekly staff meeting minutes record the discussions of the graphs and the collated incident data with staff. At interview with four staff members specifically questioned on the topic, they all confirm that this information is discussed regularly at their meetings.

There are links to residents’ incidents / events on their files as is appropriate to inform their care.

ARC and ARHSS contract requirements are met.

##### **Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.7: Human Resource Management  **(**HDS(C)S.2008:1.2.7)

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

**Attainment and Risk:** FA

**Evidence:**

All staff members’ qualifications are validated on appointment to their role. Personnel files for eight staff members reviewed include evidence of their qualifications, including two RNs, one overseas trained and registered nurse who is working as a carer, one overseas trained physiotherapist who is working as a carer, a recreation officer with the ACE dementia qualification and the level 3 core competencies certificate. All staff members have evidence of the qualifications on their personnel file. The RNs have their annual practising certificate (APC) on their file. For newly employed RNs the FM or CM validate APCs during the appointment process.

The recruitment process follows current good practice in human resources management and includes obtaining verbal references, police checks and verifying qualifications (as above), following a formal interview. There is a defined induction and orientation process which includes shadowing another staff member for two morning and two afternoon shifts and taking the new employee through the organisation’s processes on administration, communication, restraint, health and safety, infection control, quality improvement, (and where appropriate) nursing procedures and equipment.

The current ongoing training plan includes all staff members completing Care Training’s on line programme of 29 modules covering all aspects of service delivery, care and support appropriate for a health and disability service and one module which provides aged care services. Complimenting this is a programme of in-service training topics which includes external speakers, like the representatives from the companies which provide incontinence products and cleaning and laundry chemicals on their correct use; the CM delivery refreshers on the restraint policy and procedure; and the local Nationwide Health and Disability Advocate covering the Code and open disclosure. At interview with five staff members they report that both the orientation and ongoing training is sufficient to enable them to do their jobs safely and well. The FM has completed all of the 29 modules already and is going through the process of becoming an ACE workplace assessor. Sunhaven uses the ACE training qualifications for caregivers and having and in-house assessor makes it easier to have staff members work assessed in a timely way. (The FM has completed the papers and has done the assessments required which are now being moderated as part of her competency assessment in becoming an assessor.)

ARC and ARHSS contract requirements are met.

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.8: Service Provider Availability  **(**HDS(C)S.2008:1.2.8)

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

**Attainment and Risk:** FA

**Evidence:**

There is a documented process for determining the number of staff members to be rostered on any shift and the type of staff (RNs / caregivers) on each shift. Rosters are prepared by the CM and FM and on the day of audit there are rosters for the month of August.

At interview with the CM, FM and owner, and a group of five staff members (one cleaner, one RN, one cook and two caregivers) they report that while they are busier now that occupancy has increased, there are sufficient numbers of staff on each shift to be able to do their jobs safely.

There is one RN on every shift, every day of the week. The CM works Monday to Friday, 8am – 5pm and is on call outside these times. The FM works Monday to Friday 8am to 5pm and is on call outside these times.

There are four carers on each morning from 7am until 3pm. There is an additional carer on in the dining room from 7.30am until 1pm.

There are two carers on each afternoon from 3pm until 9.30pm and two from 3pm until 11pm. There are two additional carers over the afternoons – from between 5 and 9pm and in the lounge from 3 – 8.30pm.

There is one carer on the night shift plus one household assistant (who is a carer too).

There is a cleaner on duty 9am – 2pm Monday to Sunday. There is a cook 8.30am – 1pm and 2.45 pm – 6pm daily.

There is a recreation officer who works 7.30am – 11.30am and 1pm – 6.30pm Monday to Friday. Two staff members share this role. (Both are about to undertake their Diversional Therapy qualification. They each have relevant other qualifications. One is a care giver with the ACE training qualifications in care of the older person and dementia. The other person is an overseas trained physiotherapist who has just completed their Core competencies Level 3 qualification. )

ARC and ARHSS contract requirements are met.

##### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **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 **(**HDS(C)S.2008:1.3.3)

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Sunhaven provides residential care for residents assessed as requiring either Stage III Dementia (Stage III) or Aged Residential Hospital Specialised Services (Psychogeriatric) care. The clinical services component of their care is overseen by the Care Manager (CM), an experienced RN who works weekdays and is then on call at all other times. There are RNs on duty twenty-four hours a day, seven days a week, leading an experienced team of caregivers. The service is co-ordinated by the CM; there is both a verbal handover for all staff at the start of each shift and a written handover sheet, resident progress notes are updated each shift.

RNs undertake all resident assessments with a RN allocated as resident coordinator for each resident. On interview, the GP expresses her satisfaction with the care provided at Sunhaven, that she is notified promptly of any change in a resident’s condition, and that prescribed treatments are implemented.

The CM reports that in the last few months her focus has been on developing and implementing systems and processes to ensure that residents receive timely, competent and appropriate services and multiple examples of this are sighted. New developments include an initial assessment and care plan; a long term care plan, a map of life for each resident (social history, family relationships); check lists related to admission processes; standardised short term care plans for common resident issues, such as chest infections, urinary infections, weight loss); a data base to manage residents’ three-monthly GP reviews; establishing processes for involving families in resident reviews and care planning; wound register and wound assessment/management forms, and ensuring that resident documentation is complete (such as copies of EPOA on file, and resuscitation status for each resident). All the residents’ families were written to by the CM in July 2014, advising them about any documentation that was missing from the resident’s file (such as EPOA or resuscitation forms); asking them how they wanted to be kept informed about their family member, and asking if they wish to attend in person any meetings discussing the resident’s progress. The CM advises that she has had responses from approximately two-thirds of the families, and will be shortly again contacting those who have yet to respond. At the time of this surveillance visit, the residents’ records are in a transitional state – with new care plans being implemented. The CM reports that 25 of the 36 resident plans have been changed over, and are mostly complete, with 11 more residents’ records still in process. The CM anticipates that all residents’ records will have been transitioned to the new format, and the service records brought up to date by the end of September 2014. A review of seven resident records (4 psychogeriatric, 3 Stage III) reveals that despite the work undertaken by the CM, there is still considerable development required before service provision is provided within required timeframes.

The previous long term care plans sighted are undated and unsigned, meaning that it is not possible to evaluate whether they were developed within the required timeframes. Records for three recently-admitted residents (admitted March, May and July 2014 respectively) were reviewed, and while each had an initial assessment/care plan developed (though not necessarily signed and/or dated) none had a complete long term care plan in place, with clinical assessments such as falls and pressure area risk largely incomplete. None of these three residents had strategies identified for managing any challenging behaviours. In one instance, the resident is returned to hospital five days after admission because of a range of behaviours, such as repeated escapes from the facility. The documentation related to this resident’s stay at Sunhaven is minimal, although it is obvious in talking with the CM that considerable energy was expended in attempting to care for him and keep him safe.

The CM reports there have been some difficulties in organising three-monthly GP reviews because of GP unavailability and several residents were now overdue for their reviews. A schedule for the outstanding reviews is sighted and all the reviews will be current by the end of August. The previous corrective action requirements related to service provision remain as areas for improvement.

Eleven residents are on interRAI, with two staff having completed the interRAI training.

Tracer One

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

Tracer Two (Stage III care).

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

##### **Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

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.

**Attainment and Risk:** PA Moderate

**Evidence:**

Seven resident records were reviewed. In each instance either the documentation was unsigned and undated, or the documentation was signed/dated but incomplete. There was no evidence of service plans being provided within timeframes that safely meet the needs of residents, or care plans being evaluated on a regular and timely basis. There was also no evidence of care plans being updated, or short term care plans being developed, when residents’ needs change.

**Finding:**

There is little evidence of service provision being provided within timeframes that safely meet the needs of residents.

**Corrective Action:**

Provide evidence that all stages of service provision are provided within timeframes that safely meet the needs of residents.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.5: Planning  **(**HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

**Attainment and Risk:** PA Moderate

**Evidence:**

The previous corrective action related to service delivery plans describing the required support and/or intervention to achieve the desired outcomes remains an area for improvement.

There is little evidence of resident service delivery plans being updated or reviewed to reflect clinical changes, such as chest infections, or weight loss, or evidence of planning to address identified concerns, such as challenging behaviours. Refer to T2, and the summary in standard 1.3.3 for further examples. All seven service plans reviewed were either incomplete and/or there was no evidence as to when they were developed and/or updated. One resident who has very fragile skin, has nine wound care plans related to her multiple lacerations, skin tears and ulcers. Formal evaluation of and planning for the wound healing is either erratic, incomplete or undated.

There is evidence of involvement of a range of other health professionals, such as clinical dietician and psychogeriatricians, in resident care and their reports are integrated into the resident record. As the care plans are not well developed and/or current, there is limited evidence of how their recommendations are incorporated into service delivery.

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Residents’ service delivery plans are not updated or reviewed to reflect clinical changes, such as chest infections or weight loss. The planning related to wound management is erratic, incomplete and/or undated.

**Finding:**

Service delivery plans do not describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

**Corrective Action:**

Provide evidence that service delivery plans describe the required support and/or intervention to achieve the desired resident outcomes.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)**

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.6: Service Delivery/Interventions  **(**HDS(C)S.2008:1.3.6)

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The previous corrective action relating to interventions being consistent with meeting residents’ assessed needs and desired outcomes remains an area for improvement.

Although two residents and four family members interviewed express their satisfaction with the care being provided, the incomplete nature of current resident documentation, or its absence, means there is limited evidence that the provision of services is consistent with residents’ needs and desired outcomes. Refer also to T1 and T2, standard 1.3.3.

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The four family members and two residents interviewed all expressed their satisfaction with the services provided to the residents, with one resident describing the staff as “awesome”. During the audit visit, staff were observed treating the residents with dignity and respect, responding promptly to resident requests and intervening quickly to minimise the potential for challenging behaviours to impact on other residents. Nevertheless the incomplete nature or absence of, current resident documentation evident in all seven residents’ files reviewed means there is limited evidence that the provision of services is consistent with residents’ needs and desired outcomes. As described in T2 (Standard 1.3.3) short term care plans are not being developed for residents in response to identified acute health problems, such as chest infections, or pain/immobility following a fall.

**Finding:**

The incomplete nature of resident documentation, including the absence of current documentation in all seven residents’ records reviewed means that is limited evidence of the provision of services being consistent with residents’ needs and desired outcomes. In addition, short term care plans are not being developed for residents in response to identified acute health problems, such as chest infections, or pain/immobility following a fall.

**Corrective Action:**

Provide evidence that the provision of services is consistent with residents’ needs and desired outcomes.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.7: Planned Activities **(**HDS(C)S.2008:1.3.7)

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

**Attainment and Risk:** PA Low

**Evidence:**

The previous corrective action requirement related to activities being planned to develop and maintain strengths that are meaningful to the resident has been largely addressed. Two new areas are identified for improvement: the development of a planned schedule of activities; and the involvement of diversional therapy staff in the development and evaluation of resident activity plans.

Since the last surveillance audit, two qualified and experienced caregivers (one of whom is an overseas trained physiotherapist) now share responsibility for the activities programme, with 27.5 hours of activities offered each week. Both staff are enrolling in the diversional therapy course and are also booked in for Selwyn Foundation training in September. Diversional therapy activities are offered Monday-Friday and include outings, entertainers, games, puzzles, celebrating events such as Maori Language Week, and Daffodil day. Communion services are also held. Activity staff also work on an individual basis with residents who do not wish to participate in organised activities. Two family members on interview express their satisfaction with the range of activities offered to residents.

Records are maintained of residents’ participation in activities. RNs are responsible for assessing residents’ activity needs, developing and evaluating their individual plans. There is currently no involvement of the activities staff in these assessments, plans and evaluations, and this is identified as an area for improvement.

A large poster has been developed that promotes the range of activities that may be offered at Sunhaven, but there is no formal schedule for planned activities and this is identified as an area for improvement. The CM explains that activity schedules have been developed in the past (plans for 2013 sighted) but it was felt that greater flexibility with the programme was required – with activities organised in response to resident needs and behaviours on the day.

##### **Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

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

**Attainment and Risk:** PA Low

**Evidence:**

Although there is evidence of a range of activities being offered to residents, there is no evidence sighted of a planned schedule of activities.

RNs are responsible for assessing residents’ activity needs, developing an activities plan and evaluating that plan, with no formal input from diversional therapy staff.

**Finding:**

1. Although a range of activities are organised for residents and residents express their enjoyment of the activities being provided, there is no planned schedule for activities.

2. Diversional therapy staff are not involved in the assessment of residents’ activity needs and the evaluation of the outcomes of their activity plans.

**Corrective Action:**

1. Provide evidence of a planned schedule for resident activities. 2. Provide evidence that diversional therapy staff are involved in the assessment of residents’ activity needs, and the evaluation of their activity plans.

**Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.8: Evaluation  **(**HDS(C)S.2008:1.3.8)

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The previous corrective action request related to the documentation of evaluations and indicating the degree of achievement towards the desired goal remains an area for improvement. Updating residents’ plans when their needs change is also identified as an area for improvement.

The CM advises that all residents have now been allocated one RN as their Resident Coordinator (RC). The RC will be responsible for the development and ongoing evaluation and updating of that resident’s plan. The CM has also recently developed a range of standardised care plans for common conditions that residents may experience (such as eye or chest infections), but acknowledges these are not being well utilised by the RNs. No short term plans were developed for a resident (Standard 1.3.3) following her discharge from hospital earlier in the week of the audit. As described Standard 1.3.5 when wound care plans are developed there is little evidence that these are evaluated and updated on a systematic basis.

As discussed in Standard 1.3.3 and 1.3.5, the absence of formal care plans, and/or the absence of dates on the plans that do exist mean that there is little evidence of evaluation of progress towards achieving desired outcomes.

##### **Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

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.

**Attainment and Risk:** PA Moderate

**Evidence:**

There is no evidence in any of the seven resident care plans reviewed that formal evaluations of residents’ progress towards meeting desired outcomes are being undertaken in a timely or comprehensive manner.

**Finding:**

There is no evidence that evaluations of resident progress towards meeting desired outcomes are undertaken in a timely, systematic and comprehensive manner.

**Corrective Action:**

Provide evidence that evaluation of resident achievement towards meeting desired outcomes is undertaken in a timely and comprehensive manner.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Following a fall, a resident experiences pain and reduced mobility, and is also diagnosed with a chest infection. The resident’s care plan is not updated to reflect these changes. The same resident requires close monitoring of her nutritional status and there is no evidence of her care plan being updated to reflected progress towards maintaining her nutrition

**Finding:**

When resident progress is different from expected, the service does not respond by initiating changes to the service delivery plan.

**Corrective Action:**

Provide evidence that when progress is different from expected, the service responds by initiating changes to the service delivery plan.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.12: Medicine Management  **(**HDS(C)S.2008:1.3.12)

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

**Attainment and Risk:** PA Low

**Evidence:**

The previous corrective action request related to medication requests having written authorisation from the resident’s GP has been addressed. One resident is currently prescribed Warfarin and all required processes associated with this medication are in place.

Medicine management generally complies with current legislative requirements and safe practice guidelines. All ten medication charts reviewed demonstrate that residents’ allergy status is recorded; medications are appropriately prescribed, and signed and dated when discontinued; there are indications for the use of all as-required medications; and evidence of three monthly reviews of medications.

All medications are administered by a RN, all of whom completed medication competency assessments in 2013, and are scheduled to complete these again by the end of August. The CM undertakes a monthly audit of medication administration (records sighted).

Evidence is sighted of daily checks of the medication fridge temperature, which is maintained within an appropriate temperature range. Weekly checks are undertaken of controlled drugs, and the CM is responsible for medicine reconciliation when medications are received from the Pharmacy. The service uses the Packette medication system. A medication round is observed and this complies with best practice guidelines. There are no residents who are self-medicating and the facility does not use standing orders

Several areas for improvement are identified. While medication administration is being well documented, there are gaps in the specimen signatures of staff administering medications on all ten medication charts reviewed. Medications such as eye drops and eye ointments are not being dated when first used and several medications in the medicine trolley and in the medicine cupboard are past their expiry date.

##### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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.

**Attainment and Risk:** PA Low

**Evidence:**

Gaps are identified in all ten medication records reviewed of the specimen signatures of staff administering medications.

Eye drops and eye ointments in the medication trolley, currently in use, do not have the date of first use recorded on them.

There are several medications (ointments) in the medication trolley and medications in the medicines stock cupboard that are past their expiry date.

**Finding:**

1. The specimen signatures of staff administered medications are incomplete in the administration record.

2. Eye drops and eye ointments, currently in use, do not have the date of first use recorded on them.

3. There are expired medications in the medication trolley and in the medicines stock trolley.

**Corrective Action:**

Provide evidence that the medicines management system complies with legislation, protocols and safe practice guidelines.

**Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

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

**Attainment and Risk:** FA

**Evidence:**

Sunhaven’s menus are prepared by a dietitian from the Taranaki District Health Board (TDHB). The current menus in use were prepared in November 2013. The cook (interviewed during the audit) makes substitutions when required to reflect seasonal availability of individual items while remaining within the same food group. Those residents with specific dietary requirements have these recorded on entry by the CM or RN conducting the entry assessment. This is sighted for resident who is entering the facility on day two of the audit. In the kitchen with the weekly menus are notes of residents with specific dietary requirements or preferences, so that these can be provided at each meal. There are modified utensils, plates, bowls and cups available for those who require them.

The cook prepares a weekly menu from a standard shopping list. Food is purchased on set days in the week on Mondays, Wednesday and Fridays, whether it is vegetables, meat, eggs, milk or bread. Dry food supplies are stored in a well organised pantry. The chiller is similarly well organised. There is a large freezer which holds sufficient meat and bread for more than a week at a time. All food is clearly dated.

Fridge, chiller and freezer temperatures are monitored daily and recordings are maintained by the cook. The kitchen is very clean and well organised. Access to the kitchen is limited and staff entering when food is being prepared or served must wear appropriate protective clothing. There are adequate hand washing facilities in the kitchen and staff attend infection control training. The cook has a culinary arts certificate and food safety and hygiene certificate.

ARC and ARHSS contract requirements are met.

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **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.

#### Standard 1.4.2: Facility Specifications  **(**HDS(C)S.2008:1.4.2)

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

**Attainment and Risk:** FA

**Evidence:**

There is a current building warrant of fitness for Sunhaven. It expires on 22 August 2014. Chubb is the external contractor which manages the BWOF and fire and alarm safety systems for the facility.

The environment has been purpose built as an aged care facility. There are hand rails throughout and floors have linoleum which is in good condition and promotes mobility. Most of the currently 34 residents are mobile and are observed to more around the facility and grounds independently. Some use mobility equipment either independently or with assistance.

External areas are concrete paths with lawns. These are level and the property is fenced so that residents can safely access these areas independently.

The owner is required to split the facility so that there are separate dementia and psychogeriatric areas. There is no further progress to that reported in the first surveillance audit completed in January 2014. The owner reports during this second surveillance audit that he is deciding on which of the quotes, which have been received, to accept. In the meantime redecorating of rooms is occurring with repainting, replacement lighting and built-in lockable wardrobes being installed in rooms (if they do not already have them).

ARC and ARHSS requirements are met.

##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)**

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.4.7: Essential, Emergency, And Security Systems  **(**HDS(C)S.2008:1.4.7)

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

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

**Attainment and Risk:** FA

**Evidence:**

Fire evacuation training is included in the orientation programme for all new employees. Ongoing fire evacuation practices occur regularly. Emergency response training is covered in in-service training and information given to staff at the six weekly staff meetings. There is an emergency flipchart for the facility which is seen in several locations throughout the building.

There is an evacuation scheme which was approved originally in 1995 has been reviewed by the fire department and endorsed on ……. 2013. There is a 2500 litre emergency water storage tank on the property which provides the water supply should main supplies fail. A barbeque is available in the shed with two gas bottles for emergency cooking in the event that the kitchen’s gas oven is inoperable for any reason.

There is an emergency call bell system throughout the facility. This is occasionally used by residents but most often this is used by staff members to request assistance from colleagues. At interview with the CM she reports that when residents require assistance from a staff member they are more likely to call out themselves, and are responded to in a time which is described in their care plan.

As a dementia and psychogeriatric facility the units is secure for residents. During the day the main entrance is opened outside by door release button and inside by a keypad and code. Overnight the main entrance outside can only be opened from the inside. Otherwise, there are exits from residents’ bedrooms into either central courtyard, or into the fenced in external areas.

ARC and ARHSS contract requirements are met.

##### **Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

#### Standard 2.1.1: Restraint minimisation **(**HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is an emphasis on minimising the use of restraints at Sunhaven. Other than the environmental restraint of the facility being secure due to the residents’ needs, there are no other restraints in use. All equipment, devices and placement supports occurs to promote residents’ safety, wellbeing or mobility and are categorised as enablers.

For residents who use walking frames, gutter frames, walking sticks, staff members interviewed report that they may or may not use them on any day. Staff are observed to prompt residents to use their mobility aids when they are walking and appear to be unstable and will assist them to locate and use their equipment.

Some residents have placement supports while in bed to promote wellbeing such as pillows and ‘noodles’. The documentation for two residents who are immobile and both have a diagnosis of dementia are reviewed with the CM. There are assessments for the need of these supports and descriptions of how they are to be used and how staff will monitor them. The documentation for a resident who uses mobility is reviewed and this also records the assessment of need and description of the equipment to be used.

The documentation used to record this information has recently changed and the CM and restraint coordinator\*\* have not yet obtained written consent on these updated documents. However this is in process and consent has previously been maintained.

(\*\* The restraint coordinator was not on duty on the days of the audit and could not be interviewed.)

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

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

**Attainment and Risk:** PA High

**Evidence:**

The CM and the RN who holds the infection control portfolio are interviewed and the infection control records reviewed.

In January 2014 the facility experienced a gastrointestinal outbreak involving 16 residents and 5 staff. Evidence is sighted of an incident log being maintained during this outbreak, and communication with the Health Protection Team at the Taranaki DHB. A letter from the Health Protection Team states that “you and your staff did a great job in containing the illness”.

The Infection Control policy includes a surveillance template which is to be completed monthly. Urinary tract, chest, ear, eye, gastrointestinal, mouth, nose, skin, viral, vaginal and wound infections are to be recorded on this template.

The last completed surveillance report sighted is for November 2013. Until that point, data was reported monthly, and graphed across the year. A surveillance report is sighted for April 2014 (11 infections) but the analysis of the April data is incomplete. The CM reports that monthly surveillance reports have been completed for the past four months but is unable to locate the other reports during the audit visit. Processes associated with collecting, acting on, and reporting surveillance data are identified as an area for improvement.

The CM confirms on interview that surveillance results have not been formally shared with staff and management.

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

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.

**Attainment and Risk:** PA High

**Evidence:**

No evidence is sighted that surveillance data is being collected on a monthly basis, analysed and evaluated, and reported to staff and management. Only one surveillance report for 2014 is sighted (April) and the analysis of this data is incomplete. Although the CM reports that surveillance has been completed for the past four months copies of these reports were unable to be located during the audit visit.

**Finding:**

There is no evidence that surveillance data is being collected on a monthly basis, analysed, evaluated, acted on and reported to staff and management.

**Corrective Action:**

Provide evidence that surveillance data is being collected on a monthly basis, analysed, evaluated, acted on and reported to staff and management.

**Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*