**Beattie Community Trust Incorporated**

**Current Status:** **15-Jul-13**

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

**General overview**

Beattie Home provides residential care for up to 29 residents who require rest home care. Occupancy on the day of the audit was at 29. The facility is operated by Beattie Community Trust Ltd. This unannounced surveillance audit has been undertaken to verify on-going compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. The 11 areas identified as requiring improvement during the last audit have been effectively addressed. No improvements are required from this audit. The additional bed introduced since the last audit is appropriately and sufficiently resourced and managed. The service provider continues to demonstrate a strong commitment to continuous improvement through implementation of robust quality and risk management systems. Resident documentation is managed well and indicates services are provided in a timely manner.

**Audit Summary AS AT** **15-Jul-13**

Standards have been assessed and summarised below:

**Key**

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

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| **Consumer Rights** | Day of Audit  15-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit  15-Jul-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  15-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Standards applicable to this service fully attained** |

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| **Safe and Appropriate Environment** | Day of Audit  15-Jul-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  15-Jul-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  15-Jul-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

Beattie Home

Beattie Community Trust Ltd

Surveillance audit - Audit Report

Audit Date: 15-Jul-13

**Audit Report**

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Beattie Community Trust Ltd |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Beattie Home | 172 Maniapoto St |  | Otorohanga |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 15-Jul-13 **End Date:** 15-Jul-13 |
| **Designated Auditing Agency** | Health Audit (NZ) Limited |

**Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXX | RGON, BA, Reg. Lead Auditor RABQSA | 7.00 | 4.00 | 15-July-13 to 15-July-13 |
| Auditor 1 | XXXXXX | RN, B.Nursing, RABQSA  RN, B.Nursing, RABQSA | 7.00 | 4.00 | 15-July-13 to 15-July-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXX | Lead Auditor |  | 0.75 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 14.00 | **Total Audit Hours off site** *(system generated)* | 8.75 | **Total Audit Hours** | 22.75 |
| **Staff Records Reviewed** | 5 of 34 | **Client Records Reviewed** *(numeric)* | 4 of 29 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 4 |
| **Staff Interviewed** | 7 of 34 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 1 |
| **Consumers Interviewed** | 4 of 29 | **Number of Medication Records Reviewed** | 8 of 29 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

**Declaration**

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

I confirm that Health Audit (NZ) Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 23 day of July 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Beattie Home | 29 | 29 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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**Executive Summary of Audit**

*General Overview*

Beattie Home provides residential care for up to 29 residents who require rest home care. Occupancy on the day of the audit was at 29. The facility is operated by Beattie Community Trust Ltd. This unannounced surveillance audit has been undertaken to verify on-going compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. The 11 areas identified as requiring improvement during the last audit have been effectively addressed. No improvements are required from this audit. The additional bed introduced since the last audit is appropriately and sufficiently resourced and managed. The service provider continues to demonstrate a strong commitment to continuous improvement through implementation of robust quality and risk management systems. Resident documentation is managed well and indicates services are provided in a timely manner.

*1.1 Consumer Rights*

Open Disclosure procedures are in place to ensure service providers maintain open, transparent communication with residents and their family. Communications with family are documented in residents progress notes. Interpreter services are arranged with family members, staff or Health Board services as needed. Resident interviews confirm very good communication between management, care staff, families, and residents.

The service maintains appropriate systems to manage complaints and a complaints register is maintained. There have been no complaints investigated by the Health and Disability Commissioner since the last audit. There have been no investigations by Ministry of Health, Police, ACC or Coroner since the previous audit at this facility. Relevant aged care contract requirements are met

*1.2 Organisational Management*

The facility mission, values and goals are displayed in the entrance and included in resident information booklet and staff orientation programme. The service is managed by a registered nurse with aged care management experience with an experienced registered nurse managing clinical care.

The quality and risk management system continues to be used to generate improvements in service delivery. Review systems are implemented to ensure that documented guidelines and practices meet accepted good practice and comply with relevant standards.

Active risk management and health and safety processes have been maintained and quality improvement data is analysed and reviewed monthly. Adverse events are recorded, investigated, resident and family informed and causes remedied promptly.

Staffing is adequate to meet the needs of residents over the 24 hours. An experienced registered nurse or enrolled nurse is on duty or on call 24 hours a day with advanced clinical advice and assistance available at all times. All new staff since last audit have received an appropriate orientation and the in-service education programme has been maintained with evidence of good staff attendance. Practical competency in key processes is verified annually. Relevant aged care contract requirements are met.

*1.3 Continuum of Service Delivery*

The residents and family interviewed report satisfaction with the quality of care provided at the service. The service provides appropriate service provision for residents at rest home level of care. Each stage of service provision is undertaken by suitably qualified and experienced nursing and care staff. The assessment, planning, provision and review of care is provided in time frames that meet the residents' needs and complies with contractual requirements. The assessment, care planning, review and evaluation processes are implemented at the service. Where there are temporary changes in a resident's condition the service uses an acute care plan to document the resident's changed needs, this is an improvement since the last audit. The other areas of improvement that were identified at the last audit related to ensuring care plans include goals for all identified needs and ensuring evaluations indicate the degree of achievement to the interventions. These are now addressed and improvements implemented since the last audit.

The activities programme supports the interests, needs and strengths of the residents. The residents and families interviewed express satisfaction with the activities provided.

A safe and timely medicine management system is observed at the time of audit. The registered nurses and senior caregivers are responsible for medicine management and evidence competency to perform the role. All staff who manage medicines are assessed as competent to do so, this is an area for improvement implemented since the previous audit. The other required areas for improvement in ensuring the recording of stock takes and pharmacy checks for the controlled drugs is now addressed and an improvement since the last audit.

Residents express satisfaction with the food and fluid offered at the service. The menus are appropriate to the resident group and have been reviewed by a dietitian.

Relevant aged care contract requirements are met.

*1.4 Safe and Appropriate Environment*

Beattie Home has a current Building Warrant of Fitness. There have been no changes to the building since last audit. There is evidence that all staff have attended a trial evacuation in the last 12 months.

The four improvements required after the last audit relating to records of electrical safety tests, maintaining safe hot water temperatures in resident areas, secure storage for cleaning chemicals, and training for cleaners in safe handling of chemicals, have all been effectively addressed.

*2 Restraint Minimisation and Safe Practice*

The service has no residents assessed as requiring restraint or enabler use. Policies identify that enablers are voluntary and the least restrictive option for promoting or marinating the residents independence and safety. Relevant aged care contract requirements are met.

*3. Infection Prevention and Control*

The results of surveillance of infections are analysed and reported to staff and management. Where trends are identified, the service implements actions to reduce the rates of infections. The previous areas identified for improvement related to ensuring the annual review of the infection control programme is conducted and that the infection control programme is approved by the manager are now addressed. This is an implemented improvement since the last audit. Relevant aged care contract requirements are met.

**Summary of Attainment**

* 1. ***Consumer Rights***

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

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

* 1. ***Organisational Management***

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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: 0  Criteria (of 34): CI:0 FA:17 PA:0 UA:0 NA: 0 |

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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 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 | FA | 0 | 4 | 0 | 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: 7 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:15 PA:0 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 | FA | 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 | FA | 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 | FA | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 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:4 CI:0 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:3 PA:0 UA:0 NA: 0 |

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

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

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

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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 1 | 0 | 0 | 2 | 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: 3 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:3 PA:0 UA:0 NA: 2 |

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| **Total Standards (of 50) N/A:** 29 **CI:** 0 **FA:** 21 **PA Neg:** 0 **PA Low:** 0 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 43 **PA:** 0 **UA:** 0 **N/A:** 2 |

**Corrective Action Requests (CAR) Report**

Provider Name: Beattie Community Trust Ltd

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:15-Jul-13 End Date: 15-Jul-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXX

**Continuous Improvement (CI) Report**

Provider Name: Beattie Community Trust Ltd

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:15-Jul-13 End Date: 15-Jul-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXX

**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

Open Disclosure procedures are in place to ensure service providers maintain open, transparent communication with residents and their family. Communications with family are documented in resident’s progress notes. Interpreter services are arranged with family members, staff or District Health Board services as needed. Resident interviews confirm very good communication between management, care staff, families, and residents. All aged care contract requirements are met.

**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 maintains appropriate systems to manage complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner, the District Health Board, Police, ACC or Coroner since the previous audit at this facility. All aged care contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

The facility mission, values and goals are reviewed annually and displayed in the entrance, the resident information booklet and staff orientation programme. Review and coordination occurs through monthly quality and team management meetings.

The current manager is a registered nurse with a current practising certificate and more than 20 years in health service delivery including aged care. She has been in the position for two and a half years and maintains relevant on-going education. There is evidence that the manager has maintained relevant on-going education and training of more than twenty hours annually.

Relevant aged care contract requirements are met.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

There is a robust quality and risk management system that is used to generate improvements in service delivery. Quality outcomes for key components of service delivery, including quality and risk management have been reviewed within the last 12 months to ensure they are relevant and updated where necessary. There is a documented quality plan with goals and objectives identified for 2013. There is a document control system in place to ensure that staff use approved, up to date guidelines and protocols.

Review systems are implemented to ensure that documented guidelines and practices meet accepted good practice and comply with relevant standards. The manager meets regularly with staff groups for review and feedback; weekly with the clinical leader and administration staff; monthly with the quality, health and safety and infection control committee. There is evidence in meeting records and from staff interviews that issues are discussed and that appropriate actions are taken to remedy deficits and to implement quality improvements where practicable. There is evidence that feedback from family and resident and from satisfaction surveys is also used to improve services.

Active risk management and health and safety processes have been maintained. Quality improvement data relating to incidents, infections, hazards and complaints is analysed monthly to identify trends and themes. The facility benchmarks with other providers in the local group.

The internal audit monitoring system is comprehensive and has been maintained as scheduled. Six audit records reviewed indicate that the audit schedule is implemented as planned and actions are taken and verified to remedy deficits or make improvements..

There are implemented risk management and health and safety policies and procedures in place including incident, accident and hazard management. The clinical leader is involved with resident care daily and monitors clinical risks, reporting to the manager daily.

Hazard report forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate. Staff receive health and safety training at least two yearly. Falls prevention strategies are in place that include falls risk assessment on admission and re-assessment as required, review of clinical needs and medications, use of mobility aids assessed and annual review by the physiotherapist and as required. All relevant aged care contract requirements are met

**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

Individual incident and accident reports are completed for each incident/accident with immediate action noted and any follow up action required. Communication with family is recorded. The clinical leader and the facility manager sign off each incident form with recommendations for improvement if required. Incidents, accidents, unplanned or untoward events are collated monthly and feedback provided to the staff. Minutes of the monthly quality and staff meetings and provide evidence of discussion of incidents/accidents and actions taken. There is evidence that deficits are remedied and improvements are made.

The essential notifications required in relation to the service provided are defined. Interview with the manager confirms that she understands her responsibilities relating to notifications.

All relevant aged care contract requirements are met

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

There are written policies and procedures in relation to human resource management that have been reviewed within the last two years and comply with current good employment practice. There is evidence in staff files that applicants are interviewed and provide evidence of residency, qualifications and experience. Records include reference checks. Individual signed employment contracts are current for all staff.

The skills and knowledge required for each position within the facility are documented in job descriptions and task lists which outline accountability, responsibilities and authority. Job descriptions are included in each employee file (four of four reviewed). Review of the files of current incumbents indicates that appointments are appropriately made in accord with the skills and experience required in the job descriptions. Records sighted verify that there is a system in place to verify that practising certificates or licences as applicable are maintained up to date for all health personnel , including external contractors, who require them.

All new staff receive an orientation to the facility and to their respective job. Both knowledge and competence is reviewed and signed off by the care manager or the clinical manager. Five of five staff interviewed confirm that they have completed an orientation that is relevant to their job and receive supportive supervision. There is a planned programme of on-going education. The annual training programme well exceeds eight hours annually. Four of four staff interviewed confirm that they are encouraged and assisted to attend relevant external seminars as available.

Individual records are maintained for each staff member. Annual performance appraisals are conducted with every staff member; records indicate that all are up to date. Interviews with residents and family members indicate that they find the staff are knowledgeable and skilled.

All relevant aged care contract requirements are met

**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

There is a documented rationale for determining service provider levels and skill mixes that is adequate for the layout of the facility, and the level of care provided. Review of rosters for the last six weeks indicates that there is sufficient staff provide resident care. There are sufficient care givers on duty to meet all resident’s care needs. Staff interviewed who have worked in the evening and at night say that staffing levels are adequate, on call managers are readily available and assistance is provided as needed. Absence is replaced by part time staff working extra shifts. Interviews with four residents, one relative, and seven four care staff indicate that staffing numbers and skill mix are adequate for the layout of the facility, the services provided and the dependency of the residents.

All relevant aged care contract requirements are met

**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

Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitably qualified staff who are competent to perform their role. The four of four residents' files reviewed confirm that the nurse conducts the initial assessment and initial care plan on admission to the service and develops the long term care plan within three weeks. Caregivers provide most of the direct care under the direction of the care plan and RN. The care staff are suitably experienced and encouraged to complete the Aged Care Education (ACE) qualifications if they do not have a national qualification. Annual practicing certificates are sighted for all staff that require them.

The initial and ongoing assessments include bowel, mobility, sleeping, personal cleansing and dressing, skin, pain, falls risk, mental function, behaviour, communication, social, leisure, activities and interests, spirituality and culture, sexuality and medication reconciliation. The additional assessment tools include falls risk, pain chart, dietary profile and continence assessment. The four of four residents' files evidence that the long term care plan is based on the assessed needs of the resident. There is a standardised template for the long term care plan and an individualised care plan that includes the need, goals, intervention and evaluation. The ongoing care plan evaluation is conducted at least six monthly and used to form part of the multidisciplinary review, confirmed in the three of four residents' files reviewed. The remaining file is of a resident with an admission under six months and is not yet due for the full care evaluation, though evaluation is recorded in this file for changed needs.

The four of four residents' files evidence the initial medical review is conducted within two days of admission (where required). Ongoing medical reviews are conducted monthly or at least three monthly when the resident is assessed as stable (more frequently when required for the residents changing needs). The exception for the three monthly medical review is recorded in the residents’ progress notes (confirmed in the four of four residents' files reviewed).

The service is co-ordinated in a manner that promotes continuity of care. Progress notes are updated each shift (confirmed in the four of four residents' files reviewed). A handover is provided at the start of each shift, the two RNs and one caregiver interviewed report that adequate information is provided at handover, in resident progress notes and on the communication sheet.

The four residents and one family member interviewed report the residents receive care that meets their needs.

Tracer example:

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

Relevant aged care contract requirements are met.

**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:** FA

There is a previous CAR at 1.3.4.2 to ensure the care plan includes goals for all identified needs. This is now addressed and an area of improvement since the last audit.

The service is in the process of InterRAI training and has yet to fully implement the InterRAI assessment. The RN reports the service will continue to use their format for care planning and use InterRAI as the assessment component to identify resident’s needs. The four of four residents' files reviewed have the needs identified via the assessment process documented and serve as a basis for care planning. The resident reviewed has skin, wound and dietary assessments that are used as a basis for interventions on the care plan. Other files reviewed have falls assessment, communications assessments, challenging behaviour and sexuality management plans based on the residents assessed needs.

Relevant aged care contract requirements are met.

**Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

The four of four long term care plans reviewed have interventions based on the residents' needs. The service has paper based assessment and care planning records (the RN is in the final stages of their InterRAI training). The ongoing care plan records the identified need, level of assistance required and desired outcomes or goals that are individualised to the resident’s needs. A resident reviewed has interventions for wound care that are consistent with the resident's assessed needs and desired outcomes.

The two RNs and one caregiver interviewed report the care plans provide accurate information regarding the individual needs and care required for the residents. The four residents and one family member interviewed report satisfaction with the care provided and commented on the friendly and homelike nature of the service.

Relevant aged care contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The activities co-ordinator reports activities plans are individualised to the resident’s needs. The activities are individualised and developed in conjunction with the resident and where appropriate their family. The activities assessments and plans are incorporated in to the long term care plan, as sighted in the four of four residents' files reviewed, evidence shows they are up to date and reflect individualised needs of the residents. The activities assessment includes social pursuits, intellectual interests, creative pursuits, physical activity, and outdoor interests.

The activities are developed based on the resident’s needs, interests, skill and strengths. The activities coordinators interviewed report they have a number of small group activities going at one time based on the skills, strengths and abilities of the varying dependency levels of the residents. The activities cover cognitive, physical and social needs. For variety, there is a theme for each month with community events that are occurring locally included in the programme.

The four of four residents' files reviewed have activities and social assessments. The goals are updated and evaluated in each resident's file at least six monthly with person centred care plan reviews and multi-disciplinary reviews. The activities co-ordinator reports where residents have a specific need, the service endeavours to provide the resources for this.

Where possible residents' independence is encouraged to maintain links with family and community groups. Residents are provided with outings on a routine basis. One to one activities are planned to meet the resident’s interests.

The four residents interviewed report they enjoy the range and variety of planned activities.

Relevant aged care contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

There is a previous CAR at 1.3.8.2 to ensure the evaluations indicate the progress of achievement to interventions. This is now addressed and an improvement implemented since the last audit.

There is a previous CAR at 1.3.8.3 to ensure where progress is different from expected, the service responds by initiating changes to the care plan. This is now addressed and an improvement implemented since the last audit.

The four of four residents' care plans reviewed evidence evaluations are recorded at least six monthly by the RN, with input from the GP, the resident, the family and the activities coordinator. The documented evaluations indicate the resident's progress in meeting goals, and there is a multidisciplinary review, a re-assessment and the care plan is updated to reflect progress towards meeting goals, this is an improvement implemented since the last audit. The four of four care plans sighted are individualised and personalised to the residents' needs. Any changes in the residents’ condition are written in the progress notes, discussed at the staff handover to oncoming staff and updated on the care plan (confirmed at interview with the two RNs and one caregiver). The four of four residents’ files reviewed evidence the care plan is updated to reflect the changed needs of the residents; this is an area of improvement since the last audit. The care plan of the resident reviewed is updated when they returned from the acute care hospital.

Short term care plans are used to documented temporary changes in the residents' condition. The resident reviewed has a short term wound management plan.

The four residents and one family member interviewed report involvement in the evaluation process and are satisfied with the care provided.

Relevant aged care contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

There is previous CAR at 1.3.12.1 to ensure that the controlled drug are consistently signed into the register and that the second person checking out the controlled drugs consistently signs the register. This is now addressed and an improvement implemented since the last audit.

There is a previous CAR at 1.3.12.3 to ensure all staff responsible for medicine administration evidence a competency assessment. This is now addressed and an area of improvement since the last audit.

Medicines for residents are received from the pharmacy in the Douglas Pharmaceuticals Medico Pak delivery system. The signing sheet that records the Medico Paks are checked for accuracy against the resident's medicine chart (sighted on the eight of eight medicine profiles reviewed). A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or had a hospital admission. A safe system for medicine management is observed on the day of audit.

Medicines are stored in locked medicine trolleys and in the locked cupboard in the staff office. There is a monthly stock rotation recorded for the medicines that are not packed in the Medico Paks (eg eye drops). The controlled drugs are stored in a locked safe, two staff sign the register at each administration and a weekly stock count is undertaken when the controlled drugs come in from the pharmacy, this is an improvement since the last audit. The service's medicine fridge is monitored daily and temperatures are within recommended guidelines.

The eight of eight medicine charts reviewed are reviewed by the GP in the last three months. All prescriptions sighted contain the date, medicine name, dose and time of administration with any allergies highlighted in red ink. All the eight of eight medicine charts reviewed have each medicine individually prescribed and signed by the GP. All signing sheets are fully completed on the administration of medicines for the past four weeks.

There are documented competencies sighted for all staff designated as responsible for medicine management, this is an area of improvement since the last audit.

The RN reports that there are no residents assessed as competent to self-administer their medicines. The service has a policy on self-administration and a self-administration competency for residents who are able to self-administer their medicines.

Relevant aged care contract requirements are met.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

The four week rotating menu, with seasonal variations, is approved by a registered dietitian in December 2012 as suitable for aged care residents. The menu review is based on the dietitian NZ audit tool for residents living in long term care. The overall summary from the dietitian indicates the menu offers interesting meals and praises the fresh fruit with the main meal at midday. A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. For example, the service provides diabetic and texture modified diets to meet specific residents' needs. The care staff manage the additional food supplements for the residents (eg Fortisip).

Interviews with four of four residents and one family/whānau confirm they are overall happy with the food provided.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer are in their original packaging or labelled and dated if not in the original packaging. Staff have undertaken food safety management education appropriate to service delivery.

Relevant aged care contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

Beattie Home has a current Building Warrant of Fitness that expires in January 2014.

There have been no changes to the building since last audit. There is evidence that all staff have attended a trial evacuation in the last 12 months.

The improvement required after the last audit relating to records of electrical safety tests has been effectively addressed.

Both the internal and external environment has been set up and are continuously monitored with resident safety and convenience the priority.

**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:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The service has no residents assessed as requiring restraint or enabler use. Policies identify that enablers are voluntary and the least restrictive option for promoting or maintaining the resident’s independence and safety. The two RNs and one caregiver interviewed confirm the service is a restraint free environment and that if enablers are used; these will be voluntary and the least restrictive option.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 Infection control management**

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

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 previous CAR at 3.1.3 to ensure the annual review of the infection control programme is conducted. The infection prevention and control programme is last reviewed October 2012 (sighted). This is an area of improvement since the last audit.

There is a previous CAR at 3.1.4 to provide evidence the infection prevention and control programme is approved by the manager. Evidence sighted shows the infection control programme is approved by the manager (sighted as signed off by the manager in October 2012). This is now addressed and an area of improvement since the last audit.

Relevant aged care contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

Infection control data is collected on urinary tract infections, chest infections, wound infections, eye and ear infections and multi-resistant organisms. The monthly report of collected data is provided to senior management and presented at the combined health and safety/infection control/quality meetings. The surveillance data collected is based on guidelines from an aged care consultant. Infection control data is included in the quality audit programme.

All staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The data for 2013 records an increase in urinary tract infections in May, with eight UTIs recorded, which is an increase from four in April and nil in March. The analysis records that one resident with an IDC showed signs and symptoms of infection twice in May and was effectively treatment with antibiotic use. The review of the meeting minutes and interview with the manager reports the service has reviewed the management of IDC's and the policy and procedure related to changing catheter bags. There were no other trends identified, with the use of appropriately prescribed antibiotics recorded. The surveillance data indicated the UTI's have reduced to five in June 2013.

**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:**