**Dutch Village Trust**

**Current Status:** **17-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**

Ons Dorp Care Centre provides residential care for up to 44 residents who require rest home or hospital care. Occupancy on the day of the audit was 41 (19 rest home residents and 22 hospital residents). The facility is operated by the Dutch Village Trust.

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 three areas identified as requiring improvement during the last audit have been effectively addressed. Two improvements are required following this audit relating to observations after a resident fall, and maintaining safe hot water temperatures in resident areas. The service provider continues to demonstrate commitment to continuous improvement through implementation of embedded quality and risk management systems. Resident care documentation indicates services are provided in a timely manner.

**Audit Summary AS AT** **17-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 |

|  |  |  |
| --- | --- | --- |
| **Consumer Rights** | Day of Audit  17-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** |

|  |  |  |
| --- | --- | --- |
| **Organisational Management** | Day of Audit  17-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. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit  17-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  17-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. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

|  |  |  |
| --- | --- | --- |
| **Restraint Minimisation and Safe Practice** | Day of Audit  17-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  17-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** |

Ons Dorp Care Centre

Dutch Village Trust

Surveillance audit - Audit Report

Audit Date: 17-Jul-13

**Audit Report**

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Dutch Village Trust |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Ons Dorp Care Centre | 36 McLeod Rd | Henderson | Auckland |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 17-Jul-13 **End Date:** 17-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 | XXXXXXX | RGON, BA, Reg. Lead Auditor RABQSA | 8.00 | 4.00 | 17-July-13 to 17-July-13 |
| Auditor 1 | XXXXXXX | RN, B.Nursing, RABQSA | 8.00 | 4.00 | 17-July-13 to 17-July-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 8.00 | **Total Audit Hours** | 24.00 |
| **Staff Records Reviewed** | 5 of 60 | **Client Records Reviewed** *(numeric)* | 4 of 41 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 4 |
| **Staff Interviewed** | 9 of 60 | **Management Interviewed** *(numeric)* | 1 of 2 | **Relatives Interviewed** *(numeric)* | 2 |
| **Consumers Interviewed** | 4 of 41 | **Number of Medication Records Reviewed** | 8 of 41 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

**Declaration**

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

Dated this 31 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**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ons Dorp Care Centre | 44 | 41 | 20 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Executive Summary of Audit**

*General Overview*

Ons Dorp Care Centre provides residential care for up to 44 residents who require rest home or hospital care. Occupancy on the day of the audit was 41 (19 rest home residents and 22 hospital residents). The facility is operated by the Dutch Village Trust . 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 three areas identified as requiring improvement during the last audit have been effectively addressed. Two improvements are required following this audit relating to observations after a resident fall, and maintaining safe hot water temperatures in resident areas. The service provider continues to demonstrate commitment to continuous improvement through implementation of embedded quality and risk management systems. Resident care documentation 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, Ministry of Health, Police, ACC or Coroner since the previous audit at this facility.

*1.2 Organisational Management*

The facility mission, values and goals are displayed in the entrance and included in the resident information booklet and staff orientation programme. The service is managed by a business manager. A clinical manager who is a registered nurse with aged care management experience is responsible for the daily operation of service delivery.

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 are 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. A suitably qualified and experienced registered nurse is on duty 24 hours a day with clinical advice and assistance available at all times. A process is in place to maintain safe staffing in the Care Centre when a Village resident requires assistance. 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 high satisfaction with the quality of care provided at the service. The facility provides appropriate services for residents at rest home and hospital 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 are provided in time frames that meet the residents' needs and comply with contractual requirements. Where there are temporary changes in a resident's condition the service uses a short term care plan to document the resident's changed needs.

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

A safe and timely medicine management system is in place. The registered nurses, enrolled nurses and senior caregivers who responsible for medicine management evidence competency to perform the role. The areas that were required improvements at the last audit relating to the three monthly review of medicines, the weekly stock check of the controlled drugs and the sharing of prescribed medicines are now addressed and these are areas of improvement implemented since the last audit.

The meals service is provided by a contracted catering service. The menus are appropriate to the resident group and have been reviewed by a dietitian.

*1.4 Safe and Appropriate Environment*

The Care Centre 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 environment is well maintained. Electrical safety checks are done annually. Equipment is functionally checked and calibrated annually. Improvement is required to ensure that hot water temperatures are maintained within safe parameters.

*2 Restraint Minimisation and Safe Practice*

The use of enablers is voluntary and the least restrictive option to maintain resident independence and promote safety. At the time of audit there is one resident assessed as requiring the use of an enabler (bed rail). The care staff demonstrate sound knowledge of their requirements in relation to restraint and enabler use.

*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 service bench marks results with an external infection control consultancy service.

**Summary of Attainment**

* 1. ***Consumer Rights***

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

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

* 1. ***Organisational Management***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | PA Moderate | 0 | 1 | 1 | 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: 4 PA Neg: 0 PA Low: 0 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:16 PA:1 UA:0 NA: 0 |

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | 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:6 CI:0 FA: 6 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:14 PA:0 UA:0 NA: 0 |

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | PA Moderate | 0 | 2 | 1 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | 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:7 CI:0 FA: 0 PA Neg: 0 PA Low: 0 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:2 PA:1 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***

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

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

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| **Total Standards (of 50) N/A:** 34 **CI:** 0 **FA:** 14 **PA Neg:** 0 **PA Low:** 0 **PA Mod:** 2 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 39 **PA:** 2 **UA:** 0 **N/A:** 0 |

**Corrective Action Requests (CAR) Report**

Provider Name: Dutch Village Trust

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:17-Jul-13 End Date: 17-Jul-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.4 | 1.2.4.3 | PA  Moderate | **Finding:**  Accident records do not provide evidence that residents consistently have a neurological assessment after a fall or suspected fall..  **Action:**  Ensure that all residents who have had a fall, or are suspected to have had a fall, have neurological assessments recorded. | 3 months |
| 1.4.2 | 1.4.2.4 | PA  Moderate | **Finding:**  Records of hot water checks in resident areas indicate that temperatures at mmany taps consistently exceed 45C.  **Action:**  Ensure that hot water temperatures in resident areas are consistently maintained at 45C or less. | 1 month. |

**Continuous Improvement (CI) Report**

Provider Name: Dutch Village Trust

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:17-Jul-13 End Date: 17-Jul-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXX

**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. Relevant 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. Resident and family interviews confirm knowledge of the complaints process. 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. Relevant 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 stated in the Business Plan 2012-2013 and reviewed annually. They are also and displayed in the central lounge area, the resident information booklet and staff handbook. 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 35 years in health service delivery including aged care. They have been in this position for five months. 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 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 plans 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 are made aware of and 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 leaders and 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 residents and from satisfaction surveys is also used to improve services.

Active risk management and health and safety processes are 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 DHB group.

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

The clinical leaders are involved with resident care daily and monitor clinical risks , reporting to the clinical 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. 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:** PA Moderate

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 previous improvement required relating to records of notification to families where an incident has occurred has been effectively addressed. Six of 10 randomly selected incident records related to actual or suspected resident falls. Four of the six did not include evidence that neurological signs had been assessed. Improvement is required to ensure that neurological assessment occurs after every actual and suspected fall.

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 they understand their responsibilities relating to notifications.

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

Six of 10 randomly selected incident records related to actual or suspected resident falls. Four of the six did not include evidence that neurological signs had been assessed

**Finding Statement**

Accident records do not provide evidence that residents consistently have a neurological assessment after a fall or suspected fall..

**Corrective Action Required:**

Ensure that all residents who have had a fall, or are suspected to have had a fall, have neurological assessments recorded.

**Timeframe:**

3 months

**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 employee files (five of five). 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 licenses as applicable are maintained up to date for all health personnel who require them including external contractors.

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. All 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. 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 numbers and skill mixes that is adequate for the layout of the facility, and the rest home and hospital levels of care provided. Review of rosters indicates that there are sufficient staff to meet resident needs over the twenty-four hours. Staff interviewed who have worked in the evening and at night say that staffing levels are adequate, on call support is readily available and assistance is provided as needed. Absence is replaced by part time staff working extra shifts. There is a process in place to maintain safe cover in the Care Centre when a village resident requires assistance. Interviews with four residents, two relatives, and four care staff confirm that staffing numbers and skill mix are adequate for the layout of the facility, the services provided and the dependency of the residents.

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 (two rest home and two hospital) residents' files reviewed confirm that the registered nurse (RN) conducts the initial assessment and initial care plan on admission to the service and develops the long term (ongoing) care plan within three weeks. Caregivers provide most of the direct care under the direction of the person centred 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 service have commenced using the InterRAI assessment tool. One of the files reviewed has an InterRAI assessment and care plan using the momentum health format. The care manager reports that 30 residents now have InterRAI assessments and that the service will continue to use their own format for care planning. The initial and ongoing paper based assessments include an observation chart, pressure risk, skin assessment, falls risk, pain assessment, spiritual assessment, cultural assessment, nutrition risk assessment, mini mental, ADL assessment, continence assessment and dietary profile. The four of four residents' files evidence that the long term lifestyle care plan is based on the assessed needs of the resident. The ongoing long term care lifestyle plan is recorded a standardised template that is individualised to the resident's needs. The care plan identifies the need, assistance required, special instructions and goals. The format for the lifestyle care plan identifies desired outcomes for mobility, orientation/mental/emotional needs, communication, personal hygiene, skin care, nutrition, elimination, medical pain, restraint (if applicable), maintaining a safe environment, activities, sexuality, cultural values and beliefs, grief/death and dying, sleep and night cares. The ongoing care plan evaluation is conducted at least three monthly and used to form part of the multidisciplinary review, confirmed in the four of four residents' files reviewed.

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 four caregivers report that adequate information is provided at handover, in resident progress notes and on the communication sheet.

The four of four residents (one rest home and three hospital residents) and two family members report the residents receive care that meets their needs. All had high praise for all levels of staff (management, nursing, care, activities, cleaning, laundry and kitchen) and their caring and friendly nature. One family member mentioned that 'all staff go the extra mile' to make sure they and the relative receive a high level of care, support and service.

Tracer example one - hospital level of care.

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

Tracer example two - rest home level of care:

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

The ARC requirements for rest home and hospital level of care 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 1.3.6 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 residents' (two rest home and two hospital) long term care plans reviewed have interventions based on the residents' needs. The service has paper based assessment and care planning records. 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. The resident reviewed for hospital level of care has interventions in place for promoting wound healing and the rest home resident reviewed has the changed needs of the resident recorded on a short term care plan.

The four of four caregivers interviewed report the care plans provide accurate information regarding the individual needs and care required for the residents. The four residents and two family members interviewed report satisfaction with the care provided and commented on the friendly and homelike nature of the service. One family commented that their relative was initially admitted for terminal care over a year ago, they praise both the medical and care staff at Ons Dorp for the 'amazing' care that they provide, and they report that their relative has now stabilised.

The ARC requirements are met.

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

**Audit Evidence** **Attainment:** 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 residents' files reviewed. Evidence shows they are up to date and reflect individualised needs of the residents. The activities assessment include social pursuits, intellectual interests, creative pursuits, physical activity, and outdoor interests.

A monthly activities plan (sighted) is developed based on the resident’s needs, interests, skill and strengths. 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, such as activities related to the different cultural groups at the service (e.g. Dutch, Chinese, Indian and Scottish).

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 three 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 of four residents interviewed report they enjoy the range and variety of planned activities and commented and the enthusiasm of the activities coordinator.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

The four of four residents' care plans reviewed, (two rest home and two hospital), evidence evaluations are recorded at least three 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. 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 and discussed at the staff handover to oncoming staff (confirmed at interview with the four of four caregivers).

Short term or acute nursing care plans are used to document temporary changes in the residents' condition. An acute care plan documents the problem, treatment required and the outcomes of care. The file of the hospital resident reviewed shows evaluation of the condition of the wound at each dressing change. With the healing of the gangrenous area to the residents’ foot, the impact and improvement on the resident's wellbeing and happiness is recorded and commented on by the family at the MDT review. The rest home resident reviewed has a short term care plan to identify the change needs of the resident post a fracture.

The four of four residents and two of two family members interviewed report involvement in the evaluation process and are satisfied with the care provided.

The ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

The previous CAR at 1.3.12.1 identified medications (such as lactolose and paracare) that are dispensed for one resident are being administered to all residents that are prescribed that medicine in the hospital and rest home. This is now addressed. The hospital has impress stock which is used for the hospital residents and the rest home residents have smaller bottles dispensed by the pharmacy for each resident. This is an improvement implemented since the previous audit.

The previous CAR at 1.3.12.6 identified that not all medicine files sampled evidenced three monthly GP reviews and that the controlled drug checks are not consistently conducted weekly. These are now addressed. The eight of eight medicine charts reviewed evidence the GP has reviewed the medicines with the last three months. The controlled drug register evidences weekly stock take. These are improvements implemented since the previous audit.

Medicines for residents are received from the pharmacy in the robotic sachet delivery system. The signing sheet that records the sachets are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or 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 treatment room. There is a monthly stock rotation recorded for the medicines that are not packed in the sachets. The controlled drugs are stored in a locked safe, two staff sign the register at each administration and a weekly stock count is undertaken. The service's medicine fridge is monitored at least weekly and temperatures are within recommended guidelines.

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

There are documented competencies sighted for the staff designated as responsible for medicine management. The RNs administer the medications in the hospital section, and the ENs and senior caregivers assist with medicine administration in the rest home section. The RNs have also had syringe driver training and competency assessment through the hospice in May 2013.

The RN reports that there are two rest home residents assessed as competent to self-administer their medicines. The service has a self-administration competency for residents who are able to self-administer their medicines, which is evidenced in these files reviewed. The residents have a locked draw in their rooms to store their medicines.

The ARC requirements for rest home and hospital level care 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 food and fluids services are provided by a contracted catering service. The meals are prepared and cook onsite. The six week rotating menu, with seasonal variations, is approved by a registered dietitian in June 2013 as suitable for aged care residents. The menu review is based on nutritional guidelines for the older person living in long term care. 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 (e.g. Fortisip).

Interviews with four residents and two family/whānau confirm they are overall happy with the food provided. One resident had minor issues, reporting that they thought there could be more salt added in the cooking process, the resident did report they have access to table salt to add if they require and one resident commented that they though the meat was 'bit tough' at times. Other residents commented that the food is the best that they have ever had and others also had high praise for the meals.

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.

ARRC 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:** PA Moderate

The Care Centre has a current Building Warrant of Fitness that expires on 23-Nov-13.

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 environment is well maintained. Electrical safety checks and functional tests and calibration of equipment are done annually. Improvement is required to ensure that hot water temperatures are maintained within safe parameters.

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

Water temperatures are monitored monthly. Review of the records since January 2011 indicates that the hot water temperature in many taps in resident areas has consistently exceeded 45C, some up to 50C . Review of incident records indicate that there have been no incidents of harm to residents from hot water

**Finding Statement**

Records of hot water checks in resident areas indicate that temperatures at many taps consistently exceed 45C.

**Corrective Action Required:**

Ensure that hot water temperatures in resident areas are consistently maintained at 45C or less.

**Timeframe:**

1 month.

**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 have seven resident’s assessed as requiring restraint (bed rails, T belt or low/low bed) and one resident assessed as requiring enabler use. The file reviewed of the one resident with the enabler use records that the bed rail is voluntary and the least restrictive option for the resident. The four of four caregivers interviewed demonstrate good knowledge of enabler and restraint use, the monitoring, observations and documentation required and report that enablers are voluntary.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 Surveillance**

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

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

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

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 quality meetings. The surveillance data collected is based on guidelines from Simple Solutions Consultancy and the organisations infection and prevention control policies and procedures. 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. When residents have an infection, a short term care plan is commenced (evidenced in the files reviewed). The data for 2013 records that there is an increase in upper respiratory tract infections (URTIs) in June (three URTIs recorded), the analysis records that this is a seasonal variance reflective of community norms. All the URTIs for these residents are now resolved.

**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:**