**Adriel Rest Home Limited**

**Current Status:** **29-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**

Adriel Rest Home provides dementia care services for up to 23 residents within a secure rest home environment. There are 20 residents present on the day of the surveillance audit. Of the fifteen required improvements raised at the previous audit, ten have now been addressed. There are two new areas for improvement identified including good practice for resident mealtimes and completion of staff performance appraisals. The remainder from the previous audit (police vetting and referee checks, cleaning manual, corrective action completion and evaluation of activity plans and restraint) remain outstanding.

Two additional rest home beds using the existing "Snoezelen" room has increased capacity to 23 beds since the certification audit. These beds are not currently in use, but are available for short term use when required.

**Audit Summary AS AT** **29-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  29-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| --- | --- | --- |
| **Organisational Management** | Day of Audit  29-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 low risk** |

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| **Continuum of Service Delivery** | Day of Audit  29-Jul-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit  29-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  29-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| --- | --- | --- |
| **Infection Prevention and Control** | Day of Audit  29-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** |

**Adriel Rest Home**

Adriel Rest Home Limited

Surveillance audit - Audit Report

Audit Date: 29-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Adriel Rest Home Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Adriel Rest Home | 36 Osborne Road |  | Amberley |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 29-Jul-13 **End Date:** 29-Jul-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | NZRN; ADN; PG Dip Health Sciences (Nursing); US 8086 | 8.00 | 6.00 | 29-Jul-13 |
| Auditor 1 | XXXXXXXX | RCpN; MPH; NZQA 8086 | 8.00 | 4.00 | 29-Jul-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX | RN,MBA, NZQA US 8086 |  | 2.00 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 28.00 |
| **Staff Records Reviewed** | 8 of 23 | **Client Records Reviewed** *(numeric)* | 9 of 20 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 9 |
| **Staff Interviewed** | 2 of 23 | **Management Interviewed** *(numeric)* | 1 of 1 | **Relatives Interviewed** *(numeric)* | 4 |
| **Consumers Interviewed** | 2 of 20 | **Number of Medication Records Reviewed** | 7 of 20 | **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) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofThe DAA Group Limited, an auditing agency designated under section 32 of the Act.

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

Dated this 27 day of August 2013

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

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

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

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

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

# Services and Capacity

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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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Adriel Rest Home | 23 | 20 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Adriel Rest Home provides dementia care services for up to 23 residents within a secure rest home environment. There are 20 residents present on the day of the surveillance audit. Of the fifteen required improvements raised at the previous audit, ten have now been addressed. There are two new areas for improvement identified including good practice for resident mealtimes and completion of staff performance appraisals. The remainder from the previous audit (police vetting and referee checks, cleaning manual, corrective action completion and evaluation of activity plans and restraint) remain outstanding.

Two additional rest home beds using the existing "Snoezelen" room has increased capacity to 23 beds since the certification audit. These beds are not currently in use, but are available for short term use when required.

1.1 Consumer Rights

There is newly implemented communication log for every resident to record any communication with family members or their nominated representatives. This includes open disclosure of any adverse events, such as falls and skin tears. There is an active complaints process, with any concerns or matters raised with the nurse manager or owner taken seriously. Follow up actions are taken where necessary to improve resident care. A new area requiring improvement relates to implementing best practices for residents who require assistance with their meals.

1.2 Organisational Management

Adriel Rest Home is operated by a registered nurse, who is the owner manager. She takes a prominent role in leading dementia care in Canterbury and beyond and provides registered nurse cover out of hours. A new nurse manager, appointed in April 2013, oversees day-to-day operation of the service. Previous corrective actions in relation to leave cover for the manager and policy reviews are now fully addressed.

There is a 2013 strategic business plan which describes the scope, direction and goals of the service. The quality and risk management framework covers all key requirements and is focused on service improvements. There is a current risk management plan which is routinely reviewed at both the staff and quarterly quality meetings. Policies, procedures and manuals are maintained, with a system to review and update existing documents. However, the review of the cleaning manual has omitted detail and instructions of a product in use and this requires improvement.

There are examples of effective collection of data related to accidents and incidents, complaints, infection control and health and safety. A schedule of monitoring is in place through a range of internal audits and satisfaction surveys, with results analysed and followed up through a corrective action process. Corrective action planning is well described and implemented, however not all aspects are monitored or followed through to a conclusion to ensure that 'the loop' is closed and that the desired improvement is occurring.

All roles have a job description and professional qualifications are validated for registered and enrolled nurses. An orientation programme is in place, with all new care staff required to undertake Aged Care Education (ACE) training and complete the required unit standards in dementia care as required by the Aged Residential Care agreement. Rosters show that the required staffing levels are maintained with a mix of experienced staff covering the 24 hour period and weekends. A registered nurse is on call out of hours. Police checks and two referee checks are still not occurring consistently for all new employees according to the Adriel policy and this improvement is still required. Timely staff appraisal is also identified as requiring improvement. A previous improvement of the need for personal and medication records to be signed, designations included and staff signatures identifiable has been addressed.

1.3 Continuum of Service Delivery

Services are being delivered by support partners with clinical oversight from two registered nurses and an enrolled nurse. Professional expertise is accessed as required. A previous identified required improvement on ensuring service provision and clinical intervention is consistent with meeting residents' needs has been addressed.

The interRAI programme is being consistently used for the assessment of individual needs of residents, for the development of personalised goals and interventions and for the six monthly evaluation processes. Interim care plans are developed for issues that arise between the six monthly evaluations, however updates are also made to the hard copy of the interRAI plans when relevant. A separate activities plan is being developed and there are monthly summaries of resident participation in activities. An area requiring improvement is that the evaluation of goals in activities plans is needed and all activities goals need to be relevant for the person. A previous shortcoming around evaluations not showing the degree of achievement in meeting residents' desired outcomes is now met.

A quality improvement project on medicine management was undertaken. Medicines are now being managed in a safe manner and according to legislative requirements and good practice guidelines. The medicine related issues raised as requiring improvement at the last audit are no longer evident.

The nutritional and fluid needs of the residents are met through the use of a dietitian approved menu. Special diets are accommodated and personal preferences are taken into account. Safe food handling requirements are upheld as does the storage of food.

1.4 Safe and Appropriate Environment

There have been no changes to the building since the previous audit. There is a building warrant of fitness current until 1 October 2013 and a hazardous substances test certificate valid until February 2014. A previous improvement in relation to hot water temperature monitoring is adequately addressed.

2 Restraint Minimisation and Safe Practice

The organisation has three residents, who, on occasion, use an approved lazy boy chair with legs extended. Most aspects of restraint use are adequately documented, however improvement is required in relation to review and some detail in the residents' records. Enablers are not presently used at Adriel Rest Home.

3. Infection Prevention and Control

The requirements for the surveillance of infections are detailed in infection control policies and procedures. Staff are aware of the need to document infections, which are being recorded in a monthly recording form. This data is being transferred into an infection control incidence reporting form and analysed. The results are reported to staff at the staff meetings and to the quality team meetings. Staff are advised of methods of prevention in relation to the dominant infections. There is no evidence of infections not being included in the surveillance records, which indicates the area requiring improvement has been addressed.

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 | PA Low | 0 | 0 | 1 | 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:9 CI:0 FA: 2 PA Neg: 0 PA Low: 1 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:1 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 | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Low | 0 | 6 | 2 | 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 | PA Low | 0 | 2 | 2 | 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 | FA | 0 | 1 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 5 PA Neg: 0 PA Low: 2 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:15 PA:4 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 | 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 | PA Low | 0 | 1 | 1 | 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: 5 PA Neg: 0 PA Low: 1 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:13 PA:1 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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

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

1. Restraint Minimisation and Safe Practice

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

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 29 **CI:** 0 **FA:** 16 **PA Neg:** 0 **PA Low:** 5 **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:** 38 **PA:** 7 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Adriel Rest Home Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:29-Jul-13 End Date: 29-Jul-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.8 | 1.1.8.1 | PA  Low | **Finding:**  Observation of the mid-day meal practices show practices that do not demonstrate respect for individuals and nor do they demonstrate good practice  **Action:**  That feeding techniques in this service are reviewed and residents who require assistance with feeding are treated with respect. | Six months |
| 1.2.3 | 1.2.3.3 | PA  Low | **Finding:**  The cleaning manual has been updated in September 2012. However, not all products are covered in the procedure to guide staff on its use.  **Action:**  All products in use are include instructions in the cleaning manual. | Six months |
| 1.2.3 | 1.2.3.8 | PA  Low | **Finding:**  Corrective action planning is implemented for a number of service shortfalls, including internal audit results and to identify opportunities for improvement.  However, not all corrective action planning is complete to ensure the quality loop is closed and actions taken are effective.  **Action:**  The corrective action process is fully implemented and the 'quality loop' complete. | Six months |

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| --- | --- | --- | --- | --- |
| 1.2.7 | 1.2.7.3 | PA  Low | **Finding:**  Of five new staff files reviewed, three have inconsistent records of the completion of police vetting and referee checks as per the Adriel Rest Home policy.  **Action:**  All appointments are made in accordance with the Adriel Rest Home employment policy. | Six months |
| 1.2.7 | 1.2.7.5 | PA  Low | **Finding:**  Review of the performance appraisal schedule and comparison with completed appraisals confirms there are delays in evaluating and completing a number of staff performance appraisals. Two of four appraisals due in the first half of 2013 are not complete and the other two are noted to be completed several months past the due date.  **Action:**  Performance appraisals are completed in accordance with the Adriel Rest Home policy. | Six months |
| 1.3.8 | 1.3.8.2 | PA  Low | **Finding:**  Some of the individualised activity goals sighted are no longer realistic for the individual and there is no evidence of evaluation of the documented activities goals.  **Action:**  That activities goals are realistic for each resident according to their current abilities and interests. That the documented activities goals are evaluated alongside the evaluation of other care plan goals and interventions. | Six months |
| 2.2.5 | 2.2.5.1 | PA  Low | **Finding:**  There are incomplete reviews for three residents in the facility using restraint.  **Action:**  Undertake and complete a comprehensive review of all aspects restraint. | Six months |

# Continuous Improvement (CI) Report

Provider Name: Adriel Rest Home Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:29-Jul-13 End Date: 29-Jul-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

**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 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

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

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

Although this standard is outside of the scope of the surveillance, observations made during the audit are not consistent with good practice. The observations show that during mealtimes, staff actions are not consistent with good practice. Improvements around the management of meal times and the assistance that is provided to individual residents are required. Staff report that there is a lack of time and insufficient helpers at mealtimes. The manager acknowledges that the practices observed are not acceptable. A low, rather than a moderate risk, has been attributed to the finding as there is an element of subjectivity to the finding and there is no evidence of a lack of physical safety to the residents.

**Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.**

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

During observation of the medicine round at mid-day an opportunity is taken to observe what is occurring in the dining room, as a number of residents require assistance to eat their meals. As noted in 1.3.13, attention is paid to individual food preferences and nutritional requirements. Senior staff co-ordinate individual requirements and manage some of the broader issues, such as residents who may not have arrived for their meal, or who may have left the dining room before their meal is eaten. A number of staff practices while providing assistance to residents at mealtimes are not consistent with good practice and require improvement.

**Finding Statement**

Observation of the mid-day meal practices show practices that do not demonstrate respect for individuals and nor do they demonstrate good practice.

**Corrective Action Required:**

That feeding techniques in this service are reviewed and residents who require assistance with feeding are treated with respect.

**Timeframe:**

Six months

**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

Adriel Rest Home has, in 2013, introduced a contact log for each resident in an effort to ensure that family members are receiving information and being communicated with at a frequency and level of detail that they wish in accordance with the organisation's principles of open disclosure. Examples sighted in residents' records confirm that regular entries are made most months since its instigation. Each key contact is approached to determine when they would like contact to be made according to the significance of events, such as for events (e.g., falls) and changes in health, or simply a regular "catch up".

**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

Adriel Rest Home has an active complaints process which is understood and implemented. One concern noted, has been addressed with open communication, including a facilitated meeting with family members. It has resulted in the introduction of a communication log for all residents of Adriel, staff training, and entry of additional details into the interRAI nursing care plan. While not all aspects of the concerns were substantiated, the organisation has taken a positive approach to addressing and improving care concerns.

In a further example, a staff member has raised a concern in relation to resident care. This is also addressed positively with a staff training scheduled and performance management as appropriate.

**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 owner manager reports that there has been no change in the overall direction and goals of Adriel Rest Home. The strategic plan is developed for 2013 and the quality and risk management plan is in place. A strategic planning meeting is documented in April 2013 at which the new nurse manager and registered nurse owner discussed matters relating to this and scope of the service. This is also the occasion at which updates to the strategic and quality plan occurs, audits are reviewed and an updated audit schedule implemented. There is a current organisational chart. The vision and mission of the organisation remained intact and are supported by a current quality and business plan which reflects the desire to provide respect for the whole person, value each other, embracing the body, mind, heart and spirit of the individual and to maintain independence as long as possible. The introduction of the "spark of life" programme is part of this philosophy.

Adriel Rest Home is managed and overseen by the registered nurse/owner/manager. In April 2013, a new registered nurse manager is appointed to cover the five day role. She is suitably qualified for the role, having previously been involved in national training for the interRAI roll out, and has previously worked at the facility. The owner manager has attended more than forty hours relevant training in the past 12 months, including leadership sessions provided by the New Zealand Aged Care Association.

**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 1.2.2 Service Management**

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

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

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 day to day operation of the dementia facility is overseen by a full time registered nurse in the nurse manager role since April 2013 and supported by a registered nurse/owner/manager. There is also a part time enrolled nurse who provides occasional cover, with one of the registered nurses providing back up for any clinical matters. The previous required improvement has been addressed.

**Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.**

**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:** PA Low

The quality and risk management system continues to provide a framework for improvement activities within the service, with evidence of updated documents. This includes a business, strategic and quality and risk plans updated in 2013.

There are policies and procedures in place, which are updated on a schedule of review. Examples of review include alignment with recommended practices, such as for medication procedures which are now linked to the Medicines Care Guides for Residential Aged Care (2011). The document control system is adequately managing control of documents and maintains them as up to date. The cleaning manual has been updated as part of this process, but improvement is required as it omits some necessary information (previous CAR 1.4.6.1). The organisation uses one set of hard copy documents which are accessible to all staff. Obsolete documents are identified and archived. Following a recent concern in relation to residents exposure to the sun, a new policy has been developed to guide staff. There are opportunities to further enhance this by referencing care in the sun within individual plans of care. This has particular relevance for those residents who access the outdoors, many times a day. A previous corrective action is relation to document control and updates is currently addressed through the internal audit schedule which spreads reviews of documents and manuals over the twelve month period. The system has recently changed and now includes an amendment log which details any amendments made.

All key components of service delivery are established and utilised including the risk management plan. The risk register is updated when risks change such as a recent fluctuation in bed occupancy. There is a culture of event reporting and an improvement focus for complaints management. Hazards are identified in the health and safety hazard register.

Corrective action planning is implemented for a number of service shortfalls, including internal audit results and to identify opportunities for improvement, such as a number of recent errors in blister packs provided by the pharmacy. This is being monitored as part of the reconciliation process and regularly reported for trends (improvement is noted). A number of different examples are sighted, such as follow up from less than optimal recording of medication administration by care staff. Corrective action activities are also discussed at staff meetings. However, not all corrective action planning is complete to ensure the 'quality loop' is closed and that actions taken are effective. This is a required improvement.

Adriel Rest Home undertakes annual staff and family surveys. These are presently being circulated but are yet to be analysed, although inspection of a number of returned surveys confirms family satisfaction with the service. Data from incidents, falls and skin tear as well as infection rates and audits is reviewed, collated and trends analysed and reported at quality and staff meetings. There is an internal audit schedule guiding the regular monitoring activities in the facility.

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

Policies and procedures are in place and are reviewed according to a regular schedule. This includes a cleaning manual reviewed in 2012 to correspond with changes in chemical service provider. Not all products are covered in the procedure to guide staff on their use. A material safety data sheet is available for this product.

**Finding Statement**

The cleaning manual has been updated in September 2012. However, not all products are covered in the procedure to guide staff on its use. Inspection of products in use confirms that one product is not included in the policy/procedure.

**Corrective Action Required:**

All products in use include instructions in the cleaning manual.

**Timeframe:**

Six months

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

The organisation has a comprehensive corrective action planning implemented for a range of service shortfalls and identified improvement opportunities, less than optimal trends and complaints. Not all corrective action planning is complete to ensure the quality loop is closed and to ensure that the actions taken are effective.

• Actions following a complaint include performance management with dates determined to review progress with the staff member. In the interim, the staff member has undertaken a performance appraisal, but this matter is not documented as being discussed at the time of the spot audit. There is no evidence of follow up actions (meeting) being taken in the time frames set down.

• A hazard raised in March 2013 is being monitored, but to date follow-up has not ensured the elimination of this hazard. It is minuted in the staff meeting for that month, but is not entered on the hazard register.

**Finding Statement**

Corrective action planning is implemented for a number of service shortfalls, including internal audit results and to identify opportunities for improvement.

However, not all corrective action planning is complete to ensure the quality loop is closed and actions taken are effective. For example:

• Actions following a complaint include performance management with dates determined to review progress with the staff member. In the interim, the staff member has undertaken a performance appraisal, but this matter is not documented as being discussed at the time of the spot audit. There is no evidence of follow up actions (meeting) being taken in the time frames set down.

• A hazard raised in March 2013 is being monitored, but to date follow-up has not ensured the elimination of this hazard. It is minuted in the staff meeting for that month, but is not entered on the hazard register.

**Corrective Action Required:**

The corrective action process is fully implemented and the 'quality loop' complete.

**Timeframe:**

Six months

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

There is a consistently implemented system to report any adverse events within the quality management system. Numerous examples demonstrate the effectiveness of this process. Open disclosure is included in two examples sighted, and is recorded on the newly implemented communication log according to the preference of the nominated representatives. The owner manger is able to describe her obligations for reporting any essential notifications.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Registered and enrolled nurses all hold current annual practising certificates. There are position descriptions describing roles, responsibilities and levels of accountability for all current staff.

Performance appraisals are scheduled on an annual plan, but staff confirm that these are overdue for some staff. Two of four appraisals due in the first half of 2013 are not complete and the other two are noted to be completed several months past the due date. This is a required improvement.

Appointment of new staff, still does not reflect the Adriel rest Home policy on recruitment, with police vetting and referee checks inconsistently implemented. This continues to require improvements.

New staff are required to undertake Aged Care Education (ACE) training in the contractual timeframe following appointment. All but three support partners (care staff) have also completed the required dementia unit standards, however, these are in progress with an on-site assessor to support the staff. There is a training register which includes dates for revalidation of on-going competencies such as for first aid and medication. This is a useful document which would benefit from being maintained in an up to date form as a primary reference to identify upcoming training needs and scheduling.

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

Recruitment processes are established but do not yet ensure that appointments are occurring according to the organisation's policy. Of the five new staff files reviewed, three have inconsistent records of the completion of police vetting and referee checks as per the Adriel Rest Home policy.

**Finding Statement**

Of five new staff files reviewed, three have inconsistent records of the completion of police vetting and referee checks as per the Adriel Rest Home policy.

**Corrective Action Required:**

All appointments are made in accordance with the Adriel Rest Home employment policy.

**Timeframe:**

Six months

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

Performance appraisals are scheduled on an annual plan (sighted), but staff and records confirm that these are lagging and overdue for some staff. Two of four appraisals due in the first half of 2013 are not complete and the other two are noted to be completed several months past the due date.

**Finding Statement**

Review of the performance appraisal schedule and comparison with completed appraisals confirms there are delays in evaluating and completing a number of staff performance appraisals. Two of four appraisals due in the first half of 2013 are not complete and the other two are noted to be completed several months past the due date.

**Corrective Action Required:**

Performance appraisals are completed in accordance with the Adriel Rest Home policy.

**Timeframe:**

Six months

**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

Two registered nurses including the owner/manager provide cover and call and are supported by a part time enrolled nurse. Inspection of rosters for the past three weeks and the current week roster confirms that staffing level and skill mix is implemented according to the Adriel Rest Home policy and contractual minimum requirements (ARC D17 and E 4.5). There are four staff rostered on both morning and afternoon shifts (two are shorter shifts) and two staff on night shift. There is a good mix of experienced staff to support new staff on each shift, with a nominated senior role. There is a support partner with a current first aid certificate on each shift as confirmed by cross checking rosters and staff records. Activities and cleaning responsibilities are additionally assigned. Staff report there is a lack time to adequately support residents at mealtimes, and it is recommended that staffing is reviewed as part of the actions taken to address the improvement required under CAR 1.1.8.

**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:**

**STANDARD 1.2.9 Consumer Information Management Systems**

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

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

All records of residents are legible and include the signature and designation of the author. Similarly, medication charts are being signed with sample signatures and designations listed at the bottom left hand corner of the signing sheets. There is a record of GP and pharmacist signatures, including copies of evidence of current authorisation to practise. Prescriptions and medical reviews have an identifiable signature and designation, as has documentation from the pharmacy, such as the sign off of checks of medicines. Staff and management inform training has occurred and that reminders are ongoing. The areas identified as requiring correction at the certification audit have been addressed.

**Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.**

**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

This service uses the interRAI programme for all resident care documentation and planning from assessment through to evaluation.

Tracer:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence** **Attainment:** 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 residents are receiving adequate and appropriate services in order to meet their assessed needs. All care plans are reviewed and updated as individual needs change and additional professional support is accessed as required. An experienced registered nurse who was employed by this service, but left prior to the last audit, has returned and has reinstated systems that ensure service delivery and reviews occur as required. A support partner, who has since become an enrolled nurse, is also instrumental in following up with any changing needs of residents. According to the GP, progress notes in the six files viewed and in the interim care plans in place (sighted) there is no evidence that services and clinical intervention are not consistent with meeting residents' needs, including timely notification to the GP. The issues that were identified as requiring improvement at the previous audit, regarding the need for the provision of services and clinical intervention to meet the residents' needs are no longer evident.

**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

All six residents' files reviewed have a personal profile that records their interests and activities they enjoyed prior to admission. The activities co-ordinator confirms this is completed within approximately three weeks of admission. Comprehensive activities plans subsequently developed and are in place for each resident. These are in a format of personalised goals under specific headings that include mobility, culture and outings for example, followed by interventions of ways in which the person may achieve the goal(s).

A diversional therapy resident profile sheet for one resident notes art and reading are her key particular likes. There is a diversional therapy plan, which as for all files reviewed states needs under the categories of physical, emotional, sensory and intellectual. Other topics for which needs are identified from the profile assessment are speech/communication, psychosocial, environment, cultural, spiritual, special needs/interests and sexual. Each has a section that details what intervention will be taken to meet the needs/interests and the goals and objectives, which in one resident’s file includes art, walking her dog, reading the newspaper and magazines and watching horse racing and television.

An activities schedule includes a wide range of activities. The 'Spark of Life' programme has a strong influence on the activities with the 'Sunshine Club', (which is scheduled on this day of audit), and the 'Men’s Club' being examples of this (sighted photograph collage of this). The rural background of most residents and the semi-rural setting in which Adriel Rest Home is positioned also influence the activities provided. The activities co-ordinator involves herself in the lives of the residents by assisting with meals, and morning and afternoon tea, taking time to talk with the residents on an individual basis and coming in at weekends, or in evenings if the programme lends itself to this. Time for individualised one on one activities are built into the schedule. Support partners and volunteers may be scheduled to assist the activities co-ordinator and there is evidence of this on the day of audit.

Residents' files have ideas for occupying them in the night should they get up, or if they are restless during the day. Many of these are tasks such as peeling potatoes or folding washing.

One of the four family members is unsure of what activities are provided. The remaining three family members inform during interview that there is always something happening and that the support partners and activities coordinators are aware of the changing needs of these people and that encouragement, rather than force, is used to distract people from inappropriate behaviour and/or to occupy them. Most residents reportedly go on an outing once a week, which is confirmed by family members.

The area requiring improvement that was raised in the last audit has been shifted to criterion 1.3.8.2 as it specifically relates to the evaluation of the goals and interventions within residents' activities plans.

**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:** PA Low

This service is using the interRAI programme for the evaluation and review of goals within care plans. Six of six personal files have current reviews in place. Progress notes are being consistently written and reflect changes. Interim care plans are being updated and there is also evidence of updates added to hard copies of interRAI care plans. The issues relating to the lack of documentation regarding the degree of residents' progress towards meeting their goals, or when progress is different from expected, as raised at the previous audit have been addressed for residents' care plans.

The activities coordinator is writing monthly summaries of activities in each residents personal file (sighted in six of six files), however there is no evaluation of the activities goals for the residents. The need to evaluate activities goals and interventions in residents' lifestyle plans that was identified under 1.3.7.1 at the previous audit is not yet being met and remains as an area requiring improvement under criteria 1.3.8.2. There is also a need to ensure that activities goals are realistic for the person they relate to.

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

Evaluations and reviews of the care/lifestyle plans of residents are evident in six of six service plans that were reviewed. These have been completed using the interRAI system. In addition updates on interim care plans and in progress notes reflect the degree of achievement or response to support or intervention.

There are well written individualised activity goals under a range of headings and there are monthly reviews/summaries of activities for each individual. However not all of the goals in the activities plans reflect current abilities. Similarly there is no evidence that although review summaries of activities are occurring, there is no review or evaluation of the well written activities goals, and this is an area that needs improvement.

**Finding Statement**

Some of the individualised activity goals sighted are no longer realistic for the individual and there is no evidence of evaluation of the documented activities goals.

**Corrective Action Required:**

That activities goals are realistic for each resident according to their current abilities and interests. That the documented activities goals are evaluated alongside the evaluation of other care plan goals and interventions.

**Timeframe:**

Six months

**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

Medicines are stored in a medicine trolley that is held in a medicine room off the entry to the kitchen when it is not in use. A controlled medicines register is held in this room and there is a metal cabinet attached to the wall for their storage. Only one controlled medicine is currently being stored and although it has not been used for some time it is being checked by two staff, one of whom is an enrolled and/or a registered nurse, each week.

The pharmacy provides the medications in blister packaging and these are checked weekly by an enrolled nurse. The enrolled nurse describes her checking process and demonstrates what she does. Any unused medicines are returned to the pharmacy for disposal.

A quality improvement project on the storage, management and administration of medicines has been undertaken and there is evidence of the improvements made as a result of this when talking with staff, checking the records and observing procedures. All staff who administer medicines have a current medication competency and these are recorded with dates of expiry. None of the residents at Adriel Rest Home self-administer any of their medicines, as all have dementia.

The administration of medicines during the mid-day meal is observed and the medicine records of seven residents are reviewed. In addition to using photographs in the front of each medicine record, the staff person administers each person's medicine separately and speaks the name of the resident aloud to enable other staff to hear it and correct her should she go to give the medicine to the wrong person. Checks are made about the consistency of food it is to be administered with and whether or not it can be, or needs to be, crushed. Medicines are not hidden in food and when refused the staff person says they try later, or may try it with a different food such as dessert.

Each medicine is signed and dated separately by the GP and individual medicines, including pro re nata (prn) and short term medicines that have been discontinued are dated and signed. Four of the seven records reviewed show that three monthly reviews are occurring, one is signed off at two months and two are new medicine record sheets. Sample signatures of those administering medicines are recorded at the bottom left hand corner of the administration sheet and there is a separate signature and designation recording sheet for the GPs and the pharmacist. Residents' allergies and sensitivities are recorded on the medicine prescription sheet or it is noted that nil are known.. One person requires oxygen and nebulisers as prescribed and separate record sheets have been developed and are in use to ensure this occurs.

Each of the four areas around medicine management that were identified as requiring improvement at the previous audit have been addressed.

**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

A dietitian has approved a menu framework on which the six weekly rotating winter (April to November) and summer (December to March) menus are based. The dietitian approval letter is dated 2010. The manager informs seasonal and mostly home grown vegetables are used and are the main variations to the approved menu along with community provided items such as preserves.

Other than the need to ensure residents with diabetes have this accommodated, there are not currently any special diets. A person who initially chose vegetarian meals as their preference is now eating meat and chicken meals. A list of food likes and dislikes and of how residents like to have their drinks are in the kitchen, although kitchen staff and support partners state they know the needs of the individual residents. There are residents who require thickened fluids, some who require their meals to be pureed and others require a soft diet. Meal plates with raised edges are used to assist residents who have trouble feeding themselves. The serving of the main midday meal is observed and special needs and food preferences are accommodated.

Fortified drinks were ordered for one resident when she was assessed as being underweight. The care plan details the times these are to be consumed and notes that although she has started eating meat and fish she was previously a vegetarian. High calorie dairy products are provided as part of her diet and a family member interviewed is satisfied that everything possible is being done to try and maintain her weight.

The main meals are prepared by night staff and cooked by the cook the following day. Foods are being stored in a safe manner with older foods brought forward and newer ones stored at the rear. Fridge and freezer temperatures are checked weekly and the temperature of hot proteins taken daily. The kitchen is clean and a staff person informs there are additional cleaning duties in the kitchen that are undertaken at night.

**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

No changes are reported to the current building since the previous audit. There is a current building warrant of fitness valid until October 2013 and a hazardous test certificate through to February 2014.

A previous corrective action (CAR 1.4.3.2) relating to out of range hot water temperatures is addressed, with records for 2013 indicating that follow up action has occurred. Two washbasins recorded temperatures between 47 degrees to 51 degrees from January to March. Remedial actions included replacement of a tempering valve with subsequent readings consistently in the acceptable range to a maximum of 45 degrees Celsius.

**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:**

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

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

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

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

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

An approved evacuation plan is in place and there have been no modifications requiring a revised plan for the building since the previous audit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

Adriel Rest Home caters for residents with advancing dementia requiring a secure environment. These residents are unable to provide informed consent, therefore no enablers are approved or in use in the facility.

**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:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

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

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

A previous corrective action in relation to monitoring and review remains open under this criterion. There is a process for monitoring and reviewing the use of restraints, but signatures are not updated at the time of review. Documentation for all of the three people currently using restraints requires signing by the GP. Family members have yet to sign two of these. There are two restraints documented for one person, however only one of these is currently being used.

**Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:**

(a) The extent of restraint use and any trends;

(b) The organisation's progress in reducing restraint;

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

(g) Whether changes to policy, procedures, or guidelines are required; and

(h) Whether there are additional education or training needs or changes required to existing education.

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

A previous corrective action (Previous CAR 2.2.3.1) in relation to monitoring and review of restraints is not fully addressed. Although there is a system, it is not fully implemented as signatures are not updated at the time of review. Documentation for the three people is only complete for one. Restraints require signing by registered nurses and family members for two residents. One resident does not have restraint included in their interRAI assessment and thus no specific plan is in place and another resident and a third example does not have the type of restraint documented in the plan of care.

**Finding Statement**

There are incomplete reviews for three residents in the facility using restraint. For example:

1. The GP has signed for the continuing use of approved restraint, but the person holding EPOA and the RN have not done so for two of three residents.

2. One resident does not have restraint included in their interRAI assessment.

3. One resident does not have the type of restraint documented in the plan of care.

**Corrective Action Required:**

Undertake and complete a comprehensive review of all aspects restraint.

**Timeframe:**

Six months

**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

Details of the surveillance for infections are in the infection control manual. The documents define systematic surveillance and describe the process the infection control officer uses. There is a list of infections to be included in surveillance records and each of these is defined. They include: skin and wound, respiratory tract, gastro-enteritis, urinary tract and eye infections. Surveillance of infections involves the collation of monthly reports. The infection control monthly reporting record form is used to record the date, type of infection, resident's name, bacteria/organism, signs/symptoms, whether classified as an infection, treatment, antibiotics and date of resolution. The infection rate per 1,000 bed days is calculated and the data is provided to the nurse manager in a separate 'incidence of infection monthly report form'. The manager includes a summary infection control report and an analysis of the infection control data in staff meetings and the three monthly quality meetings.

Two staff interviewed report they are informed about infections at staff meetings and that they are reminded of ways to prevent them. The main infection is reportedly urinary tract infections and staff inform they are constantly reminded of the need to keep fluids up and of the need to wash their hands. The manager informs that infection reports are also provided to, and discussed at, the three monthly quality meetings.

An example of a person for whom a urinary tract infection has been recorded is sighted. A staff person explains that although the course of antibiotics for this infection has been completed and the presenting symptoms have resolved, it is not possible to obtain a urine sample to confirm infection is resolved. Records of the presenting symptoms of the infection are evident as are the doctor's involvement in prescribing antibiotics and his follow-up.

The issue of an infection not being recorded in the surveillance data, which raised a required improvement at the last audit, is no longer evident.

**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:**