**Kaylex Care Limited**

**Current Status:** **27-Aug-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**

An unannounced surveillance audit was conducted on the 27 August 2013. On the day of audit there are 43 residents in the home. Fifteen of these are assessed as requiring rest home level care and 28 residents require dementia level care. There are two separate secure dementia units in the facility. The most significant change to the service since the previous certificate audit is the appointment of a new facility manager and clinical nurse manager.

Of the criteria assessed there are three improvements required. These are related to communication and specifically notifying family about incidents; staff competency in administering medicines; and ensuring that service provision occurs within the required timeframes.

**Audit Summary AS AT** **27-Aug-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 Audit27-Aug-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 Audit27-Aug-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit27-Aug-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 Audit27-Aug-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 Audit27-Aug-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 Audit27-Aug-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** |

Eastcare Residential Home

Kaylex Care Ltd

Surveillance audit - Audit Report

Audit Date: 27-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Kaylex Care Ltd |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Eastcare Residential Home | 194 Nixon Street      |       | Hamilton |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 27-Aug-13 **End Date:** 27-Aug-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 | XXXXXX  | NZRPNBSocSci,DIp MSNZQA 8086 | 8.00 | 4.00 | 27 -Aug-2013 |
| Auditor 1 | XXXXXX | NZRN BHSci, NZQA 8086 | 8.00 | 4.00 | 27 -Aug-2013 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXX | RN, MBA, NZQA US 8086 |       | 2.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 10.00 | **Total Audit Hours** | 26.00 |
| **Staff Records Reviewed** | 5 of 40 | **Client Records Reviewed** *(numeric)* | 2 of 43 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 2 |
| **Staff Interviewed** | 11 of 40 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 2 |
| **Consumers Interviewed** | 2 of 43 | **Number of Medication Records Reviewed** | 12 of 43 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

# Declaration

I, (full name of agent or employee of the company) XXXXXX (occupation) Director of (place) Wellington 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 Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 12 day of September 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Eastcare Residential Home | 49 | 43 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Executive Summary of Audit

General Overview

An unannounced surveillance audit was conducted on the 27 August 2013. On the day of audit there are 43 residents in the home. Fifteen of these are assessed as requiring rest home level care and 28 residents require dementia level care. There are two separate secure dementia units in the facility. The most significant change to the service since the previous certificate audit is the appointment of a new facility manager and clinical nurse manager.

Of the criteria assessed there are three improvements required. These are related to communication and specifically notifying family about incidents; staff competency in administering medicines; and ensuring that service provision occurs within the required timeframes.

1.1 Consumer Rights

There is an open disclosure policy and staff demonstrate an understanding about its requirements. There a lack of evidence that the service notifies the nominated contact person about changes in a resident's condition or incidents that have impacted on them; this requires an improvement.

There have been no known complaint investigations by the office of the Health and Disability Commissioner since the previous certification audit in 2012. The service is recording all complaints received. There is sufficient detail documented about the investigation into these and evidence that they are resolved quickly at the lowest level.

1.2 Organisational Management

The quality and risk management system is being maintained. There is regular monitoring of all service areas through internal audits, and monthly collection, collation and analysis of quality data.

Human resources are managed well according to policy and good employer practices. There is evidence that new staff are recruited in ways that ensure their suitability for the position. Orientation to the facility and its policies and procedures, including emergency systems, is provided to all new staff by senior management and 'on the floor' staff. Staff training is planned and co-ordinated by an allocated registered nurse educator who is employed part time. Education is planned to ensure that staff receive relevant and timely training on subjects related to older people. Training occurs at monthly in-service sessions, and through self-directed learning and presentations by external experts. Staff competency assessments and performance appraisals occur regularly.

There are sufficient numbers of care staff and auxiliary staff allocated on all shifts, seven days a week to meet the needs of residents who are assessed as requiring both dementia and rest home level care. There are registered nurses (RNs) on site Monday to Friday and available on call 24 hours a day seven days a week.

1.3 Continuum of Service Delivery

Eastcare Residential Home employs a clinical nurse manager who oversees all assessments, planning and evaluation of service delivery with support from the GP and other service providers. There is an improvement required relating to the initial nursing assessment, long term care plans and care plan evaluations being completed and reviewed within the required time frames.

There are three activities co-ordinators who are employed Monday to Friday to provide activities for residents and activity plans for each of the three areas (one rest home and two dementia wings) and evidence is seen of related resident and family consultation. Residents and family interviewed report they are involved and enjoy the activities provided.

Medication management systems comply with current legislation and all caregivers involved in medicine management receive training and competency assessment annually. However, there is an improvement required relating to a medication error by an enrolled nurse who had not completed her practical medication assessment as part of orientation, and prior to commencing medication management.

 Eastcare Residential Home uses a four weekly seasonal menu cycle approved by a dietitian. Initial dietary assessments identify special dietary requirements. There is food and snacks available 24 hours a day for residents with dementia. All food and safety standards are met.

1.4 Safe and Appropriate Environment

There is a current building warrant of fitness. There have been no significant changes to the building, plant or equipment since the previous audit and these are being well maintained. There is evidence of new furniture and soft furnishings being installed.

2 Restraint Minimisation and Safe Practice

There are no residents who require physical restraint or enablers. There are clear policies and procedures in place if physical restraint or enablers are required. The definition of an enabler is congruent with the standards Staff education on restraint minimisation is provided during orientation/induction and regularly as part of the in-service education programme.

3. Infection Prevention and Control

Eastcare Residential Home has identified processes for surveillance of infections. Documentation is sighted of completed forms by clinical staff of infections which are collated and graphed by the manager. The facility is benchmarked against the other five facilities in the group.

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 | PA Low | 0 | 1 | 1 | 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: 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: 0Criteria (of 48): CI:0 FA:3 PA:1 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 | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:17 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **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 | PA Low | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 1 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 2 | 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 | PA Low | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 4 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: 0Criteria (of 51): CI:0 FA:12 PA:2 UA:0 NA: 3 |

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

1. Restraint Minimisation and Safe Practice

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **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: 0Criteria (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 | 3 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 1 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 1 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 2 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 7 |

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| **Total Standards (of 50) N/A:** 34 **CI:** 0 **FA:** 13 **PA Neg:** 0 **PA Low:** 3 **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:** 3 **UA:** 0 **N/A:** 10 |

# Corrective Action Requests (CAR) Report

Provider Name: Kaylex Care Ltd

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:27-Aug-13 End Date: 27-Aug-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.9 | 1.1.9.1 | PAModerate | **Finding:**There is a lack of evidence that the residents' nominated person is being advised about incidents or changes in the residents' condition.**Action:**Ensure families are advised and updated about issues that impact on residents and document when this occurs. | Three months |
| 1.3.3 | 1.3.3.3 | PALow | **Finding:**In four of the six files reviewed(two rest home and four dementia) the documentation is not completed in a timely manner for assessment, evaluation and clinical risk plans. There is insufficient evidence to ensure each stage of service provision is completed within required timeframes.**Action:**Ensure all documentation is completed as required to ensure assessment, evaluation and clinical risk plans are up to date. | 6months |
| 1.3.12 | 1.3.12.3 | PAModerate | **Finding:**Two enrolled nurses commenced employment the week prior to the audit. There is evidence they both have completed induction and the theory part of medicines competency but the last stage of competency, the observation of practice did not occur before they began administering medicines. There is an incident this week where one of the ENs administered another resident's medicine to a resident with a similar. **Action:**Ensure that only staff who are fully assessed as competent to administer medicines, do so. | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Kaylex Care Ltd

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:27-Aug-13 End Date: 27-Aug-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXX

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

**STANDARD 1.1.9 Communication**

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

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

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

There is policy on open disclosure and although staff demonstrate an understanding that the residents nominated person will be notified about incidents or changes in the resident's condition, there is a lack of evidence that this is occurring. Three of the six residents' records sampled do not reliably document incidents in the incident summary form and the majority of incident records document that no one is notified. An interview with the family member of a recently admitted resident reveals that staff are not initiating communication and providing information about all events, changes in treatment or changes in the resident's condition.

There is a policy about interpreters and staff know where and when to access interpreter services but there are currently no residents who require this.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

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

There is a lack of evidence that the resident's nominated person is being advised about incidents or changes in the resident's condition. Three of the six residents' records sampled do not reliably document incidents in the incident summary form and the majority of incident records sighted document that no one is notified. One of the records sampled contains evidence in the progress notes that the family were notified when an X-ray confirmed the resident had a fracture, but the actual incident the day before was not notified. An interview with the family member of a recently admitted resident reveals that staff are not initiating communication and providing information about all events, changes in treatment or changes in the resident's condition.

**Finding Statement**

There is a lack of evidence that the residents' nominated person is being advised about incidents or changes in the residents' condition.

**Corrective Action Required:**

Ensure families are advised and updated about issues that impact on residents and document when this occurs.

**Timeframe:**

Three months

**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

There are no known complaints to the Office of the Health and Disability Commissioner since the previous certification audit. The service has received eight complaints since March 2012. The complaints register records the date received, what it is about and who and how the matter is resolved. One of the eight complaints is of significance. This relates to the quality and extent of information provided to the emergency department at Waikato Hospital, about residents who were transferred by ambulance for assessment. There is evidence the manager investigated the complaint, reviewed what had been provided and responded to the allegation within a reasonable timeframe (confirmed by review of the complaint file and interview with the facility manager). It appears the service provided what it could in terms of written and verbal information.

Staff are provided instruction on the complaints procedure at orientation (confirmed by review of the orientation records of two enrolled nurses (ENs) recently employed). Two residents and two family members interviewed confirm they are informed about how to make a complaint.

As per the requirement in ARC D13.3h, the complaints procedure is included in the admission agreement.

**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 service has a clearly defined scope, direction and goals which is documented in the service marketing literature and the 2013 business and quality improvement plan. Systems and methods for monitoring and reporting organisational performance are implemented and monitored.

Interview with the facility manager and the clinical nurse manager confirms ongoing professional development. The facility manager has been in the role since February 2013 and the clinical nurse manager since July 2012. Both attend regular nursing/clinical education and study days in subjects related to care of older people and in relation to managing a care facility. The clinical nurse manager has completed training in interRAI and attends local provider forums.

The requirements of the Age Related Residential Care Contract A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; 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 evidence that the quality and risk management system is integrated with service delivery, that it reflects continuous quality improvement and that staff understand their role in it. This was a previous area of continuous improvement and although the service is maintaining a robust quality system there has been no additional or new approaches that have significantly impacted on service delivery or consumer care.

The service uses a standardized quality system of policies and processes (the Jelica system) and the systems moderator/external consultant notifies the service when policy changes occur. Review of a sample of policies and forms confirms that these are current and modified as required in a controlled and informed way across the group.

Quality monitoring includes regular checks and audits of service delivery, and the collection, reporting and benchmarking of quality data. The facility manager reviews and collates all reported incidents and accidents, medicine errors and infections. This information is discussed at weekly management meetings, and trends are presented to the quality and risk committee. Each month the quality data is sent, along with an overall managers report to the business owners who analyse and benchmark the data against the two other facilities owned by them (confirmed by telephone interview with the business owner, interview with the facility manager and review of the quality data). The most significant area of concern revealed by benchmarking is the number of falls in the secure units. There is a quality improvement action plan in place to reduce the number of falls. So far the service has implemented a number of interventions, such as increased staffing, improved lighting and resident footwear, purchase of more sensor mats and a new trial of motion sensors when sensor mats are not effective, and the purchase of more hi/low beds. There is evidence that these interventions have significantly reduced the rate of falls for one resident who's care is included in the sample of records reviewed.

There is evidence that care staff are kept informed about trends, changes in policy or procedure and quality improvements at bi-monthly staff meetings or via the communications book (confirmed by the review of records from staff meetings which have occurred from November 2012 to July 2013).

All other areas requiring improvement as identified from incident/accidents, complaints, consumer feedback or outcomes from internal audits, are documented on quality improvement action plans for tracking and monitoring by the facility manager. There is evidence that actions are implemented (confirmed by review of current quality improvement action plans, interview with the facility manager and the education co ordinator and/or visual inspection of physical improvements (e.g. there is new furniture purchased following negative feedback from relatives)).

Business and service delivery risks are managed by ensuring staff understand and adhere to health and safety procedures. The clinical nurse manager is the designated health and safety officer. This person is part of the management team, sits on the quality and risk committee and reports health and safety matters at staff meetings. Staff orientation/induction and the education programme includes information on health and safety (this is confirmed by review of two new enrolled nurse orientation records).

All newly identified hazards are reported and added to the hazard register (sighted). Environmental audits for safety are conducted regularly and reactive facility maintenance occurs. Chemical safety data sheets, which identify hazardous chemicals, are available where chemicals are stored. Six residents' files demonstrate that clinical risks are identified in the service delivery plans, that informed consent has been obtained and that there is multidisciplinary team input.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

Review of the accident/incident reporting system and a sample of incident reports for 2013 demonstrate a process that records incidents, documents any investigation of the incident and makes recommendations to prevent recurrence. There are 77 reported incidents and accidents to date for 2013. The majority of these are resident falls in the secure wings (see evidence in standard 1.2.3). The facility manager receives and collates all incidents according to the type of incident, the time it occurred and where it occurred (eg in which wing, so a differentiation can occur between dementia and rest home level care). Staff state that incidents and accidents are reported and discussed at shift handover, and that there is a summary of incidents in each resident's file. In three of the six records sampled these incident summary reports are not updated (there are corrective actions related to this in standards 1.1.9 and 1.3.3). Incident and accident trend data is shared with staff by displaying the data in the staff room and discussing this at bi-monthly staff meetings as confirmed by interview with three health care assistants and review of a sample of staff meeting minutes from November 2012 to July 2013.

There are 16 medicine errors reported since January 2013, the majority of which are the discovery of discarded tablets in both secure units, and one incident of the wrong person being administered another person's medicine due to both residents having similar names and the staff administering being new to the service (refer to standard 1.3.12).

The owners and the facility manager are responsible for essential notification and reporting and they are conversant with the statutory and regulatory obligations. There have been no serious or sentinel events which required notification since the previous certification audit.

There is a requirement in standard 1.1.9 to provide more evidence that consumers and/or family/whanau are reliably notified about adverse events. (confirmed by review of incident/accident records and sample of family notification records and interview with one relative).

The service meets the requirements of ARC D19.3a.vi.; D19.3b; D19.3c.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Human resources are well managed. There is evidence that new staff recruitment is according to good employment practices (confirmed by interview with the owner and the RN and review of two recently employed enrolled nurses' files).

The suitability of prospective staff is assessed by the facility manager and the clinical nurse manager, contacting referees and carrying out police checks before confirming an employment agreement. The service has a policy that people with a criminal record will not be employed and staff have been performance managed recently for not revealing criminal convictions. Individual employment agreements include a trial 90 day period. Each role has a job description. There is evidence the three RNs and two enrolled nurses have current practising certificate (sighted in personnel records and confirmed by interviews).

There is a strong ethos of facilitating safe and effective practice by a commitment to regular and thorough staff training. The organisation employs an RN education co-ordinator for 16 hours a week. Staff complete education that is related to the care of older people as per the requirements of ARC 17.6 and 17.8. All care staff and the activities staff maintain first aid certificate and competency in medicines administration. All care staff are expected to enrol in and complete the National Certificate in Health, Disability and Age Care including the NZQA unit standards in dementia care. There are identified compulsory topics that must be attended at least annually, such as fire drill evacuations, manual handling, medicines, civil defence and emergency preparedness. Fire drills occur in June and December.

There is a recent focus on performance managing staff who do not attend regular training (confirmed by interview with the facility manager, the nurse education co-ordinator and three health care assistants who state staff lose their jobs if they do not attend training). Training provided this year includes four different sessions on restraint and managing challenging behaviour following an incident in June (refer standard 2.1.1), falls prevention and manual handling, infection prevention and control including wound management, hand washing, urinary incontinence and taking specimens, managing multi-resistant organisms, palliative care, abuse and neglect, cultural safety, privacy, resuscitation, chemical safety and there is a session on catheter management and infection control scheduled to occur.

A service general practitioner and the RN are available 24 hours a day seven days a week for advice and support. On-going staff performance appraisals occur annually as required in ARC 17.7. All staff have engaged in a performance review this year as confirmed by interview with the facility manager, and review of personnel records.

**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

Rosters sighted and interview with staff and the facility manager confirm there is an appropriate numbers of skilled and experienced staff on all shifts for the current number of residents (eg, 28 dementia and 14 rest home level care residents) and to meet the minimum requirements of ARC D17.1 and D17.3 (a-g) and E4.5 (a-b).

The RN facility manager is on site Monday to Friday 7am to 3pm, the clinical nurse manager 8am to 4pm and the RN education co-ordinator works 8am-4pm Monday and Tuesday. The RN managers are rostered on call after hours. Two healthcare assistants are rostered on in each of the dementia units 7am to 2.30 or 3.3.00pm and from 3pm-11pm. There is one healthcare assistant allocated to rest home residents each morning and afternoon shift. There are three healthcare assistants on night shift from 10.45 pm to 7am and one other from 12 to 8am who covers each area.

There is an activities co-ordinator working in each of the three wings Monday to Friday from 9am to 1pm with the overall co-ordinator working 9am to 5pm. Rosters and staff interviews demonstrate that auxiliary staff (eg, cooks, cleaners and laundry staff) are allocated sufficient hours to complete their duties. A maintenance person and gardener are also employed.

Only care staff who have completed, or are in the process of completing qualifications in dementia care, are rostered to work in the dementia units (confirmed by sighting a list of all care staff with dates they have completed NZQA unit standards 23920-23923).

Staff interviewed (the facility manager, three activities co-ordinators and three health care assistants) stated there is an appropriate number of care staff on site and that more caregivers are called in when required. Two residents and two relatives interviewed, said they perceive there are enough staff on all shifts.

**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:** PA Low

Service delivery is overseen by the clinical nurse manager (CNM). The CNM reported at interview that the two enrolled nurses (EN) employed are being orientated to assist with documentation and care plans under the supervision of the CNM.

In four of the six files reviewed (two rest home and four dementia) there is no evidence of initial assessment, care plans being completed and clinical risk tools being reviewed within the required timeframes. This includes in two dementia files the initial assessments are not completed including the family input and this does not ensure the residents assessments are accurate. The evaluation in two rest home file is not completed in the six month timeframe and the residents have had no input to ensure their assessments and goals are still relevant. There is an area for improvement relating to ensuring each stage of service provision documentation is completed within required timeframes.

There is use of relevant assessment tools, which include falls risk, skin integrity, continence and behaviour management. The CNM and the Education Coordinator (RN) report there is a process for six monthly multidisciplinary resident reviews. The family /whanau are sent a copy of the outcome of the meeting (which includes GP, RN, Occupation Therapist (OT) and Activities Coordinator). The family/whanau is given the opportunity to organise a meeting with the CNM or doctor if they choose. The families/whanau are asked to sign the letter and return if no meeting is required.

Handover at the beginning of each shift is undertaken in the CNM office for privacy. The GP visits weekly or at other times if required. The six clinical staff interviewed report that they are given information concerning service delivery at handover and any other time if there is a change in service delivery requirements. Evidence is seen of visits from the Mental Health Service for the Older Person (MHSOP) and the dietitian from the Waikato District Health Board

Tracer Methodology Rest Home

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

Tracer Methodology Dementia Unit

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

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

In four of the six files reviewed( two rest home and four dementia) the documentation is not completed in a timely manner for assessment, evaluation and clinical risk plans. There is insufficient evidence to ensure each stage of service provision is completed within required timeframes. This includes in two dementia files the initial assessments are not completed including the family input and this does not ensure the residents assessments are accurate. The evaluation in two rest home file is not completed in the six month timeframe and the residents have had no input to ensure their assessments and goals are still relevant.

**Finding Statement**

In four of the six files reviewed(two rest home and four dementia) the documentation is not completed in a timely manner for assessment, evaluation and clinical risk plans. There is insufficient evidence to ensure each stage of service provision is completed within required timeframes.

**Corrective Action Required:**

Ensure all documentation is completed as required to ensure assessment, evaluation and clinical risk plans are up to date.

**Timeframe:**

6months

**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

In four of the six files reviewed( two rest home and four dementia) there is not documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are assessed at required timeframes to ensure residents' desired outcomes are being met (refer criterion 1.3.3.3).This includes the rest home resident who had a severe chest infection with acute shortness of breath and was seen by the doctor who prescribed antibiotics and a nebuliser. There was no short term care plan during this time of acute chest infection.

The six clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education if required. Evidence is seen of one resident and one of his pastimes is to feed the birds. The staff report they ensure that there is bird food available on his window ledge. The two relatives spoken to express satisfaction with the service their family/whanau member is receiving.

 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

There are three activities coordinators employed at Eastcare Residential Home to provide activities for all residents. The senior activities coordinator works full time and has worked at the facility for four months but has eight years’ experience in the field. The two part time activity coordinators have worked for five years at the facility.

The planned activities reflect ordinary patterns of life as much as possible. The monthly activity plan does take into consideration the assessed needs of rest home and dementia level residents. The four residents interviews report the activities are positive and include walking, men’s' group and puzzles.

The two part time activity coordinators report there is equipment available for care staff when they are not on duty and in the weekend. Evidence of minutes from the two monthly residents' meetings are sighted where activities are discussed. There is focus on both bringing the community to the facility and external visits.

All ARC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

In four of the six files reviewed evidence is not seen of documentation if an event occurs that is different from expected and requires changes to service delivery (refer criteria 1.3.3.3). Long-term care plans are not reviewed every six months or earlier as required. Evidence of this was not sighted in four of the six files reviewed. The six monthly reviews of two dementia residents are not completed. One of the two residents documentation that was not reviewed showed the resident was requiring assistance with feeding and had weight loss. There was no evidence of this on the resident’s documentation. Progress notes are signed once every duty by the caregivers. Evidence is seen of the family/whanau involvement in the care reviews and the two relatives report they are consulted regarding care reviews. The four residents and two relatives interviewed report they are involved in their, or their relatives, care and the six clinical staff interviewed have knowledge of the care plan documentation requirements.

All ARC contracts 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:** PA Low

Eastcare Residential Home uses the robotic medicine system whereby medicines are delivered fortnightly. These are checked individually on arrival and before being given to the resident. There are controlled drugs on the premises on the day of the audit. There are systems in place when these are required.

There is evidence in all twelve medication charts reviewed of three monthly reviews by the GP. Evidence is seen of this process overseen by the CNM.

There are individual standing orders in place at this facility which are signed by the GP and reviewed annually.

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The GP reported that he works with the pharmacy but he is responsible for all medicines administered to his residents. The facility has recently introduced the use of a new insulin administering system to ensure compliance with 'no recapping' of needles.

The CNM and qualified caregivers responsible for medicine management have an annual competency review prior to administering medicines. Evidence of this is seen in five staff files reviewed. Two enrolled nurses commenced employment the week prior to the audit week. There is evidence that the last stage of their medication competency has not been completed. There is an incident this week where one of the ENs administered another residents' medications to a resident with a similar name. There is an area for improvement to ensure all staff are assessed as fully competent to administer medicines prior to them doing so. The caregiver was observed during the lunchtime medicines round and correct procedures were followed. The gerontology nurse specialist for the WDHB also gives in-service education relating to safe medication procedures in aged care.

A self-administration of medicines policy, including a form to be signed by the GP is available. Medicine sheets are signed in ink as required following administration. All four rest home residents spoken with report the GP discusses their medicine requirements with them.

ARC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

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

Two enrolled nurses commenced employment the week prior to the audit. There is evidence that they have both completed induction and the theory part of medicines competency but the last stage of competency, the observation of practice did not occur before they began administering medicines. There is an incident this week where one of the ENs administered another resident's medicine to a resident with a similar.

**Finding Statement**

Two enrolled nurses commenced employment the week prior to the audit. There is evidence they both have completed induction and the theory part of medicines competency but the last stage of competency, the observation of practice did not occur before they began administering medicines. There is an incident this week where one of the ENs administered another resident's medicine to a resident with a similar.

**Corrective Action Required:**

Ensure that only staff who are fully assessed as competent to administer medicines, do so.

**Timeframe:**

3 months

**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 seasonal menu is appropriate and varied. Evidence is seen of the summer and winter menu being reviewed two yearly by an approved dietitian. An individual dietary assessment is completed on admission which identifies individual needs and preferences. This is carried out in consultation with the family/ whanau as required.

Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.

All aspects of food requirements are within legislative requirements. Evidence is seen of completed cleaning schedules and there is adequate supplies for emergency requirements. A bain marie is used to transport meals to the dementia wings. Evidence is seen of temperature checking of fridges, freezers and meals. Food Safety Certificates are up to date for all kitchen staff (evidence sighted in four staff files reviewed).

Resident surveys sighted support the meals are satisfactory and individual needs are recognised.

All ARC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

There is a current Building Warrant of Fitness which expires on 7 November 2013. There is evidence the building, plant and equipment is being well maintained by maintenance staff and/or contractors. Inspection of all areas inside and outside the facility reveal no areas of non-compliance. The organisation has identified the need to modify and heighten the exterior fences surrounding the secure wings following an incident where a new resident scaled the fence and left the premises and another resident was seen to be attempting the same.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The service has no restraint or enablers in use at the time of this audit and it has always taken the approach of using alternatives to restraint. This is made clear in the organisation's restraint minimisation and safe practice policies and associated procedures. The policy meets the required Health and Disability Service Standards and identifies how NZS 8134.2.2 is met if restraint is required. The definition of an enabler is congruent with the definition in NZS 8134.0.

There was an incident on 18 June 2013 where a resident was observed to be trying to climb the external fence. The resident was very agitated and required two staff to sit beside and hold him for a period of time. Review of the incident by management resulted in further investigation about the length of time the holds were in place. The staff involved attended a review and education session about the incident on 24 June with the owner and the facility manager (confirmed by review of the incident, interview with the facility manager and the education co-ordinator). The discussions identified alternate strategies that could have been tried at the time. All staff are expected to attend at least one education session on restraint and management of challenging behaviour and use of de-escalation each year. There is evidence this has occurred in February, April and May 2013 as well as the June session. All new staff are provided with information about the restraint policy, philosophy and approach during their orientation.

**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

There are definitions of infection and a template form for the reporting and analysis of infections. Evidence is seen of staff involved at meetings and handover, of notification of infections. A corrective action was undertaken in July as the incidence of lower respiratory infections was high. Evidence is seen of education and reduction the next month. The manager on interview reports she implements corrective actions on any issues that are of concern as a result of surveillance data.

An annual summary of the number and type of infections per month is maintained and sighted for the 2012. A register is kept of all residents who develop infections, the type of infections, results of cultures (where obtained) and details of treatment provided. The register notes whether further follow-up is required. One resident is noted to have repeated xxxxxxx infections secondary to underlying health conditions.

**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:**