

Papatoetoe Residential Care Limited

CURRENT STATUS: 17-Sep-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 17 September 2013. On the day of audit there are 25 residents in the home, all are assessed as requiring hospital level care.

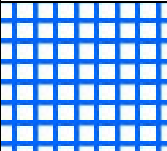
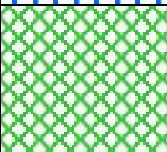


The most significant change to the service since the previous certificate audit are improvements to the physical environment. There is new carpet throughout the facility, a new enlarged dining room is installed and the internal reception and management offices have been reconfigured.

Of the criteria assessed there are two improvements required. These are related to the validity of residents' advance directives and maintaining the complaints register. There is evidence of improvements regarding the management of policies and procedures, which was required at the previous audit.

AUDIT SUMMARY AS AT 17-SEP-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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

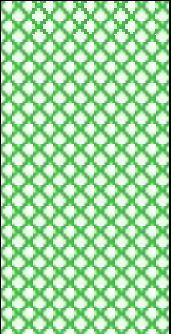
Consumer Rights	Day of Audit 17-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk

Organisational Management	Day of Audit 17-Sep-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

Continuum of Service Delivery	Day of Audit 17-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained

Safe and Appropriate Environment	Day of Audit 17-Sep-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

Restraint Minimisation and Safe Practice	Day of Audit 17-Sep-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

Infection Prevention and Control	Day of Audit 17-Sep-13	Assessment
<p>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.</p>		<p>Standards applicable to this service fully attained</p>

Papatoetoe Residential Care

Papatoetoe Residential Care Ltd

Surveillance audit - Audit Report

Audit Date: 17-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Papatoetoe Residential Care Ltd
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Premise Name	Street Address	Suburb	City
Papatoetoe Residential Care Ltd	3 Fairview Road	Papatoetoe	Auckland

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

Type of Audit	Surveillance audit and (if applicable)	
Date(s) of Audit	Start Date: 17-Sep-13	End Date: 17-Sep-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	NZRPN NZQA8086 Dip Mgment BSocSci	8.00	4.00	17-Sept-13
Auditor 1	XXXXXXXX	RN, RM, PG Dip HSM & PG Cert in Neuro-surgical nursing & NZQA 8086	8.00	4.00	17-Sept-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 <i>(system generated)</i>	10.00	Total Audit Hours	26.00
Staff Records Reviewed	3 of 31	Client Records Reviewed <i>(numeric)</i>	5 of 25	Number of Client Records Reviewed using Tracer Methodology	1 of 5

Staff Interviewed	9 of 31	Management Interviewed <i>(numeric)</i>	2 of 2	Relatives Interviewed <i>(numeric)</i>	1
Consumers Interviewed	5 of 25	Number of Medication Records Reviewed	10 of 25	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	1

Declaration

I, (full name of agent or employee of the company) XXXXXXXX (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 of The 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 10 day of October 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*):

Executive Summary of Audit

General Overview

An unannounced surveillance audit was conducted on the 17 September 2013. On the day of audit there are 25 residents in the home, all are assessed as requiring hospital level care.

The most significant change to the service since the previous certificate audit are improvements to the physical environment. There is new carpet throughout the facility, a new enlarged dining room is installed and the internal reception and management offices have been reconfigured.

Of the criteria assessed there are two improvements required. These are related to the validity of residents' advance directives and maintaining the complaints register. There is evidence of improvements regarding the management of policies and procedures, which was required at the previous audit.

1.1 Consumer Rights

Staff demonstrate knowledge and understanding about the principles of open disclosure which are defined in policy. Staff training in open disclosure occurred recently. The service notifies the nominated contact person about changes in a resident's condition or incidents that have impacted on them.

One of the resident's records reviewed does not contain clear and sufficient evidence that the person was competent to request a not for resuscitation order as an advance directive and this requires improvement.

Resident and their families and staff are informed about the complaints management process. There have been two complaints received this year which have been investigated and managed well to resolution. Although there is information about both complaints in staff meeting records and in the quality reports, only one of the complaints received is entered in the complaints register. There is an improvement required related to maintaining an up to date register. There have been no known complaint investigations by the office of the Health and Disability Commissioner since the previous certification audit in March 2012.

1.2 Organisational Management

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. A quality and risk management system is being maintained and there is regular monitoring of all service areas through internal audits and monthly collection, collation and analysis of quality data. The organisation benchmarks its infection data against 24 other facilities.

Human resources are managed well according to policy and good employer practices. There is a very low staff turnover. Of the three staff employed in the past 18 months, there is evidence that new staff are recruited in ways that ensure their suitability for the position and that orientation occurs. Staff training is planned and co-ordinated to ensure that all staff receive relevant and timely training on subjects related to older people. Training occurs at monthly in-service education sessions which is delivered primarily by external educators. 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 hospital level care. There is at least one registered nurse (RN) on site, and another available on call, 24 hours a day seven days a week.

1.3 Continuum of Service Delivery

The residents' records reviewed provide evidence that all residents have been assessed appropriately prior to admission to this facility by the needs assessment service co-ordinators for Counties Manakau District Health Board. The provider has well implemented systems to assess, plan and evaluate the

care needs of the residents. The residents` needs, outcomes and/or goals have been identified in the interRAI assessments and subsequent care plans and these are reviewed six monthly or more often as required. A team approach to care delivery and continuity of service delivery is encouraged.

Medication management is safely implemented. A visual inspection of the medication systems and the lunchtime medication round evidences compliance with respective legislative requirements, regulations and guidelines. The revised Ministry of Health Medication Guidelines 2013 are available. There is evidence of the three monthly medication reviews being completed by the general practitioners. These reviews are completed more frequently if required. The contracted pharmacist audits the medication records. The robotic medication system is utilised.

Food services are managed effectively. Nutritional guidelines and advice is available which is appropriate for this service setting. The service is managed by an experienced kitchen manager. The menu plans have been reviewed by a contracted dietitian and are suitable for the elderly and/or disabled residents. The menus are clearly documented and displayed daily. The individual dietary needs are identified during the assessment process for each resident and choices are provided. Meals are provided at appropriate times of the day.

An activities programme is provided and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are planned that are meaningful and the programme is developed and implemented to ensure the interests of residents are included. Community outings are arranged and entertainers are invited to participate in the programme.

1.4 Safe and Appropriate Environment

There is a current building warrant of fitness. There have been significant upgrades and changes to the building and internal environment since the previous audit.

2 Restraint Minimisation and Safe Practice

On the day of audit, there are no residents who require physical restraint and one resident who continues to request and use enablers for safety and mobilisation. Staff demonstrate knowledge and understanding about the requirements of this standard and there is evidence they adhere to the organisation's restraint policies and procedures. 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

Papatoetoe Residential Care has infection prevention and control policies and procedures relevant to the level of care provided. The clinical nurse leader is the infection control co-ordinator and oversees all areas of the infection prevention and control programme which is integrated into the quality and risk management system. A contracted infection control consultancy service provides expertise in the way of advice, policies and procedures which are reviewed two yearly. Training is provided to all staff at orientation and is ongoing. Outbreak management and the surveillance programme is well managed. The service is committed and involved with benchmarking against other like services to continually improve the infection prevention and control management programme for this service.

Summary of Attainment

1.1 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 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	Not Applicable	0	0	0	0	0	2
Standard 1.1.7	Discrimination	Not Applicable	0	0	0	0	0	5
Standard 1.1.8	Good practice	Not Applicable	0	0	0	0	0	1
Standard 1.1.9	Communication	FA	0	2	0	0	0	4
Standard 1.1.10	Informed consent	PA Low	0	0	1	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	PA Low	0	1	1	0	0	3

Consumer Rights Standards (of 12):	N/A:9	CI:0	FA: 1	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 48):	CI:0	FA:3	PA:2	UA:0	NA: 0			

1.2 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 1.2.7	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

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

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	Not Applicable	0	0	0	0	0	5
Standard 1.3.2	Declining referral/entry to services	Not Applicable	0	0	0	0	0	2
Standard 1.3.3	Service provision requirements	FA	0	3	0	0	0	6
Standard 1.3.4	Assessment	Not Applicable	0	0	0	0	0	5
Standard 1.3.5	Planning	Not Applicable	0	0	0	0	0	5
Standard 1.3.6	Service delivery / interventions	FA	0	1	0	0	0	5
Standard 1.3.7	Planned activities	FA	0	1	0	0	0	3
Standard 1.3.8	Evaluation	FA	0	2	0	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	Not Applicable	0	0	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	Not Applicable	0	0	0	0	0	2
Standard 1.3.12	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

Continuum of Service Delivery Standards (of 12):	N/A:6	CI:0	FA: 6	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:14	PA:0	UA:0	NA: 0		

1.4 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	FA	0	5	0	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating	Not Applicable	0	0	0	0	0	3

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:8	PA:0	UA:0	NA: 0			

2 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

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

3 Infection Prevention and Control

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

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			

Total Standards (of 50)	N/A: 32	CI: 0	FA: 16	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					
Total Criteria (of 219)	CI: 0	FA: 45	PA: 2	UA: 0	N/A: 0				

Corrective Action Requests (CAR) Report

Provider Name: Papatoetoe Residential Care Ltd
 Type of Audit: Surveillance audit

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

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.1.10	1.1.10.7	PA Moderate	<p>Finding: Two of the five residents' records sampled contain advance directives for not for resuscitation. Although staff state the resident is competent and that the general practitioner witnessed the consent, one of the records does not make clear that the resident is competent nor is the record dated.</p> <p>Action: Ensure that all residents' advance directives (for not for resuscitation) are validated by a registered medical professional confirming the resident's competency to make the decision.</p>	Three months
1.1.13	1.1.13.3	PA Low	<p>Finding: Only one of the two complaints received is logged in the complaints register.</p> <p>Action: Ensure the complaints register is kept up to date with all complaints received.</p>	Six months

Continuous Improvement (CI) Report

Provider Name: Papatoetoe Residential Care Ltd

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:17-Sep-13 End Date: 17-Sep-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 1.1.9 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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is policy on open disclosure. Review of adverse event forms and staff interviews, demonstrate an understanding that the resident's nominated person is notified about incidents or changes in the resident's condition. Residents families are asked whether they want to be notified and for what reasons and this is documented in the resident's file (this is confirmed by review of five residents' records and interview with one family member).

The service has used the Counties Manukau District Health Board (CMDHB) interpreter services.

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 1.1.10 Informed Consent

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

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 a required improvement in criterion 1.1.10.7 related to advance directives. Two of the five residents' records sampled contain advance directives for not for resuscitation. Although staff state the resident is competent and that the general practitioner witnessed the consent, one of the records does not make clear that the resident is competent nor is the record dated.

Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Two of the five residents' records sampled contain advance directives for not for resuscitation. Although staff state the resident is competent and that the general practitioner witnessed the consent, one of the records does not make clear that the resident is competent nor is the record dated.

Finding Statement

Two of the five residents' records sampled contain advance directives for not for resuscitation. Although staff state the resident is competent and that the general practitioner witnessed the consent, one of the records does not make clear that the resident is competent nor is the record dated.

Corrective Action Required:

Ensure that all residents' advance directives (for not for resuscitation) are validated by a registered medical professional confirming the resident's competency to make the decision.

Timeframe:

Three months

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: PA Low
<p>There are no known complaints to the Office of the Health and Disability Commissioner since the previous certification audit. The service has received two complaints since March 2012. The complaints register only contains details about one of the complaints. This includes the date received, what it is about and who and how the matter is resolved. There is a required for improvement related to this in criterion 1.1.13.3.</p> <p>Staff are provided with instruction on the complaints procedure at orientation (confirmed by review of the orientation records of two recently employed staff). Five residents and one family member interviewed confirm they are informed about how to make a complaint.</p> <p>As per the requirement in ARC D13.3h, the complaints procedure is included in the admission agreement.</p>	

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: PA	Risk level for PA/UA: Low
<p>There have been two complaints from residents received since March 2012. Although these are reported in the management meeting minutes and both the executive director and the nurse manager interviewed provided details about each complaint, only one complaint is logged in the register. This was amended on the day of the audit.</p>		
Finding Statement		
<p>Only one of the two complaints received is logged in the complaints register.</p>		

Corrective Action Required:

Ensure the complaints register is kept up to date with all complaints received.

Timeframe:

Six months

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.

The nurse manager attends ongoing professional development (this is confirmed by review of education records and interview). The nurse manager has been in the role since 1996 and the clinical nurse leader since 2010. 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. Three RNs, including the clinical nurse leader, have completed training in interRAI.

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
<p>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 relation to it. The previous area requiring improvement related to review and update of policies is resolved. The service has reviewed all its policies since the previous audit and confirm these are current and reflect known best safe practice (this is confirmed by interview with the executive director and nurse manager and review of a sample of policies).</p> <p>Quality monitoring includes regular checks and audits of service delivery, and the collection, reporting and benchmarking of quality data. The nurse manager reviews and collates all reported incidents and accidents, medicine errors and infections. This information and trends are presented and discussed at monthly management meetings and staff meetings (confirmed by a review of a sample of management and staff meeting minutes for 2012 to 2013). Infection data is submitted for external benchmarking against 49 other facilities (this is confirmed by review of data and interview with the nurse manager).</p> <p>There is evidence that care staff are kept informed about trends, changes in policy or procedure and quality improvements at monthly staff meetings or via the daily diary. This is confirmed by the review of records from staff meetings and content of the diary.</p> <p>Any areas requiring improvement as identified from incident/accidents, complaints, consumer feedback or outcomes from internal audits are discussed at management meetings and staff meetings and corrective actions are documented in meeting minutes for tracking and monitoring by the nurse manager</p>	

(confirmed by sample of meeting minutes sighted and observation of a corrective action being implemented on the day of audit). The nurse manager also provides verbal and written reports about improvements required to the executive director as they occur.

Business and service delivery risks are managed by ensuring staff understand and adhere to health and safety procedures. One of the RNs is the designated health and safety officer. This person conducts environmental hazard inspections and ensures reactive facility maintenance occurs. The health and safety person works with the nurse manager in reporting health and safety matters at staff meetings (confirmed by interview with the nurse manager and interview with five care staff).

All newly identified hazards are reported and added to the hazard register (sighted). Five 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
<p>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 on average six reported incidents and accidents each month. The majority of these are resident falls and have been related to one resident who is a 'serial faller'. The nurse manager receives and collates all incidents according to the type of incident, the time it occurred and where it occurred. All resident incidents and accidents are documented in the progress notes of each resident's file and these are reported and discussed at shift handover (this is confirmed by review of five residents' records and interview with two managers and two care staff). Incident and accident trend data is shared with staff at monthly staff meetings as confirmed by interview with two caregivers and review of a sample of staff meeting minutes for 2013. There is one medicine error reported since January 2013.</p> <p>The executive director and the nurse 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.</p>	

There is evidence that consumers and/or family/whanau are reliably notified about adverse events (confirmed by review of incident/accident 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 occurs according to good employment practices (confirmed by interview with the executive director and the nurse manager and review of two newly employed staff files).

The suitability of prospective staff is assessed by the nurse manager, contacting referees and carrying out police checks before confirming an employment agreement. Each role has a job description. There is evidence that all RNs and other allied health staff (general practitioners, podiatrist, dietitian, physiotherapist and pharmacist) have a current practising certificate or maintain their membership with the relevant professional body (sighted in electronic records and confirmed by interview with nurse manager).

The service demonstrates a commitment to providing regular and relevant staff training. 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 are expected to enrol in and complete the National Certificate in Health, Disability and Age Care (or its equivalent) and all care staff have achieved this. All registered nurses and the activities co-ordinator have a current first aid certificate and have been assessed as competent with medicines administration in the previous year as confirmed by review of the database of staff education and interview with one RN, the nurse manager and the administrator who maintains the database. There are identified compulsory topics that must be attended at least annually. These include fire drill evacuations, medicine competency, chemical safety, infection prevention and control and restraint. Fire drills occur in June and December.

Training provided this year includes restraint and managing challenging behaviour, falls prevention, infection prevention and control (an online training) management of incontinence and complaints. There is recent focus on delivering safe and appropriate palliative care and training is provided by hospice. 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. There is evidence that staff non performance is managed effectively (interview with executive director and nurse manager).

All staff have had a performance review this year (confirmed by interview with the nurse manager, review of three personnel records and staff interviews).

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 Mal 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 nurse manager confirm there is an appropriate numbers of skilled and experienced staff on all shifts for the current number of residents and to meet the minimum requirements of ARC D17.1 and D17.3 (a-g).

The nurse manager is on site Monday to Thursday 8am to 4.30pm and shares rostered on call after hours with the clinical nurse leader and another RN. The clinical manager is on site Monday to Friday weekdays 7am to 3.30pm. There is an additional RN available for six hours one day a week to allow the clinical manager time for administration.

Six caregivers are rostered for day shifts (two from 7am to 3.00pm, two from 7am to 2.30 and one 7am to 1pm and one 7am to 11am) and four in the afternoon (one from 3pm-11pm, one from 3pm to 9.30pm, one from 3pm to 9pm and one from 5pm to 8pm).

The activities co-ordinator works Monday to Friday from 8am to 3.30pm. There are no staff employed for laundry duties as laundry is contracted out, including the cleaning of personal clothing.

Rosters and staff interviews demonstrate that auxiliary staff (eg, administration, cooks and cleaners) are allocated sufficient hours to complete their duties. Building maintenance and gardening is contracted out.

Staff interviewed (the clinical nurse leader, activities co-ordinator and five caregivers) stated there is an appropriate number of care staff on site and that more caregivers are called in when required. Five residents and one relative interviewed, said they perceive there are enough staff on all shifts. The family member expressed concern that staff frequently appear to do double shifts. Management state that care staff request and volunteer for extra duties if they are available, but no one works more than 12 hours a shift or 40 hours a week. This is confirmed by interview with five caregivers.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

At Papatoetoe Residential Care the development of the care plan is a partnership process. The registered nurses work collaboratively with the individual resident and the resident's family/whanau, advocate or other health providers to complete the comprehensive care plan. All (five of five) records evidence the NASC service assessments are completed on all residents prior to admission to this service. The initial care plan is developed and within three weeks of admission the long term care plan is developed. Three registered nurses are fully trained for managing the admission, assessment and care planning process on 'interRAI'. Hard copy records are printed off and are visible in the individual resident's records. The plans are evaluated when needs change and no less than once every six month period. Evaluation includes consultation with the resident, the multidisciplinary team, resident's family and/or advocate. Family are invited to attend the care planning update.

Each stage of service delivery is undertaken by qualified and suitably skilled staff. One of the three trained registered nurses conducts the nursing assessment for each individual resident on admission, develops the care plan, evaluates and reviews (with consultation with caregivers, referral information, resident and family/whanau). The GP conducts the medical assessments and reviews the resident's condition. There are three GPs that cover this service. The caregivers provide the majority of the personal care for the residents. There is an appropriate education schedule for staff that covers the essential components of the organisation and service delivery. The annual practising certificates (APCs) are available and sighted for all staff and contracted health professionals, such as the physiotherapist, three GPs, the podiatrist, pharmacist and the dietitian.

The (five of five) residents' records reviewed have routine comprehensive assessments as per the interRAI assessment process identifying all needs for the resident on admission, inclusive of physical, clinical nurse leader and cultural aspects of each resident. The interRAI tool utilises and covers personal care needs, rest and sleep, nutrition, mobility, continence, pain, skin integrity, sexuality, death and dying, family, spirituality and other needs. The clinical nurse leader interviewed has a good knowledge and understanding of this assessment tool. Interventions are documented. The date and registered nurses name is included to verify who has completed the assessment/care planning process. Clinical and non-clinical staff interviewed and the clinical nurse leader interviewed confirm that team work is encouraged and continuity of care is promoted at all times. One general practitioner interviewed visits regularly and covers the after-

hours for this service. The GPs are not involved with interRAI presently. The one family member interviewed reports high satisfaction with the care and services provided at this private hospital.

The ARRC requirements are met.

Tracer Methodology:

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
<p>The service has adequate dressing and continence supplies to meet the needs of the residents. The (five of five) interRAI plans reviewed record interventions that are consistent with the resident`s needs and desired goals. Observations on the day of audit indicate residents receiving care that is consistent with their identified needs. The (five of five) residents and (one of one) family interviewed report that the service meets their needs/the needs of their relative. The caregivers interviewed and members of the multidisciplinary team report that the care plans are accurate, up to date and do reflect the individual resident`s needs and the interventions to meet these needs effectively.</p> <p>The ARRC requirements are met.</p>	

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

Information regarding each resident's activity needs, choices and preferences is gathered on admission and regularly reviewed thereafter. Relevant information is shared with members of the multidisciplinary team. Documentation identifies that the activities co-ordinator gains an understanding of a residents' preferred use of time and develops an individual plan that meets their needs, abilities and preference.

The activities co-ordinator interviewed is very experienced working in a rest home for eleven and a half years as the activities co-ordinator. The co-ordinator explained that she has been in this current role for one year and is adapting her experience to hospital level care residents successfully. One on one activities are also provided as required for the more frail residents who cannot participate in group activities. The South Auckland support activities group for activities co-ordinators and diversional therapists from other aged care facilities in the region meets six weekly on a regular basis and the networking is reported to be very valuable to the co-ordinator.

The activities co-ordinator explained how information is sought for each resident, inclusive of choices of activities they enjoy, risk factors with health status, social information, specific health concerns, physical/functional state, interests, hobbies, church affiliations, other relative information and especially their life history. This information forms the basis of developing the resident's activities plan to maintain the resident's strengths and interests. The resident's individual plans (five of five) sighted are reviewed six monthly, signed and dated by the activities co-ordinator and clinical co-ordinator.

The activities plans are displayed in each resident's room, in each wing and in the lounge and dining room notice boards. Daily activities are arranged. Attendance records sighted are maintained in a diary. External events as well as internal events are held, such as sports events. The service uses `Dial a Ride` for outings to the Botanical Gardens, beaches, parks and to exhibitions in the community. A wheel chair hoist is available if required. The activities plan sighted is meaningful, motivating and maintains special interests of residents. External groups from schools and individual entertainers are welcome and a music session was being held today with a regular entertainer who states that he enjoys coming to this facility and to see the residents participating and singing.

Residents meetings are held monthly and the minutes of the meetings are maintained. The activities co-ordinator attends the residents' meetings. The ARRC 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

Nursing reviews and assessments, medical and specialist consultations and admission discharge summaries are clearly documented in the five of five residents' records reviewed. The current interRAI records are maintained by three registered nurses and are up to date. The clinical nurse leader has two recently admitted residents to complete their interRAI documentation. Documentation reflects the evaluations of the care plans in this hospital are conducted six monthly or more often if required. Interventions are changed if required to ensure all needs and goals set can be effectively met.

If a resident is not responding to the service interventions being delivered or their health status changes this is discussed with their GP. The GP interviewed validates this information and comments that the communication between the staff and the three GPs is commendable. Short term care plans are utilised for wound care, infections, changes in mobility, changes in food and fluid intake and skin care. These processes are clearly documented on the short term care plan, medical and nursing assessments and the resident's progress notes. Multidisciplinary reviews occur six monthly. The family member interviewed reports that the nurse manager or the clinical co-ordinator are available any time if they have a concern or there is a change in the resident's condition. A record is made of any contact with family/whanau.

The ARRC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The organisation has policies and procedures in place to reflect safe and timely medicine management. Procedures comply with current legislative requirements and guidelines. The newly implemented guidelines are available from the Ministry of Health and the service has a copy. The Waitemata District Health Board aged care guidelines (inclusive of medication administration guidelines and safe practice) are also available and sighted in the nurses' station. Pharmacy reconciliation of each resident's medication chart is undertaken on admission and at least six monthly. The GP interviewed provides assurance that this occurred and the GPs all have good communication with the service's contracted pharmacist. The GP interviewed ensures the medications are reviewed at each visit. The pharmacist is able to ring the GP at any time.

The clinical nurse leader and the registered nurses administer the medications but senior care staff still complete competencies annually in relation to medication management. Training and education is provided. The clinical nurse leader was observed administering the lunchtime medications in a safe and appropriate manner. No residents self-administer medicines.

Ten of ten medication records reviewed are recorded appropriately and all allergies/sensitivities are recorded in red ink or 'Nil Known' is documented to ensure the resident/family has been consulted. Photograph identification is available in all files sighted on the cover and on the signing record sheet.

The blister pack robotic system is utilised and all medications are checked on arrival from the pharmacy by the registered nurses. The controlled drugs are stored in a locked safe in a cupboard in the locked medication room. The controlled drug record book is available and sighted.

The ARRC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The menu plans are developed and implemented for a monthly cycle. Summer and Winter menu plans are sighted. The contracted very experienced New Zealand Registered Dietitian has reviewed the menu plans on the 19 November 2010 and again in 2012. A letter is available (sighted) and is retained in the food service record folder. The menu is displayed on the dining room tables (café style) each day. Some flexibility is available. Special days are celebrated (eg, birthdays, anniversaries, Easter, Christmas and others).

On admission the registered nurses ensure a nutritional assessment for each resident and this information is shared with the kitchen staff to ensure all needs, likes and dislikes and special diets can be catered for appropriately. The kitchen manager uses a white board to document special dietary needs. The assessments are filed for reference and updated if any needs change. All residents are re-assessed six monthly. Five of five residents interviewed and one family member confirm they are happy overall with the food and fluids provided. The dining room is new, fresh and café style with a built in china cabinet and flowers on each table. Tea and coffee facilities are available. The residents' surveys undertaken six monthly includes food satisfaction.

The kitchen manager (cook) interviewed has been in this position for eighteen years and the kitchen-hand for twenty eight years. A job description is available in the cook's personal record (sighted) and was provided at commencement of employment. Food hygiene courses have been completed and certificates are framed and displayed in the kitchen. Weight monitoring of all residents occurs and a record is maintained in the 'pink folder' in the kitchen. The kitchen manager reports to the nurse manager. The kitchen manager orders all food required, except for milk and bread purchased locally. A relief cook and kitchen hand is available. All food is checked on arrival and a system explained by the cook for storage of food in the pantry that works efficiently, rotating food with a colour coding system identifying which foods to use first.

Any high cleaning is performed by the hospital's maintenance person and a schedule is utilised for daily cleaning requirements. Temperature monitoring occurs for the large double fridge/freezer and two smaller fridges available. One small fridge is located in the annexe of the kitchen which can be accessed by staff for orange drinks and nutritional supplements. Nutritional guidelines for the elderly are in the main folder sighted to guide kitchen staff. A list of diabetic patients is kept on the whiteboard. Ethnicity of residents is considered. Portion sizes, lip plates and soft mouli foods are considered to meet the needs of the residents.

The ARRC requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

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

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

STANDARD 1.4.2 Facility Specifications

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

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

Evaluation methods used: D SI STI MI CI Mal 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 11 April 2014. Building upgrades and improvements to the interior have occurred since the previous audit and these are reported in standard 1.4.7. Plant and equipment is maintained by service contractors. Areas inside and outside the facility, promote safe mobility and are suited to older people.

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:		

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 D15.3j; 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
Although there have been changes to the physical environment there has been no need to amend the approved evacuation scheme (confirmed by interview with executive director and the fire engineer involved in the building renovation). An extra fire door and a new security feature which allows staff to identify visitors who approach the building after hours is installed (observed on day of audit). Fire drills are occurring every six months and this is confirmed by sighted fire drill reports for June 2013 and December 2012. Staff training in fire safety and other emergencies is ongoing. The call bell system is functional and three residents who were asked about staff response to the call bell said staff respond within five to ten minutes and there are no concerns.	

Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		

Corrective Action Required:

Timeframe:

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:

Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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's restraint policy is clear about the differences between restraint and enablers and contains definitions which are congruent with this standard. Currently there is one resident who has requested and continues to use enablers for safety reasons. The resident prefers a lap belt when seated in a wheelchair and bed rails when in bed to prevent slipping or injury. The resident's file contains a recent (July 2013) comprehensive re-assessment of the need to continue using the enablers. This includes

identification and description of the risks related to the enablers in use and an indication of the resident's consent (the resident cannot sign but provides clear verbal consent and instructions, which is confirmed by interview with the resident). The use of enablers is reviewed three monthly (evidence of review documents sighted in the restraint register). Staff education in restraint minimisation and management of challenging behaviour occurs every six months and this is confirmed by review of staff education records and interview with the nurse manager and one caregiver.

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
<p>The organisation has a system in place to ensure infection control is managed effectively. An Infection Control company chosen for advice and guidance and for maintaining the policies and procedures for this organisation. The manual is available and has been reviewed. The guidelines for infection control are updated two yearly. The GP interviewed is also available to seek advice for infection control issues and is pleased to participate whenever needed. The contracted pharmacist is also available for consultation.</p> <p>The infection control co-ordinator (the clinical nurse leader) is responsible for the surveillance programme for this service and provides all relevant information to the Infection Control company on a monthly basis. Information analysis summary is completed which covers all infections inclusive of sites of infection, notifiable diseases, antimicrobial agents, potential therapy issues, types of infection, organisms if known, multi-drug resistant organisms and outcomes. When</p>	

collated by the representative details are distributed back three monthly to the service provider. The benchmarking results are fed back in the form of summaries, graphs (eg, wound infections, skin infections, urinary tract infections) by month. Information is then fed back to the staff at the staff meetings. Minutes are sighted for 27 August 2013 and include infection prevention and control. The surveillance programme is appropriate for the size and nature of this private hospital setting.

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: