**Springlands Senior Living Limited**

**Current Status:** **16-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**

Springlands Lifestyle Village provides rest home and hospital level care for a potential 76 residents with 54 occupied on the day of the audit (31 rest home and 23 hospital). There is one rest home resident in the serviced apartments.

Springlands Lifestyle Village has a village manager (non clinical) who is responsible for operational management of the service. She is supported by the managing director and a clinical nurse manager.

There is a quality and risk management programme that includes analysis of incidents, complaints and an implemented internal audit schedule. There is a schedule of meetings that provide an opportunity for all staff and residents to be engaged in analysis and discussion of issues.

Residents and family members interviewed spoke highly of the services provided at Springlands Lifestyle Village.

The service has addressed the following shortfalls identified in their certification audit including; advanced directives; complaint management; policy implementation; quality management; hazard monitoring; incident reporting; staff orientation, appraisals and in-service education; and care planning including assessment, intervention and evaluation; medication competence; activity plans; restraint practice and the infection control programme.

Improvements continue to be required around wound care assessments.

This surveillance audit identified that improvements are required around aspects of medication management, the use of short term care plans and wound care plans.

**Audit Summary AS AT** **16-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 |
|  | 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 Audit16-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. |  | **Standards applicable to this service fully attained** |

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| --- | --- | --- |
| **Organisational Management** | Day of Audit16-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** |

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| **Continuum of Service Delivery** | Day of Audit16-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. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit16-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** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit16-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** |

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| --- | --- | --- |
| **Infection Prevention and Control** | Day of Audit16-Sep-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** |

**Springlands Senior Living**

Springlands Senior Living Limited

Surveillance audit - Audit Report

Audit Date: 16-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Springlands Senior Living Limited  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Springlands Lifestyle Village  | 5 Battys Road | Springlands | Blenheim |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 16-Sep-13 **End Date:** 16-Sep-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RN, auditor certificate | 9.00 | 6.00 | 16-Sept-13 |
| Auditor 1 | XXXXXXX | RN, auditor certificate | 9.00 | 5.00 | 16-Sept-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 1.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 18.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 30.00 |
| **Staff Records Reviewed** | 8 of 50 | **Client Records Reviewed** *(numeric)* | 7 of 54 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 7 |
| **Staff Interviewed** | 9 of 50 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 8 of 54 | **Number of Medication Records Reviewed** | 14 of 54 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

I confirm that Health and Disability Auditing New Zealand Limitedhas 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*): 🗷

# 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Springlands Lifestyle Village  | 76 | 54 | 21 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Executive Summary of Audit

General Overview

Springlands Lifestyle Village provides rest home and hospital level care for a potential 76 residents with 54 occupied on the day of the audit (31 rest home and 23 hospital). There is one rest home resident in the serviced apartments. Springlands Lifestyle Village has a village manager (non clinical) who is responsible for operational management of the service. She is supported by the managing director and a clinical nurse manager.

There is a quality and risk management programme that includes analysis of incidents, complaints and an implemented internal audit schedule. There is a schedule of meetings that provide an opportunity for all staff and residents to be engaged in analysis and discussion of issues. Residents and family members interviewed spoke highly of the services provided at Springlands Lifestyle Village.

The service has addressed the following shortfalls identified in their certification audit including; advanced directives; complaint management; policy implementation; quality management; hazard monitoring; incident reporting; staff orientation, appraisals and in-service education; and care planning including assessment, intervention and evaluation; medication competence; activity plans; restraint practice and the infection control programme. Improvements continue to be required around wound care assessments.

This surveillance audit identified that improvements are required around aspects of medication management, the use of short term care plans and wound care plans.

1.1 Consumer Rights

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service continually and as required. Family are involved in the initial care planning, at care plan review and receive and provide on-going feedback. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. The service has documented complaints and there is evidence of follow up. The electronic computer complaints register reviewed included verbal and written complaints.

1.2 Organisational Management

The quality process being implemented includes regularly reviewed policies, an internal audit programme, education programme and a health and safety programme that includes hazard management. The service purchased the new quality programme/system in February 2013 provided by an external quality consultant who provides regular updates and review of policies and procedures. Quality data gathered includes the use of comprehensive forms and on line data entry. Data is collated monthly and trends identified. Corrective action plans, implementation of plans and solution occur when trends are identified. There is discussion of quality data and any identified improvements required at management meetings, monthly quality meetings, infection control and health and safety meetings and bi monthly staff and RN meetings. There is an implemented annual education programme for all staff. Staff training records are maintained. There are comprehensive human resource/ management policies and staff files reviewed evidence completed reference checks, job descriptions, evidence of orientation and training, employment agreements and annual appraisals. Staff an residents interviewed report that staffing levels are sufficient.

1.3 Continuum of Service Delivery

Assessments, care plans and evaluations are completed by the registered nurses within the required timeframes. Formal risk assessment tools are in place for residents and evaluated at least six monthly or earlier if required due to changes in health status. Long term care plans are current and up to date. Families and residents participate in the care planning process. There are improvements required around the use of assessment tools, short term care plans and long term care plans and evaluations are completed within the required timeframe. There continues to be an improvement required around the completion of wound management plans. The Diversional therapists and activity assistant provide an activities programme for the residents in the rest home and hospital. Activity plans include goals and are evaluated at least six monthly at the time of the long term care plan evaluation.

There are policies and processes that describe medication management that align with accepted guidelines. Since the previous audit improvements have been made around signing on administration of medications and dating eye drops are dated. However there is an improvement required in the area of monitoring of self-medicating residents and monitoring fridge temperatures. Meals are prepared on site. There is dietitian review of the menu plan and individual and special dietary needs are catered for.

1.4 Safe and Appropriate Environment

Legislation and regulatory requirements are met for local authorities and the MoH. There is access to necessary and essential equipment which have all been checked for function. Partial achievements in the previous verification audit in regards to the completion of the new wing have been addressed including the external landscaping. The building holds a current warrant of fitness and approved fire evacuation plan.

2 Restraint Minimisation and Safe Practice

There is documented definition of restraint and enabler which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. There are currently two residents requesting the use of bedrails as an enabler. There are six residents requiring the use of bedrails as a restraint and two resident requiring the use of a lazy boy chair and waist belt as a restraint. The restraint standards are being implemented and implementation is reviewed through the internal audits and facility meetings and restraint approval group.

3. Infection Prevention and Control

The infection control policy includes surveillance. The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Trending and analysis of infection control data collected is completed monthly by the infection control coordinator and any areas for improvement are highlighted and discussed at the monthly infection control meetings and various facility meetings.

Summary of Attainment

* 1. Consumer Rights

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

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| --- |
| Consumer Rights Standards (of 12): N/A:9 CI:0 FA: 3 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 48): CI:0 FA:4 PA:0 UA:0 NA: 1 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 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 | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Moderate | 0 | 0 | 1 | 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 Moderate | 0 | 2 | 2 | 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:3 CI:0 FA: 7 PA Neg: 0 PA Low: 0 PA Mod: 2 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:14 PA:3 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 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 | FA | 0 | 1 | 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 | 2 | 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:5 CI:0 FA: 3 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:6 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | FA | 0 | 1 | 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: 4 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: 0Criteria (of 21): CI:0 FA:2 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | FA | 0 | 1 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

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| --- |
| Infection Prevention and Control Standards (of 5): N/A: 2 CI:0 FA: 3 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:4 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 25 **CI:** 0 **FA:** 23 **PA Neg:** 0 **PA Low:** 0 **PA Mod:** 2 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 47 **PA:** 3 **UA:** 0 **N/A:** 1 |

# Corrective Action Requests (CAR) Report

Provider Name: Springlands Senior Living Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:16-Sep-13 End Date: 16-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.6 | 1.3.6.1 | PAModerate | **Finding:**i) Five of twelve wound assessment and management plans do not document the type of wound, location and size of wound, ii) There is no short term care plan completed for a resident with weight loss. (iii) One resident with weight gain outside of the desired range as documented in the care plan has not had a review of the nutritional assessment. **Action:**i) Ensure wound assessment and management plans are fully completed and include the type of wound, location and size of wound currently being treated. ii) Ensure short term care plans are completed for any changes in resident condition/health.  | 3 months |
| 1.3.12 | 1.3.12.1 | PALow | **Finding:**The medication fridge in the rest home has not had regular weekly temperature checks completed from March to June 2013. **Action:**Ensure the medication fridge is checked on a regular basis | 1 month |
| 1.3.12 | 1.3.12.5 | PAModerate | **Finding:**There are no medication charts available for the RN to check off medications when delivered for the self-medicating residents. **Action:**Ensure there are medication charts in place to allow reconciliation of medications to occur for those residents who are self-administering medications. | 1 month |

# Continuous Improvement (CI) Report

Provider Name: Springlands Senior Living Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:16-Sep-13 End Date: 16-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.9 Communication**

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

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

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

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

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Three relatives state that they are always informed when their family members health status changes.

Interpreters are available through the DHB if required. There have been no residents who have required or do require interpreting services.

D11.3 The information pack is available in large print.

Eight residents and three family members interviewed state that there is good communication with the staff and all 'know' the clinical nurse manager, the village manager and director. All family members state that they are informed when there is an incident and the incident forms reviewed reflects this.

**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:**

**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:** FA

The previous certification audit identified that two resuscitation forms where DNR was medically indicated were not correctly completed. This audit evidenced that this finding has been addressed and seven of seven resuscitation forms reviewed were completed correctly.

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

**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

D13.3g: The service has complaints management policies and procedures in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack, as confirmed by three of three family interviewed.

D13.3h. information around the complaints procedure is provided to residents within the information pack at entry.

Staff including five health care assistants, one diversional therapist, two RNs and clinical nurse manager are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau.

Residents and family confirm they are aware of the complaints process and they would make a complaint to the clinical nurse manager or village manager if necessary.

There is an electronic complaints register in place. Six complaints tracked indicate that the issues and responses are addressed as per timeframes in the policy. This is an improvement implemented following a finding at certification audit which found that responses to complaints were not always documented. The village manager advises that she has been in contact with the DHB regarding one complaint received and provided information pertaining to this complaint which has been resolved. (documentation sighted).

**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 philosophy is documented and this is included in the welcome pack. There is a managing director and village manager. The village manager (non clinical) provides operational management at all times. The managing director visits twice a week. There is a clinical nurse manager (RN) who supports the village manager.

Staff, residents and family interviewed state that the managing director and village manager along with the clinical nurse manager are the key to the service and state that they provide hands on and visible support for residents.

The service provides rest home and hospital level care for a potential 76 residents with 54 occupied on the day of the audit (31 rest home and 23 hospital). All are swing beds. Of the 20 apartments, all can be used as rest home beds and one is occupied by a resident requiring rest home care (included in total numbers).

ARC,D17.3di (rest home, hospital), The clinical nurse manager and village manager have maintained more than eight hours annually of professional development activities related to managing the service.

**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

The certification audit conducted in 2012 identified that policies and procedures were not reviewed to ensure best practice and that there was no dedicated committee or forum to discuss health and safety, infection control or restraint. The service now has policies, procedures, processes and systems that support the provision of clinical care and support including care planning and these are reviewed annually to two yearly by the external quality consultant noting that these have been put in place in February 2013. The service has a strategic plan and quality risk management plan that are implemented. Progress with the quality plan is monitored through the weekly management meetings, monthly quality meetings, bi -monthly staff meetings and bi-monthly RN meetings. There is restraint, health and safety, infection control and quality committees. The quality meetings include a report from each of the committees and other areas such as laundry/cleaning, kitchen and maintenance. The village manager provides a monthly report to the Director and four monthly reports to the shareholders. The management meeting agenda and the staff meeting agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Minutes are maintained and easily available to staff. Meeting minutes were sighted. Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Springlands commitment to on-going quality improvement and the previous findings within this standard at certification audit have been addressed. Discussions with the clinical nurse manager, chef, two RNs, diversional therapist, maintenance and five health care assistants confirm their involvement in the quality programme.

Resident/relative meetings take place six weekly. Minutes of resident meeting held on 09-Aug-13 were sighted. Residents interviewed were able to confirm that they are able to attend resident meetings and are involved with discussions around service provision and are able to make suggestions for improvement if required which are acted upon where possible.

There is an internal audit schedule 2013 and internal audits evidenced completed include: admission, weight and nutrition, care plans, laundry and cleaning, admission agreements, restraint/enabler, informed consent, advance directives, personal privacy and safety, medication management, food service questionnaire, diversional therapy, continence, cultural safety, complaints management, hygiene and grooming, wound and skin management, infection control and staff training. Any corrective actions identified from completed audits have a corrective action plan implemented which details actions to be taken, by whom and timeframes for completion. Corrective action plans were evidenced completed and signed off when the actions had been implemented. These are improvements implemented since the 2012 certification audit. The service has a health and safety management system and this includes the identification of a health and safety officer. There is a hazard register in place, which has been updated which is an improvement implemented following a finding in 2012 certification audit. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Advised by the village manager than an annual review of the quality programme implemented in February 2013 will be completed in February 2014.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

Policies and procedures align with the client care plans. Policies are provided by an external quality consultant who provides the service with regular updates and completes policy reviews.

D19.2g Falls prevention strategies such as falls risk assessment, walking aids, physiotherapy assessment, use of appropriate footwear, correct seating, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and evidence RN assessment and monitoring where appropriate. All incident/accident forms are seen by the clinical nurse manager who completes any additional follow up and collates and analyses data to identify trends. Results are discussed with staff at shift handovers, staff meetings, the monthly quality meetings, RN meetings and management meetings. The absence of trending and analysis of data and discussion of trends was a finding from certification audit which has now been addressed.

A resident/next of kin survey conducted in May 2013. Forty four surveys were sent out and 22 were returned. The responses evidence that residents and families are over all very satisfied with the service. A survey evaluation has been conducted for follow up and corrective actions required. Improvements identified from the resident/next of kin survey concluded that some residents and family members were unsure of who the key personnel are within the service. A letter was sent out to family and residents detailing the key personnel and a description of their roles within the service. A copy of the letter sent out to relatives and residents was sighted.

**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

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The November 2012 certification audit identified that not all incidents documented in progress note were captured by the use of an incident/accident form. This audit identified that individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Incident reports are completed and scanned on to the computer and entered into the incident/accident register. Therefore the finding has been addressed. There is an adverse events policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at quality meetings, management meetings, health and safety and bi-monthly staff and RN meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

There is an open disclosure policy and three family members interviewed stated they are informed of changes in health status and incidents/accidents.

Next of kin/EPOA advise on admission if they wish to be/do not wish to be informed of minor injuries such as skin tears, bruising resulting from falls.

This information was evidenced documented in seven resident files reviewed.

There were 24 incident forms completed for August 2013. Eight of these were reviewed and evidence immediate action is documented with assessment competed by a registered nurse. The incidents were traced back into the relevant resident’s files. Progress notes in eight resident files reviewed document the incident and follow up by an RN, any further monitoring required and contract with family.

Five health care assistants and two registered nurses interviewed are all familiar with the incident/accident reporting process and describe discussion of these at the staff an RN meetings.

**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

The 2012 certification audit identified that employee files did not contain copies of key information such as CVs, employment contracts and reference checks; that the in-service education programme did not meet the requirements of the standard; and that completed orientations were not evidenced in employee files reviewed. These findings have been addressed.

The recruitment and staff selection process now requires that relevant checks are completed to validate the individual’s qualifications and experience.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development which have been implemented since February 2013 when the new quality programme was purchased. Eight staff files were reviewed (two registered nurses, three health care assistants, one diversional therapist, one chef and one kitchen hand). Reference checks are completed before employment is offered and these were evidenced completed in staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Five health care assistants interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists were evident in seven staff files reviewed. Annual practicing certificates were sighted for registered nurses, podiatrist, physiotherapist, pharmacist and general practitioners.

Discussion with the village manager, clinical nurse manager, two registered nurses and five health care assistants confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Health care assistants interviewed have either completed the national certificate in care of the elderly or have commenced the aged care education programme. Education provided in 2013 included: de-escalation, restraint and enablers, palliative care, infection and surveillance, health of older people, syringe driver competencies, chemical safety, business continuity/emergency plans, cultural awareness, code of rights advocacy, abuse and neglect and complaints, infection control, medication management/administration and use of sling and standing hoists. Training records include date, session topic and content and names of attendees. Those staff who do not attend training are provided with the hand outs of the education session. Fire drill/education was completed 12-Mar-13 with eleven staff attending.

The annual training is presented by the village manager, clinical nurse manager, with presentations by other external specialists. Five health care assistants were all able to describe attending education sessions and attending external courses at the NMDHB. Registered nurses are funded to attend external training. RNs provide a teaching session to other staff on their return from an external course.

**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

Staffing levels and skill mix policy in place. Sufficient staff are rostered on duty to manage the care requirements of the rest home and hospital level care residents. There is a registered nurse on duty on each shift. The clinical nurse manager works 40 hours per week and provides on call cover for any clinical issues. The village manager is on call 24/7. Interviews with five health care assistants, eight residents and three family members identify that staffing is adequate to meet the needs of residents. The clinical nurse manager advised that if there was an emergent issue with the resident in the serviced apartments receiving rest home level care during the night the policy is that a health care assistant who has a current first aid certificate would attend and report back to the RN who would then direct staff as to any interventions required which may include calling an ambulance, dependent on the situation.

**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 1.3.1 Entry To Services**

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

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

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

The previous certification audit identified that some admission agreements including residents in the serviced apartments receiving rest home level care were not available or on file. This audit identified that seven resident files sampled (four hospital and three rest home) had admission agreements in place.

**Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

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

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

D16.2, 3, 4: The files reviewed (3 rest home (one in serviced apartment) and 4 hospital), identified that in all seven files an assessment was completed within 24 hours and all seven files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan are reviewed by a RN and amended when current health changes. All seven care plans evidenced evaluations completed at least six monthly.

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); Robinsons resident acuity assessment, coombes falls risk assessment, Braden pressure area assessment, food and nutritional assessment, continence assessment, pain assessment, challenging behaviour assessment.

There is a verbal handover for all oncoming shifts and a written handover sheet detailing any resident significant care or medical events. There is also an RN to RN handover in the hospital wing. In the rest home the night shift hands over to the oncoming shift and the RN receives an update/handover at 8am.

D16.5e: Seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. There are six GP's from different practices who provide medical services to their patients at the facility. The RN interviewed stated the residents retain their own GP. The GPs conduct three monthly review visits and are notified by fax with any resident concerns. GP's are available for home visits if required. Specialist referrals are made by the GP's. RN's can initiate urgent transfers to the emergency department. After hours medical service is accessed through the Wairau after hours clinic.

There is evidence of allied health professional involvement in the provision of service such as wound care nurse, district nurse, palliative care/hospice, physiotherapist, dietitian, speech language therapist and podiatrist.

Three rest home resident files and four hospital resident files were sampled.

Tracer Methodology: Hospital level

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

Tracer Methodology: Rest Home level resident

  *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 1.3.4 Assessment**

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

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

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

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); Robinson's Resident Acuity assessment, Coombes falls risk assessment, Braden pressure area assessment, food and nutritional assessment, continence assessment, pain assessment, challenging behaviour assessment. There was a shortfall identified in the certification audit around the use of formal assessments. Formal assessments are in place for the seven resident files sampled. An improved continence assessment has been implemented. Outcomes of assessments completed in the seven resident files sampled are documented in the long term care plan. The shortfalls in the previous audit have been addressed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

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

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

 The partial achievement at certification audit identified that care plans did not consistently document the needs of the residents or communication with the GP. All seven resident files sampled at this audit identified that care plans reflected the care needed including documented instructions, management and treatments from GP's and other allied health professionals involved, therefore this finding had been addressed.

**Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.**

**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:** PA Moderate

Family members ( two hospital and one rest home) and residents (four hospital and four rest home) interviewed reported the residents needs were being appropriately met. Care plans identify the residents problems/needs, objectives and interventions to assist the resident in achieving their goals including input from other allied health professionals involved in resident care. This is an improvement implemented following a finding at certification audit.

The Registered Nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for five wounds and three skin tears in the rest home and seven wounds and six skin tears in the hospital wing. Chronic wounds are linked to the long term care plan. There is an improvement required around the completion of wound assessment and management plans. The previous finding at certification audit regarding the completion of wound assessments has not been addressed.

Food and nutritional assessments are completed on admission and reviewed at least six monthly or earlier if required. Residents are weighed monthly. This audit identified there is an improvement required around the use of short term care plans/assessments for the management of weight loss/gain.

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

Wound assessment and wound management plans are in place for five wounds and three skin tears in the rest home and seven wounds and six skin tears in the hospital wing. Chronic wounds are linked to the long term care plan.

Food and nutritional assessments are completed on admission and reviewed at least six monthly or earlier if required. Residents are weighed monthly.

**Finding Statement**

i) Five of twelve wound assessment and management plans do not document the type of wound, location and size of wound, ii) There is no short term care plan completed for a resident with weight loss. (iii) One resident with weight gain outside of the desired range as documented in the care plan has not had a review of the nutritional assessment.

**Corrective Action Required:**

i) Ensure wound assessment and management plans are fully completed and include the type of wound, location and size of wound currently being treated. ii) Ensure short term care plans are completed for any changes in resident condition/health.

**Timeframe:**

3 months

**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

A qualified Diversional Therapist coordinates the activities programme for the hospital and rest home. The DT is a member of the N.Z. DT Society and attends forums and inter-rest home meetings for the sharing of ideas, suggestions and other networking. The DT is employed fulltime and has an activity assistant for two days a week. There are volunteers who visit residents for activities such as sensory stimulation, foot spa, manicures, card making and conversation. There is one programme for the hospital and rest home and activities take place in the rest home lounge or hospital day room. The DT plans to have two programmes running on the days the activity assistant is on duty. The weekly programme is bright colourful, in large print and copies of the programme are delivered to resident rooms and displayed on notice boards. A variety of group activities are offered including; newspaper reading, story hours, exercises, walking group, housie, crafts, bowls, yoga, movies and happy hour. There are inter home visits and activities for quizzes, picnics and dances. Guest speakers visit the home and speak on various topics including Rock and Mineral club, crafts, slide shows, old time movies. Musical entertainers visit the home regularly. There are outings scheduled in the rest home van and a wheelchair taxi is hired for those residents who require wheelchair transport. Interdenominational church services are held weekly with Catholic services held fortnightly.

The DT facilitates the resident meetings where the activity programme is discussed and feedback sought as well as suggestions and ideas for the programme. On admission of a new resident the DT involves the resident and family to complete a resident profile. The care plan is completed within three weeks and there is a team approach to the development of the care plan and six monthly review. An attendance form is maintained that indicates invitations to activities, attendance or declined. There is evidence of communication with the family. Residents and families interviewed commented positively on the activity programme.

D16.5d Seven resident files reviewed identified that the individual activity plan with identified goals are reviewed six monthly at the time of the long term care plan review. This is an improvement implemented since the last audit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

There are three monthly written resident reviews which involve the RN, Diversional therapist and GP. There is evidence of resident/family/whanau involvement in the review of care plans. The family/whanau/resident representative contact sheet records discussion and notifications including changes to health, medications, GP visits, care plan reviews, incidents, infections and referrals. Short term care plans are evaluated with nursing problems resolved or if an on-going problem transferred to the long term care plan. In the previous audit it was identified that formal evaluations were not completed six monthly and short term care plans were not evaluated or linked to the long term care plan where appropriate. A review of seven of seven files identified that all seven long term care plans have been evaluated six monthly or more frequently and short term care plans have been evaluated and where appropriate if a condition is no acute has been transferred into the long term care plan. Therefore these findings have been addressed.

D16.4a Care plans (seven sampled) and short term care plans are evaluated six monthly more frequently when clinically indicated by the RN.

D16.3c: All initial care plans of seven files sampled were evaluated by the RN within three weeks of admission

**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 Moderate

All medications are stored safely in the rest home and hospital wings medication room. The supplying pharmacy deliver the blister packs which are checked in by the RN on duty. A medication reconciliation record is kept of all medications checked for new admissions and transfers into the facility. Any discrepancies are fed back to the pharmacy. The rest home and hospital have a controlled drugs (CD) safe. Weekly checks of controlled drugs are completed and a six monthly pharmacy audit occurs. The medication fridge in the rest home has not had regular weekly temperature checks completed from March to June 2013. The clinical nurse manager has implemented a weekly check list which includes fridge temperatures, oxygen cylinder checks, expiry dates of medications and returns to the pharmacy. Sharps are disposed of into an approved sharps container. All medications in trolleys are within the expiry date and eye drops dated on opening. This is an improvement implemented since the previous audit. Healthcare assistants and RN's complete annual medication competencies and attend annual education provided by the pharmacy. RNs attend syringe driver education and annual refresher with Hospice Marlborough. There is a current medication competent persons signing list and all staff sign the administration signing register. There is a current standing order for household remedies. The hospital wing hold a stock of emergency medications such as glucagon. There are three self-medicating rest home residents in the serviced apartments. Competency assessments have been carried out by the GP. There are no medication charts in place for these residents.

All medication charts sampled (14) had recent photograph identification and allergies documented. There are no gaps in the signing sheets. This is an improvement since the last audit. The time of PRN medication administration is recorded on the signing sheet. Two persons sign the administration form for CD's.

D16.5.e.i.2; 14 medication charts reviewed identified that the GP had seen the reviewed the resident at least 3 monthly and the medication chart was signed.

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

All medications are stored safely in the rest home and hospital wings medication room. The supplying pharmacy deliver the blister packs which are checked in by the RN on duty. A medication reconciliation record is kept of all medications checked for new admissions and transfers into the facility. Any discrepancies are fed back to the pharmacy. All medications in trolleys are within the expiry date and eye drops dated on opening. This is an improvement implemented since the previous audit

**Finding Statement**

The medication fridge in the rest home has not had regular weekly temperature checks completed from March to June 2013.

**Corrective Action Required:**

Ensure the medication fridge is checked on a regular basis

**Timeframe:**

1 month

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

There is a self-medicating rest home resident in the serviced apartments. Competency assessments have been carried out by the GP. GP documents three monthly review in the residents medical notes.

**Finding Statement**

There are no medication charts available for the RN to check off medications when delivered for the self-medicating residents.

**Corrective Action Required:**

Ensure there are medication charts in place to allow reconciliation of medications to occur for those residents who are self-administering medications.

**Timeframe:** 1 month

**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 main cook on duty has completed Level 3 chef qualification. The second chef provides mentoring and support for the cook and kitchen hands. All food services staff have attended NZQA food safety and hygiene standards in June 13. There is a weekend/reliever qualified cook. The menu is planned ahead and written into the cook’s diary. The dietitian has reviewed the menu plan to ensure the nutritional guidelines for the elderly are met. Copies of resident profiles are available in the kitchen and resident likes and dislikes are known. The cook is notified of any changes and is aware of any resident with weight loss. A communication book is used between food services and clinical staff. All meals and baking is done on-site. Food is served from the bain marie for residents in the rest home dining room. Meals are delivered in hot boxes to the hospital and serviced apartment dining areas. Meals such as vegetarian and pureed are name labelled before delivery. The kitchen has a good work flow with delivery, storage, meal preparation, baking, serving and dishwashing areas. The kitchen is well equipped with gas hobs and oven, combioven and deep fryer. Dry goods are ordered weekly and there is rotation of foods on delivery. The pantry is tidy with all foods in sealed and labelled containers. Fridge, chiller and freezer temperatures are recorded daily. The cook was able to describe the action taken for temperatures outside of the acceptable range. All equipment has a current electrical test and tagged. The dishwasher is checked two weekly for function and temperature checks. Staff are observed wearing appropriate protective clothing.

The chef and/or cook attends resident meetings, staff meetings and interacts with residents attending happy hours and receiving feedback on the service. Residents interviewed (four hospital and four rest home) state they enjoy the meals and home baking.

D19.2 staff have been trained in safe food handling.

**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

The certification audit in November 2012 identified that the following findings; That prior to occupancy of the new wing a Certificate of Public Use (CPU) was to be in place, that furniture and fittings were to be in place and that he landscaping was to be completed. These findings have been addressed.

There is a current building warrant of fitness dated 19 April 2013.

There is a Fire service letter of approval of evacuation scheme dated 27 May 2013 following the completion of a new wing. The new wing is fully furnished with all fixtures and fittings in place. There is ready access for residents between the wings. The landscaping around the new wing has been completed and there are seating areas with shade available in the gardens.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, walking frames, wheelchairs, hospital level lazy boy chairs, hoists, chair scales, heel protectors, transferring aids.

**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 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

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 link corridor between the older wing and new wing was not yet completed at the last audit and this was a finding which has now been addressed an the link corridor now in place.

**Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

 There is documented evidence of staff attendance at a fire drill around fire safety and evacuation of residents from the new wing. A fire drill was completed on 12-Mar-13 and is scheduled for the end of September 2013. These improvements were implemented from certification audit. There is an approved evacuation plan dated 27 May 2013. This was obtained following the completion of the new wing.

**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:**

**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

Documented systems are in place to ensure the use of restraint is actively minimized. Registered nurse interviewed (one) is the restraint coordinator. There are two residents who have requested the use of bed rails as an enabler. Six residents require the use of bed rails, and two residents require the use of a lazy boy chair and waist belt as a restraint.

Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.

The 2012 certification audit identified that staff had not received any formal education around challenging behaviours or the use of restraints and enablers. This finding has been addressed. Staff education on challenging behaviour management/de-escalation, restraint and enablers was completed was conducted in March 2012 and attended by nine staff. Restraint minimisation and safe practice audit was conducted in April 2013 and July 2013 with corrective actions identified being signed off as having been completed and discussed at staff meetings.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

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

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

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

The November 2012 certification audit identified that service had no restraint approval group in place and that discussion of restraint use was not discussed at any other meetings. These findings have been addressed. The service now has a restraint approval group in place which meets three monthly. Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. A registered nurse in each area are restraint coordinators.

Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool and enabler assessment tool available. The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. The continued need for restraint is discussed at the restraint approval group meetings and restraint use is evaluated three monthly in resident care plans. Two residents files requiring the use of a restraint were reviewed and evidenced three monthly evaluation of the need for restraint has occurred. Minutes of the restraint approval group meetings were sighted. Discussion on restraints occurs at restraint approval group meetings, monthly quality meetings, management meetings and bi monthly staff and RN meetings.

**Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.**

**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 3.2 Implementing the infection control programme**

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

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

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

The November 2012 certification audit identified that the service needed to establish a forum to facilitate the implementation of the infection control programme. The service has an appointed infection control nurse. An infection control committee has been established which includes a cross section of staff from all areas of the facility. The infection control committee meets monthly where discussion of monitoring, evaluation of issues/trends in respect of infections occurs. The service has access to Southern Community Laboratory Microbiologist, GPs and infection control nurse specialists at NMDHB.

**Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

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

Following the November 2012 certification audit the service has purchased a new quality programme in February 2013 which includes a suite of policies on infection prevention and control which are current and comply with best practice. Therefore this finding has been addressed.

**Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

Infection surveillance is an integral part of the infection control programme and is described in Springlands infection control and surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Trending and analysis of infection control data is completed by the infection control coordinator. Graphs are printed and made available for staff. Outcomes and actions are discussed at the monthly infection control meetings, management meetings, quality meetings, and bi monthly staff and RN meetings

**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:**