**Sprott Care Limited**

**Current Status:** **18-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**

Sprott House provides rest home, hospital and dementia level care for up to 96 residents. There were 92 residents on the day of the audit.

Sprott House has a General Manager who is responsible for operational management of the service. She is supported by a Clinical Services Manager, Quality Manager, Finance Manager, Finance Administrator, Support Service Manager, HR Manager, Receptionist/administration and three care managers (one in each wing).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 Sprott House.

The service has addressed all shortfalls identified at their certification audit including; complaints documentation, quality process and documentation, care plan and assessment documentation, aspect of medication management, and human resources.

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

**Audit Summary AS AT** **18-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 Audit  18-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 Audit  18-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 Audit  18-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 Audit  18-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 Audit  18-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 Audit  18-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** |

**Sprott House**

Sprott Care Limited

Surveillance audit - Audit Report

Audit Date: 18-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Sprott Care Limited |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Sprott House | 29 Messines Road | Karori | Wellington |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 18-Sep-13 **End Date:** 18-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 | 18-Sept-13 |
| Auditor 1 | XXXXXXX | RN, auditor certificate | 9.00 | 5.00 | 18-Sept-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXX |  |  | 1.00 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 18.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 30.00 |
| **Staff Records Reviewed** | 17 of 102 | **Client Records Reviewed** *(numeric)* | 12 of 92 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 12 |
| **Staff Interviewed** | 17 of 102 | **Management Interviewed** *(numeric)* | 5 of 5 | **Relatives Interviewed** *(numeric)* | 9 |
| **Consumers Interviewed** | 8 of 92 | **Number of Medication Records Reviewed** | 32 of 92 | **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 Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 17 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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sprott House | 96 | 92 | 72 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Executive Summary of Audit

General Overview

Sprott House provides rest home, hospital and dementia level care for up to 96 residents. There were 92 residents on the day of the audit .

Sprott House has a General Manager who is responsible for operational management of the service. She is supported by a Clinical Services Manager, Quality Manager, Finance Manager, Finance Administrator, Support Service Manager, HR Manager, Receptionist/administration and three care managers (one in each wing).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 Sprott House.

The service has addressed all shortfalls identified at their certification audit including; complaints documentation, quality process and documentation, care plan and assessment documentation, aspect of medication management, and human resources.

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

1.1 Consumer Rights

Cultural awareness training occurred as part of the annual training programme. 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 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.

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 is active in analysing data collected and corrective actions are required based on benchmarking outcomes. The facility receives two monthly benchmarking reports from a consultant. Benchmarking reports are generated throughout the year to review performance. Quality improvement forms are utilised and document actions that have improved outcomes or efficiencies in the facility. Responsibilities for corrective actions are identified. Reports and all meeting minutes from the various facility meetings are reviewed by the monthly quality oversight committee meeting and include areas identified for improvement and actions initiated. 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 and residents interviewed report that staffing levels are sufficient.

1.3 Continuum of Service Delivery

Care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are current and reflect the outcomes of risk assessment tools and written evaluations. This is an improvement from the previous audit. Families and residents participate in the care planning and review process. The previous shortfall around updating care plans in regards to behaviour management has been addressed. There is an improvement required around the documentation of interventions where progress is less than the expected goal for the resident.

The activity co-ordinators and Unit Manager/Occupational Therapist (dementia care) provide an activities programme for the residents in the rest home, hospital and dementia care units. The programme is varied, interesting and meets the recreational needs and preferences of the consumer group. There are policies and processes that describe medication management. There is an improvement in the documentation of the route of the medication since the previous audit. However there is an improvement required in some aspects of medicine management around PRN medications and self-medicating residents. Provision of food services are contracted. All meals are prepared on site. There is dietitian review of the menu and individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit.

1.4 Safe and Appropriate Environment

The Sprott House building holds a current warrant of fitness. The interior and exterior buildings are well maintained. There is access to necessary and essential equipment.

2 Restraint Minimisation and Safe Practice

Sprott House has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. There are six residents with an enabler (bedrail) in use and nine residents requiring the use of a restraint(s). Eight residents require the use of a bed rail as a restraint and one resident requires the use of a bedrail, lap belt and fall out chair as a restraint.

3. Infection Prevention and Control

The quality manager uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other aged care facilities through a consultant benchmarking programme. Staff receive on-going training in infection control. The facility entered a submission to the CCDHB Quality Improvement Innovation Awards 2013 regarding their Outbreak management plan.

Summary of Attainment

* 1. Consumer Rights

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

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| Consumer Rights Standards (of 12): N/A: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: 0  Criteria (of 48): CI:0 FA:5 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | 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: 0  Criteria (of 34): CI:0 FA:17 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 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:5 CI:0 FA: 5 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  Criteria (of 51): CI:0 FA:12 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 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:7 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:4 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 32 **CI:** 0 **FA:** 16 **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:** 41 **PA:** 3 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Sprott Care Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:18-Sep-13 End Date: 18-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 | PA  Moderate | **Finding:**  i)One chronic wound in the rest home is not linked to a short or long term care plan ii) One resident in the hospital with swallowing difficulties had a weight loss of 2kg in one month. Another hospital resident has had a weight loss of 3kg over three months. There is no short term care plan or interventions in place as per the weight management policy for the two residents with weight loss. iii) One hospital resident experiences pain at the wound site and the interventions to keep the resident comfortable have not been documented in the short term care plan iv) One rest home resident suffers from breathlessness and is prescribed a controlled drug to reduce breathlessness. Medical intervention for this resident is not documented in a short term or long term care plan.  **Action:**  Ensure interventions are documented to reflect the residents current needs for wound care, pain, medical problems and weight loss. | 3 months |
| 1.3.12 | 1.3.12.1 | PA  Low | **Finding:**  i) Two prn medications do not have an indication for use on the medication chart. ii) There are two oxygen cylinders unrestrained in the hospital (North) treatment room.  **Action:**  i) Ensure prn medications prescribed have an indication for use. ii) Oxygen cylinders are to be stored safely. | 1 month |

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| --- | --- | --- | --- | --- |
| 1.3.12 | 1.3.12.5 | PA  Moderate | **Finding:**  The competency assessments in place are incomplete and have not been reviewed three monthly as required. There is no monitoring of the self-administration of medications. One resident is self-medicating a controlled medication.  **Action:**  Ensure self-medication competencies are completed, reviewed at least three monthly and monitoring occurs as per the self-medication policy. | 1 month |

# Continuous Improvement (CI) Report

Provider Name: Sprott Care Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:18-Sep-13 End Date: 18-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 1.1.4 Recognition Of Māori Values And Beliefs**

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

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

Cultural awareness and safety education has been integrated into the orientation programme for new staff. Education in Cultural awareness and safety has been added to the two yearly rotating education programmes. Cultural awareness and safety education sessions were provided in 2011 following a finding at certification audit. The 2013 education planner documents that another education session is planned to occur 19-Sept-13. Therefore this finding has been addressed.

**Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. RN's demonstrated their responsibility to notify family/whānau of any incident/accident that occurs and contact with family/next of kin is recorded.

D16.4b Nine relatives stated that they are informed when their family members health status changes. Access to interpreter services is identified as through the local DHB. This includes language support, the DHB, Hearing Association and the Blind Foundation.

Sprott House has multi-cultured staff and residents, registered nurses and health care assistants described being able to interpret for some residents when needed.

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. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D11.3 The information pack is available in large print and advised that this can be read to residents.

D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Dementia unit (Duncan Lodge) in the form of a Welcome booklet providing information for family , friends and visitors visiting the facility is included in the enquiry pack along with a new residents handbook providing practical information for residents and their families.

There is a family representative on the restraint committee which meets three monthly.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

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

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

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights.

D13.3h. A complaints procedure is provided to residents within the information pack at entry. The complaints register for 2012 documented 15 complaints were received. All complaints evidence follow up and resolution.

In 2013, 12 written complaints have been received. Three of the complaints received were with regards to catering, three about the laundry service, three care related and three other; which included a complaint regarding communication, missing property and a resident found in another residents room.

A new catering manager has been appointed by Medirest and residents report this has improved resident satisfaction with the catering/food service.

There are catering/cleaning contract meetings which occur monthly and evidence discussion of complaints. Minutes of August 2013 meeting were sighted.

The residents interviewed stated they were happy with the laundry services and felt that their clothing was returned promptly and was neatly folded or hung up in their wardrobe.

Housekeeping meetings occur monthly and include discussion on complaints/compliments.

A letter was sighted from HDC dated 16-Mar-12 regarding a complaint made in 2011. The letter from HDC stated no further action was required.

Six written complaints were tracked, indicating that they had been actioned according to investigation/follow-up letter timeframes and all identified resolution.

There are quarterly staff meetings, monthly wing meetings, monthly clinical meetings, three monthly resident meetings and monthly quality oversight meetings which identified discussion of complaints and outcomes.

Discussion with eight residents (four rest home, four hospital) and nine relatives confirmed they were provided with information on complaints and where complaints forms are located in the facility.

E4.1biii.There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

The previous certification audit identified that where complainants choose not to use a formal complaints form, the service has no process to ensure they are provided with Health and disability information and that education for staff regarding complaints management was required.

Education on complaints was completed in 2011 and in June and August 2013. A total of 34 staff attended the June and August 2013 Complaints management education sessions. There is another education session on complaints scheduled on the 2013 education planner, so that all staff have an opportunity to attend.

Contacts for the Health and Disability Advocacy Service were observed to be printed on the Sprott House Compliments/Suggestions/ Complaints forms.

Information leaflets from the Health and Disability Commissioner's Office were placed beside Compliments/Suggestions/Complaints forms in each wing.

Incident and accident forms have an added section requiring staff to actively advise any complainant of and their right to access Health and Disability Services. Therefore this finding has been addressed.

**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

Sprott House is a not for profit, charitable trust. There is an Organisational chart and a board of trustees.

The service has a mission and values, organisation objectives and an established quality and risk management system.

The Philosophy, Values and Principles are documented.

The Mission statement states that "Sprott House Trust fosters a learning environment where we aim to provide quality care and independence for elderly people while respecting their dignity and individuality."

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

Sprott House provides care for up to 96 residents including a 72 rest home and hospital level care beds and 24 dementia beds in a secure unit. On the day of the audit, there were 46 hospital level care residents, 22 rest home level care residents (including one in serviced apartments) and 24 residents in the dementia unit. There are 72 swing beds. There were no residents receiving care under a Medical Contract.

The General Manager is qualified as a RN (though does not hold a practising certificate), BA (SocSci) with HR qualifications and a PG Dip in information management with extensive experience in managing services. The General Manager is supported by a Clinical Services Manager, Quality Manager, Finance Manager, Finance Administrator, Support Service Manager, HR Manager, Receptionist/Administration and three Care/Unit Managers (one in each wing – two are RNs and one is an OT).

**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

Sprott House has an established quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings and also to the Trust Board.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The facility has a master copy of all policies & procedures with a master also of clinical forms filed in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The Policy Review Committee, now the Quality Oversight Committee meetings include discussion on policy approval and review. Meeting minutes were sighted for 16-Sept-13.

The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. Discussion regarding policy development/revision occurs quality oversight meetings, clinical, RN/team leader meetings, staff meetings and at wing meetings. Release of updated or new policy/procedure/audit/education occurs across the facility (sighted). Review of policies and documentation occurred in April 2013.

All meeting templates were reviewed and amended following a finding in 1.2.3.1 at certification audit which required the service to ensure all quality data is reported back to staff.

Added to this the quality manager attends all wing meetings once a month. Therefore this finding has been addressed.

Findings in 1.2.3.3 and 1.2.3.5 at certification audit identified that policies and procedures are an agenda item at wing meetings however they were not documented as being discussed and that staff were not aware of changes to policies. It also identified that the updated quality programme had yet to be fully implemented and established. The process now is that once policies have been though the review process they go to the care managers to discuss with staff. Staff then read and sign to state they have read and understood the policies. The quality system was evidenced to be established and implemented. Caregivers interviewed were able to describe the agenda and content of meetings. Therefore these findings have been addressed.

RN and Clinical Team consultation has occurred as the GM advises that the facility is moving towards implementing a Best Practice Manual which is based on evidenced based research.

Key components of the quality management system link to the monthly QM reports through quality reports provided from departments.

Monthly reports by General Manager to the Board of Trustees provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the quality manager that break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents; b) The complaints process is linked to the quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Complaints are included in the GM monthly report to the Board of Trustees.

The monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. The service is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided via graphs and benchmarking reports.

The facility receives two monthly benchmarking reports from Healthcare Help. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality improvement forms are utilised and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.

Reports and all meeting minutes provided to the monthly quality oversight committee meeting include areas identified for improvement and actions initiated. Meetings were evidenced conducted as per the meeting planner. These improvements were implemented following a finding in 1.2.3.7 at certification audit.

D19.3:There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management policy guides practice.

The facility in August 2013 presented three submissions in the CCDHB Quality and Innovation Awards 2013. The entries were in the following categories; Leadership achievement award, Commitment to quality improvement award- Wound mapping and Excellence in Innovation Award- Sanitizer for all Contact surfaces: Chlorine based Bleach.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, review of medication with GP, hi/lo beds, assessment and exercises by the physiotherapist, and sensor mats. A physiotherapist is contracted for eight hours per week.

**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

D19.3c: The service collects incident and accident data.

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. Individual incident reports are completed for each incident/accident, with immediate action noted and any follow up action required. The data is linked to the Healthcare Help benchmarking programme and this is used for comparative purposes. Minutes of the monthly quality oversight meetings, three monthly H&S meetings, staff meetings and Wing meetings reflect a discussion of results.

Fifteen incident forms for July 2013 in Duncan Lodge were reviewed which included seven falls and eight skin tears.

In North wing incident forms for six falls and three skin tears were reviewed.

In West wing incident forms for six falls and one skin tear were reviewed.

In Rennie wing one incident form was reviewed for a skin tear.

All forms were fully completed, with assessment by an RN documented and any follow up/ preventative action documented and implemented where applicable. Communication with family is documented in resident files and the incidents were evidenced documented in progress notes.

There was one incident of serious harm (Medication error) documented as occurring in December 2012. The DHB, MOH and ACC report were evidenced completed. An Investigative report was completed and corrective action implemented to minimise the risk of reoccurrence.

**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

Register of registered nurses' practising certificates is maintained. Website links to the professional bodies of all health professionals have been established and are available on the computers and in a folder.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seventeen files reviewed files (two registered nurses, three care managers, one quality manager, ten caregivers, ). Eight of ten files had up to date performance appraisals. Two staff had not been employed for more than 12 months therefore annual appraisals were not yet due. All staff files included a personal file checklist.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g. caregivers two weeks, RN four weeks), during this period they do not carry a clinical load. Completed orientations are in staff files. This is an improvement implemented following a finding identified at certification audit. Staff interviewed (two registered nurses and eight caregivers) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. One caregiver interviewed had recently commenced employment at the facility and reported that the orientation process was thorough, with on-going support being provided by more senior care givers the care manager, clinical services manager, QM and GM.

Interviews with the QM confirmed that the caregivers when newly employed complete an orientation booklet. There is an annual education schedule that is being implemented. External education is available via the DHB. There is evidence on RN staff files of attendance at the RN training day/s and external training. There is specific Spark of Life training for all staff.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the staff meetings.

A competency programme is in place. Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.

Two RNS ( clinical services manager and one care manager) have attended InterRAI training. One Care Manager and one RN is enrolled to attend in October 2013 and four RNs will attend training in January 2014.

There is one RN who is supported on NETP course.

Registered nurses have access to PDRP via CCDHB.

E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

Fourteen staff work in the dementia unit, nine have completed Careerforce dementia standards, one is in the progress of completing dementia unit standards. Of the four staff members who have not yet completed dementia unit standards, two have started working in the dementia unit in the last six months and two are completing Career force core competencies and will then will complete dementia unit standards.

The quality manager advised that they are able to use other members of staff from the hospital and rest home to cover for staff sickness and holidays in the dementia unit as six other staff members have completed dementia unit standards.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

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

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

There is a roster for each area that aligns with contractual requirements and includes skill mixes.

There are three units/departments within the facility. There is an experienced care manager in each area, who work Monday-Friday 40 hours per week.

Two of the care managers are registered nurses and the care manager of Duncan Lodge dementia unit is an occupational therapist.

The service provides 24 hr RN cover. The Clinical Services Manager and Care Managers provide on call over on a three weekly rotating roster. Interviews with relatives and residents all confirmed that staffing numbers were good. Caregivers/registered nurses interviewed stated that staffing ratio to residents is good, that they have input into the roster and management were supportive around change when times are busier and resident acuity levels were higher.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

D16.2, 3, 4: The 12 files reviewed (three rest home, five hospital and four dementia care), identified that in all 12 files an assessment was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed by a RN and amended following three monthly multidisciplinary review meetings and when current health changes. Seven residents interviewed (four rest home and four hospital) reported their needs are being met.

All 12 care plans evidenced evaluations completed at least six monthly. A range of assessment tools were completed in resident files on admission as appropriate and completed at least six monthly including (but not limited to); a) dietary profile b) coombes falls risk c) waterlow pressure area risk d) pain assessment (wong baker pain scale and Abbey pain scale e) wound assessment f) challenging behaviour

The Liverpool care pathway is in place with support, advice and resources available from the Mary Potter hospice. InterRAI training is occurring for the RN's.

A physiotherapist is contracted for eight hours a week. There is evidence of other allied health professional involvement in the delivery of service to meet the residents assessed needs including dietitian, podiatrist, speech language therapist, wound care nurse, continence nurse, hospice, district nurses, assessment liaison nurse, geriatricians, psychogeriatricians and mental health services for the older person.

D16.5e: Twelve 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 3 monthly. There is evidence of more frequent GP visits for residents with more complex or acute needs. The home GP visits twice a week and co-ordinates appointments for resident three monthly reviews and other resident visits where there are health or medical concerns. The GP's provide medical cover for each other’s leave. The Care Managers provide afterhours call for the facility. The medical central have an afterhours service and a GP is able to be contacted. Residents are transferred to the hospital Emergency department as necessary.

Three rest home resident files sampled are as follows: 1) resident recently admitted to rest home with wound 2) resident receiving palliative care and controlled drugs for breathlessness 3) resident with chronic pain

Five hospital residents files sampled (two from North wing, two from west wing, one from Rennie wing) as follows: 1) `resident with swallowing difficulties and weight loss 2) resident serial faller , now resolved 3) resident with chronic leg ulcer 4) fall with fracture - resident re-assessed to hospital level 5) resident blind has chronic lumbar pain and has challenging behaviours.

Four dementia care resident files sampled as follows: one resident identified as a high falls risk. one resident with a fracture and wound following a fall, one resident who is a recent admission and one resident with challenging behaviours.

Tracer Methodology; Dementia

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

Tracer Methodology: Hospital resident

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

Tracer Methodology: Rest home 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

There is a previous finding around the results of risk assessments not being reflected back into the long term care plans for residents in Duncan Lodge (dementia care). A range of assessment tools are completed in resident files on admission as appropriate and reviewed at least six monthly including (but not limited to); a) dietary profile b) coombes falls risk c) waterlow pressure area risk d) pain assessment (wong baker pain scale and Abbey pain scale e) wound assessment f) challenging behaviour. The results of the risk assessments are reflected in the long term care plans. This is an improvement from the previous audit.

**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 1.3.6 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

When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist nurse consultation. The RN and Healthcare assistants interviewed stated that they have all the equipment referred to in care plans necessary to provide care, including hoist, pressure relieving mattresses and cushions, shower chairs, transfer belts, slippery sams, wheelchairs, walking frames, chair scales, gloves, aprons and masks.

D18.3 and 4 All staff report that there are adequate continence supplies and dressing supplies. The Registered Nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

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 by the clinical manager and RN's. Continence management in-services have been provided.

Comprehensive wound assessments are carried out with each dressing change and include monitoring the size of the wound, condition of the surrounding skin, exudate, odour, signs of infection, type and frequency of dressing changes. Wound dressing changes are also recorded in the resident progress notes. The RN assesses and evaluates all wounds. There are four skin tears, one surgical wound, one biopsy site, three ankle ulcers and one chronic sacral ulcer in the hospital wing (includes Rennie wing). The rest home wounds include four limb wounds, one pressure area of toe and two skin tears. One chronic wound in the rest home is not linked to a short or long term care plan. There are no wounds in the dementia care unit. There is access to wound care nurses and specialists as required. Wound care education has been provided.

Food and dietary requirements are completed on admission and reviewed six monthly or earlier if required. Residents are weighed monthly. One resident in the hospital with swallowing difficulties has had a weight loss of 2kg in one month. Another hospital resident has had a weight loss of 3kg over three months.

Pain assessments are completed for all residents on pain relief for new or chronic pain. The pain assessments are reviewed at least six monthly or earlier if required. Pain management is reviewed at the three monthly resident reviews with the MDT team.

There is an improvement required around the use of short term care plans for weight management and pain management

Falls risk assessments are carried out on admission and reviewed at least six monthly or earlier when a resident falls. The risk level is documented in the long term care plan and any interventions required to maintain the residents safety. There is evidence of a resident serial faller having monthly reviews of risk assessment, short term care plan in place, physio referral and physio assessment , falls minimisation checklist completed, GP and family notified and closer observation of the resident is maintained around the time falls have occurred. The dementia care unit use sensor beams for high risk falls residents.

Long term care plans include medical problems, medication and interventions required for the resident to meet their goals. One rest home resident suffers from breathlessness and is prescribed a controlled drug to reduce breathlessness. Medical intervention for this resident is not documented in a short term or long term care plan therefore an improvement is required.

The number of resident files sampled extended from 10 to 12 to seek further evidence of wound care documentation and weight loss management.

Improvements are required around the documentation of interventions to reflect the resident’s current needs for wound care, pain, medical problems and weight loss. The shortfall in the previous audit in regards to management of behaviours has been corrected.

**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

Comprehensive wound assessments are carried out with each dressing change and include monitoring the size of the wound, condition of the surrounding skin, exudate, odour, signs of infection, type and frequency of dressing changes. Wound dressing changes are also recorded in the resident progress notes. The RN assesses and evaluates all wounds. Food and dietary requirements are completed on admission and reviewed six monthly or earlier if required. Residents are weighed monthly. Pain assessments are completed for all residents on pain relief for new or chronic pain. The pain assessments are reviewed at least six monthly or earlier if required. Pain management is reviewed at the three monthly resident reviews with the MDT team.

Long term care plans include medical problems, medication and interventions required for the resident to meet their goals.

**Finding Statement**

i) One chronic wound in the rest home is not linked to a short or long term care plan ii) One resident in the hospital with swallowing difficulties had a weight loss of 2kg in one month. Another hospital resident has had a weight loss of 3kg over three months. There is no short term care plan or interventions in place as per the weight management policy for the two residents with weight loss. iii) One hospital resident experiences pain at the wound site and the interventions to keep the resident comfortable have not been documented in the short term care plan iv) One rest home resident suffers from breathlessness and is prescribed a controlled drug to reduce breathlessness. Medical intervention for this resident is not documented in a short term or long term care plan.

**Corrective Action Required:**

Ensure interventions are documented to reflect the resident’s current needs for wound care, pain, medical problems and weight loss.

**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

The activity team includes three activity coordinators (one has almost completed DT qualifications). Two activity persons work fulltime and the third does 24 hrs a week. The Unit Manager in Duncan Lodge (dementia care) is a qualified Occupational Therapist and oversees the activities programme. The OT is available to receive RN referrals for OT assessment if required. The team meet weekly to plan the programme and monthly with the clinical services manager. The team attend education and in-service relevant to their roles. There is a main programme with shared activities open to all residents (as appropriate) that include entertainment, mental stimulation (such as crosswords and word finds), weekly church services, canine friends visits and bowls/exercises. Each unit has specific programme activities that are appropriate to the resident’s physical and cognitive needs such as exercises, news/current affairs, crosswords, chat/discussion groups. There is one on one time with residents evidenced in the individual monthly progress notes. A Link programme with the local school has an adopt a grandparent scheme. RSA members visit residents on a regular basis. Volunteers visits in the weekends and spend time with residents including playing bowls, crosswords, reading and conversation. The community van and mobility taxi are used for outings. The activity person makes contact with a resident and their family/whānau within 24 hours of admission. Their activity care plan is developed within three weeks of admission in consultation with the resident/family/whānau. Attendance sheets and individual monthly progress notes are maintained. Reviews take place every three months. The lifestyle plans for residents in Duncan Lodge (dementia care unit) are developed by the OT and RN and include biological, societal, interpersonal, creative (24 hr plan) and symbolic (cultural) areas of person centred care. There are spacious areas within each unit where activities take place. Feedback on the programme is received through three monthly resident meetings and regular surveys. Residents interviewed (four rest home and four hospital) stated they enjoyed the activities, entertainers and outings provided.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

The long term care plan is reviewed at least six monthly. Written evaluations are evident in the resident records. Three monthly MDT reviews occur involving the GP, RN, caregiver and relevant allied health professionals involved in the residents care. Resident/family/whānau are invited to attend the MDT. The family contact record evidence family/whānau input into the review process. Relatives (three rest home, two dementia, four hospital ) and residents (four rest home and four hospital) confirm they are involved in the review of the care plans and the three monthly review with the GP. The GP examines the residents three monthly and reviews the medication chart. Improvements are required around the documentation of interventions to reflect the residents current needs for wound care, pain, medical problems and weight loss. Monitoring charts such as blood sugar level monitoring, behaviour monitoring, weight charts and effectiveness of pain relief are evidenced in use. Changes are made to the long term care plan or a short term care plan commenced for any changes/interventions required as a result of the review process. This shortfall identified in the previous certification audit has been addressed.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated

D16.3c: All initial care plans 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

There are medication policies and procedures in place that meet legislative requirements. All clinical staff who administer medications are competency assessed and attend annual medication education provided by the supplying pharmacy. The RNs attend syringe driver training and annual refresher at the Mary Potter hospice. The pharmacy provides the blister packs and these are checked by the night shift RN on delivery. Discrepancies are reported back to supplier. There are no standing orders in use. Verbal order forms are available. The main medication room with a controlled drugs safe and medication fridge is located in the hospital wing (North). The hospital unit holds a stock of Liverpool care pathway medications. There is evidence of weekly stocktakes of controlled drugs and six monthly pharmacy audit. The medication fridge temperatures are within an acceptable range. Each area has a locked medication trolley kept in a locked treatment room or cupboard within their unit. All eye drops are dated on opening. Expiry dates of medications in stock are monitored. There is a self-medication policy and self-medication competency assessments in place for the two residents in west wing that are self-medicating. There is an improvement required around the self-administration of medications. The use of prn medications are monitored and signed with times when administered. All prn antipsychotic medications require the authorisation of the RN before administration by medication competent care givers. Staff are required to demonstrate that alternative strategies has been used prior to the use of prn medication for agitation/aggressiveness. Controlled drugs are signed on the administration sheet by two medication competent persons. Thirty two medication charts sampled had photo identification and allergies/adverse reactions documented. All medication charts documented the route of medications. This is an improvement from the previous audit. Two prn medications (morphine elixir and risperidone) do not have an indication for use on the medication chart. Medication information in the medication folder includes approved abbreviations and the rights of medication administration. There is a current specimen signature list of medication competent persons.

D16.5.e.i.2; Thirty two medication charts sampled (18 hospital, eight dementia, six rest home) identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

The RN's carry out weekly checks on emergency equipment. There are two oxygen cylinders unrestrained in the hospital (North) treatment room. There is an improvement required around the safe storage of oxygen cylinders. Sharps are disposed of into approved biohazard containers.

**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

i) The use of prn medications are monitored and signed with times when administered. All prn antipsychotic medications require the authorisation of the RN. Staff are required to demonstrate that alternative strategies has been used prior to the use of prn medication for agitation/aggressiveness.

ii) The RN's carry out weekly checks on emergency equipment. There are two oxygen cylinders unrestrained in the hospital (North) treatment room. Oxygen cylinders are to be stored safely.

**Finding Statement**

i) Two prn medications do not have an indication for use on the medication chart. ii) There are two oxygen cylinders unrestrained in the hospital (North) treatment room.

**Corrective Action Required:**

i) Ensure prn medications prescribed have an indication for use. ii) Oxygen cylinders are to be stored safely.

**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-medication policy. Self-medication competency assessments are in place for the two residents in west wing that are self-medicating.

**Finding Statement**

The competency assessments in place are incomplete and have not been reviewed three monthly as required. There is no monitoring of the self-administration of medications. One resident is self-medicating a controlled medication.

**Corrective Action Required:**

Ensure self-medication competencies are completed, reviewed at least three monthly and monitoring occurs as per the self-medication policy.

**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

A catering company have the contract to provide meals for the residents at Sprott house. All food is prepared and cooked on the premises. There is a four weekly winter and summer menu that has been reviewed by the Medirest dietitian. The summer menu is currently being reviewed and will include resident choices as fed back from resident meetings and verbal feedback. There is a chef/site manager, cook and two kitchen hands on duty daily. The main meal is at midday. Trolleys with individual meal trays and heat lids are delivered to the unit serveries. The chef receives a dietary requirements form for each new resident admission with documented nutritional needs, likes and dislikes. Vegetarian, gluten free and modified/soft/pureed meals are provided. Alternative meals are offered as required. Sandwiches and nutritious snacks are delivered to the dementia care unit daily. The kitchen is notified of any dietary changes, special requirements and any residents with weight loss. Temperature monitoring carried out on hot food daily. The walk-in chiller, fridges, freezer and dishwasher temperatures are monitored at least daily. The company who hold the chemical supply contract conduct quality control checks on the dishwasher and monitor chemical usage and effectiveness. Chemicals are stored safely.   
E3.3f, there is evidence that there is additional nutritious snacks available over 24 hours

D19.2 The chef and cooks are fully qualified. All kitchen staff have been trained in safe food handling and chemical safety.

**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

Sprott House provides rest home, hospital and dementia care in wings (North, West, Rennie and Duncan Lodge) within the same facility. There is secure access to Duncan Lodge (dementia care). The building has a current warrant of fitness dated 18-Jul-14.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities.

D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, wheelchairs, walking frames, hoists, heel protectors, transferring aids. Clinical equipment is calibrated annually.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; There is a safe and secure outside area that is easy to access. There is a draft plan for an upgrade of the garden areas and improving the indoor/outdoor access for residents.

**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 1.4.4 Personal Space/Bed Areas**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.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:** Not Applicable

**Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.**

**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

Sprott House has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers.

The policy includes that enablers are voluntary and the least restrictive option. Forms include a restraint and enabler register, a restraint assessment form, a restraint consent form and restraint monitoring form.

Strategies are in place to minimise the use of restraint including, sensor mats, hi-low beds, mobility aids and regular observation of residents.

There are six residents with an enabler (bedrail) in use and nine restraints. Eight residents require the use of a bed rail as a restraint and one resident requires the use of a bedrail, lap belt and fall out chair as a restraint.

One enabler file was reviewed and included consent and assessment.

Three restraint files reviewed contained assessments, consents and evaluation of the need for continued use of restraint. Restraint monitoring was evidenced completed by staff. Restraint/enablers are reviewed monthly at the quality oversight committee and monthly at the restraint oversight committee meetings and three monthly in resident care plans. There is a consumer representative on the restraint committee.

E4.4a: the care plans reviewed in Duncan Lodge dementia unit focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 Surveillance**

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

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

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

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The quality manager uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the quality manager. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality oversight committee meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme.

Results of infection control data collated is graphed and also discussed at staff and at wing meetings.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

Infection control is part of benchmarking with Healthcare Help which compares infection control data gathered with that of other NZ aged care facilities.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.

The facility had a gastroenteritis outbreak in March 2012 and again in May 2012. The outbreak in May 2012 was confirmed as Norovirus by the Public Health Team. The outbreak lasted for a week with 9% of residents and no staff being affected.

The service had reviewed their cleaning and laundry processes following the original outbreak in March 2012 and found that there was among all the cleaning agents in use there was no sanitizing chemical being used. The facility has implemented using a chlorine bleach as a disinfecting agent to clean all toilets and surfaces.

The facility entered a submission to the CCDHB Quality Improvements Innovation Awards in 2013 for their outbreak management. CCDHB acknowledge the effective infection control measures that were implemented and have requested permission to use it as an example of how to manage an outbreak.

The DHB and public health were notified of the outbreaks. Staff received education on hand washing techniques and use of PPE.

Contact with family is documented in the residents files. The progress notes record the monitoring and care given to those residents who were affected by the virus.

**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:**