**Rosebank Residential Limited**

**Current Status:** **07-Oct-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**

Rosebank Residential Limited is a 100 bed facility that continues to provide aged care services to people in the town of Ashburton. The facility's 35 bed hospital wings were fully occupied on the day of the surveillance audit, and 60 of the 65 rest home beds were in use.

Quality management systems are being consistently implemented and quality improvement projects are being developed. However, these systems and projects are not filtering into all areas of service delivery, as reflected in the areas identified as requiring improvement.

Of the nine areas identified as requiring improvement in the previous audit, six have been addressed. Further improvement is required in relation to GP reviews of care plans; family and residents' involvement in the development of care plans and the need for activities staff to have a first aid certificate. Additional areas that require improvement relate to the need for the menu to be reviewed, for staff to meet their education and training requirements, that care plans and activity plans detail interventions, that evaluations of care plans show progress towards the achievement of personal goals and that the care plan is updated when changes occur. Medicine management also requires improvement with some current practices presenting as high risk.

**Audit Summary AS AT** **07-Oct-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  07-Oct-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  07-Oct-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit  07-Oct-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  07-Oct-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  07-Oct-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  07-Oct-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** |

**Rosebank Home and Hospital**

Rosebank Residential Limited

Surveillance audit - Audit Report

Audit Date: 07-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Rosebank Residential Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Rosebank Residential Limited | 77 Walnut Avenue |  | Ashburton |

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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:** 07-Oct-13 **End Date:** 07-Oct-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | RCpN, MPH; NZQA 8086 | 8.00 | 4.00 | 07-Oct-13 |
| Auditor 1 | XXXXXXXX | NZRN, Post grad dip (Otago) Lead Auditor NZQA 8086 | 8.00 | 4.00 | 07-Oct-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX | RN,MBA,NZQA 8086 |  | 2.00 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16 | **Total Audit Hours off site** *(system generated)* | 10 | **Total Audit Hours** | 26 |
| **Staff Records Reviewed** | 12 of 130 | **Client Records Reviewed** *(numeric)* | 10 of 95 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 10 |
| **Staff Interviewed** | 13 of 130 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 8 of 95 | **Number of Medication Records Reviewed** | 20 of 95 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXXX (occupation) Director of (place) Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofThe DAA Group Limited, an auditing agency designated under section 32 of the Act.

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

Dated this 23 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rosebank Home and Hospital | 100 | 95 | 10 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Rosebank Residential Limited is a 100 bed facility that continues to provide aged care services to people in the town of Ashburton. The facility's 35 bed hospital wings were fully occupied on the day of the surveillance audit, and 60 of the 65 rest home beds were in use.

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Of the nine areas identified as requiring improvement in the previous audit, six have been addressed. Further improvement is required in relation to GP reviews of care plans; family and residents' involvement in the development of care plans and the need for activities staff to have a first aid certificate. Additional areas that require improvement relate to the need for the menu to be reviewed, for staff to meet their education and training requirements, that care plans and activity plans detail interventions, that evaluations of care plans show progress towards the achievement of personal goals and that the care plan is updated when changes occur. Medicine management also requires improvement with some current practices presenting as high risk.

1.1 Consumer Rights

Open disclosure is occurring and records of this are evident in residents' records and are documented in incident reporting forms.

A complaints process is implemented according to policies and procedures, which meet the timeframes required in the standard. A complaints register shows two complaints for 2013, both of which have been followed up by the manager in a timely manner.

1.2 Organisational Management

A vision and mission statement provide an organisational philosophy. Nine quality based objectives guide organisational management and the quality system. There is a continuous quality improvement committee, which is instrumental in overseeing the control of the organisational policies and procedures, the internal audit system, the review of data on complaints and incident reporting and for ensuring staff are aware of results and planned interventions for quality improvement.

Human resource processes guide the employment, performance and education of staff. Recruitment processes are in place, although the recording of these requires attention. Professional qualifications are validated, a comprehensive orientation programme is provided to new staff and the orientation checklists are being consistently signed off. Staff education and training is recorded electronically in a spread sheet and show registered nurses now have current first aid certificates, which was not evident at the last audit. The need for activities staff to have a current first aid certificate, as identified at the certification audit, and attendance at staff training sessions still require improvement.

1.3 Continuum of Service Delivery

There is a multidisciplinary team approach in assessing the residents' needs on admission and on an on-going basis. The admitting registered nurse (RN) develops care plans to guide care staff in service provision and reviews these at least six monthly, or if progress is less than expected, to reflect the resident's changing needs and desired outcomes. This occurs as a verbal consultation with the resident and their support person, however it is not documented and this area still requires improvement. Short term care plans are detailed and easy for staff to follow reflecting the residents' needs, however long term plans require some improvement in the detail of interventions provided. Observation of care staff, review of written progress notes, and resident and family interviews, verify that staff provide individualised care. There is evidence in residents' files of referral to other health services and that the choices of residents and their families are being respected.

Activities are age appropriate and varied. Families interviewed state that activities they have observed are suitable for their family member and this is also verified by residents interviewed, however individual activity plans do not detail resident's specific interests and this is an area of required improvement.

Policies and procedures, storage and reconciliation of medicines meets legislation and guidelines. A 'robotic pack' system is implemented. Medication administration is observed on the day of the audit. A RN or care staff assessed as competent to do so, follow a GP prescription record to administer medications. A previous required improvement regarding controlled drugs has been addressed, however improvements are required related to RNs transcribing; faxed prescription records; bracketing and dating prescription records; crushed medications; and detail for 'as required' medications.

A dietary profile is completed for each resident on admission and any special dietary needs are provided. Personal likes and dislikes are catered for, and residents have a role in menu preferences at residents' meetings. Those interviewed are satisfied with the meals provided. Appropriate storage refrigeration and food preparation is occurring. The current menu has not been reviewed by a dietitian and this area requires improvement.

1.4 Safe and Appropriate Environment

The building warrant of fitness is current. There have not been any structural changes to the facility since the previous certification audit. Two areas for improvement that were identified at the previous audit are reported on as part of section 1.2 under staff education and training.

2 Restraint Minimisation and Safe Practice

Restraint minimisation and safe practice policies and procedures define enablers and different types of restraint in a manner that meets the standard. The managers and staff are aware of the difference between them and there is documentation in residents' records that demonstrate enablers are being used according to the service provider's policies and procedures.

3. Infection Prevention and Control

There is a defined infection prevention and control programme that includes monthly surveillance data collection. The Infection control nurse has recently resigned and the nurse manager has assumed the role in the interim and provides reports to the quality committee, and governance regarding all collated data, trends and patterns. Infection control education is evaluated and collected data is detailed and includes all relevant information and these areas of improvement are now met.

Summary of Attainment

* 1. Consumer Rights

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 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:10 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:4 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 | PA Moderate | 0 | 2 | 2 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:15 PA:2 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 | PA Moderate | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Low | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Low | 0 | 0 | 2 | 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 High | 0 | 2 | 2 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Low | 0 | 2 | 1 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 1 PA Neg: 0 PA Low: 3 PA Mod: 1 PA High: 1 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:7 PA:7 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:8 CI:0 FA: 0 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:0 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 | FA | 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: 3 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 34 **CI:** 0 **FA:** 10 **PA Neg:** 0 **PA Low:** 3 **PA Mod:** 2 **PA High:** 1 **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:** 29 **PA:** 9 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Rosebank Residential Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:07-Oct-13 End Date: 07-Oct-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.7 | 1.2.7.3 | PA  Low | **Finding:**  Although there is no evidence that service providers are not appropriate to safely meet the needs of the residents, there are inconsistencies in the documentation retained in the staff records. Not all staff records include evidence of initial interviews, or of referee checks that demonstrate these safety mechanisms are in place.  **Action:**  That evidence of initial interviews and of referee checks having been made is retained in staff files for all employees. | Six months |
| 1.2.7 | 1.2.7.5 | PA  Low | **Finding:**  The electronically maintained staff training records show that a significant number of staff have not completed, or attended updates, on education topics that have been identified as compulsory. Examples include infection control, emergency response, health and safety and safe food handling (kitchen staff). Neither do the records clearly indicate caregivers' levels of attainment in the ACE programme. The diversional therapist and the assistant activities coordinator transport residents off site. Neither person has a current first aid certificate.  **Action:**  1) That all staff complete and/or update on the mandatory staff training topics and that caregivers participate in the ACE programme as per the ARRC contract. 2) That staff responsible for residents when transported off site have a current first aid certificate. | Six months |

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| --- | --- | --- | --- | --- |
| 1.3.3 | 1.3.3.3 | PA  Moderate | **Finding:**  Ten resident care plans are reviewed (the sample size has been increased from seven to ten to verify consistency). Six hospital wing and four rest home wing residents. Residents files reviewed have GP routine reviews however four of six files in the hospital wing, and one of four files in the rest home wing have three monthly GP reviews, but do not have evidence that the GP indicates the resident is clinically stable and a three month review (rather than one month) is recommended.  Residents' care plans reviewed do not have evidence of family or resident input. Family and residents interviewed (three of three family and five of five residents) also verify they do not have input into care plan development, or view care plans, but all state that they are happy with the level of care provided.  **Action:**  1) Documented evidence is required that the GP recommends the resident is clinically stable and requires three monthly reviews, rather than monthly as per ARRC agreement. 2) Resident care plans are developed and updated with documented evidence of resident and family input. | Three months |
| 1.3.6 | 1.3.6.1 | PA  Low | **Finding:**  Ten care plans are reviewed. Six in the hospital and four in the rest home. There is not sufficient documented detail in the care plan interventions of those reviewed. For example a resident with bilateral below knee tubigrip applied during the day and taken off at night, has makeup applied daily by staff, attends the hairdresser weekly, does not have these support needs included in the interventions on her care plan. Two residents with oxygen concentrators and one who has a xxxxxxx that care staff attend to, do not have the support detail included for staff to manage these interventions on a daily basis. One resident who has specific activity preferences does not have this included on her activity plan.  **Action:**  Care plans and activity plans include the detailed interventions that are consistent with the resident's identified needs and outcomes. | Six months |
| 1.3.8 | 1.3.8.2 | PA  Low | **Finding:**  Ten care plans are reviewed. In all those reviewed the evaluations does not indicate the achievement toward the resident's goals or needs. For example a resident with increased oedema does not have the decreasing level of oedema, with the use of tubigrip, included in the evaluation. Two other residents who require assistance to mobilise have "no change" as an evaluation when the progress notes indicate increased supervision with mobilisation is required. Two residents who have an indwelling catheter in place, have "catheterised" as the evaluation.  **Action:**  Evaluations are documented to indicate the degree of achievement of the intervention in meeting the desired outcome. | Six months |
| 1.3.8 | 1.3.8.3 | PA  Low | **Finding:**  The facility has a yellow short term care plan form that is detailed and includes interventions and evaluations. However long term care plans are not always updated on review when progress is different than expected, for example reduced mobility (now requires a full hoist) and indwelling catheter, bowel management for a resident who is faecally incontinent, and the application of tubigrip when bilateral leg oedema is present.  **Action:**  Where progress is different than expected the long term care plan is updated to reflect the change. | Six months. |
| 1.3.12 | 1.3.12.1 | PA  High | **Finding:**  Twenty medication files are reviewed. Not all medication management is in line with legislation and guidelines and this requires improvement.  1. Fifteen have been transcribed by the facility Registered Nurse and signed (initialled) by the GP.  2. Six of twenty records have been bracketed when signed by the GP.  3. Eight of twenty do not have a date against each record.  4. Eight medication records are faxed records that have not had the original record signed by the GP within the next two working days (as per medication guidelines).  5. Medications (10 of 20) are crushed, but there is no signed authority for this to occur.  **Action:**  A medication management system is in place that is in line with legislation, protocols and guidelines. | One month |
| 1.3.12 | 1.3.12.6 | PA  Low | **Finding:**  Five of twenty medication records reviewed do not include the reason for PRN medication, for example morphine, paracetamol, and laxatives.  **Action:**  Medicine management information is recorded to a level of detail, and frequency to comply with legislation. | Six months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.13 | 1.3.13.1 | PA  Low | **Finding:**  The current menu that has recently changed has not yet been reviewed by a dietitian and there is no evidence to show that previous winter menus have been reviewed.  **Action:**  That menus are reviewed by a dietitian to ensure residents are provided with food and fluid that meets their nutritional needs. | Six months |

# Continuous Improvement (CI) Report

Provider Name: Rosebank Residential Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:07-Oct-13 End Date: 07-Oct-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.9 Communication**

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

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

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

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

A policy on open disclosure includes the right for the person/resident to be fully informed. There is evidence in completed incident forms that relatives are being contacted. Three of three recently completed incident forms for minor injuries to residents note the name of the relative that has been informed, their relationship to the client and the time and date of the contact. All have been reported to family members within twenty four hours.

There are not currently any residents requiring formal interpreter services. One resident who has immigrated from a foreign nation understands English but since the onset of dementia has only spoken in her native language. Her sister assists staff with helping to understand the resident's specific needs. An interpreters' list with contact details of specific languages, which is associated with the spiritual care/cultural, translator and interpreter policies is sighted. The interpreter policy is included in the consumer rights policy.

**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

There is a complaints policy and procedure, which details response timeframes that are consistent with the standard. Seven of seven staff asked during interview are familiar with the complaints process and would seek assistance if a resident or family member expresses concerns or wishes to make a complaint. All are aware of the complaints form and two staff inform that the advocacy service has been used in this facility.

A complaints action log is sighted. This shows that two complaints have been lodged so far this year, both of which were received from relatives. The dates of the complaints, the dates they were acknowledged and the dates that written responses were sent from the manager all meet the requirements of the complaints process. Sighted copies of the completed complaints forms and of the responses from the manager. There are not currently any complaints that remain open.

**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

A two person board, which meets monthly provides a governance structure to the service. One of the directors is the owner, while the other is a nurse who is also a consultant in risk management. The board is responsible for reviewing the scope of the service, the mission statement, the vision and the objectives of the service annually as part of the annual plan and formally every two years. This review process is evident as an additional organisational objective relating to the service providing a safe working environment was added during the 2013 review.

The scope of the service is noted as being to provide services to the sick, disabled, those convalescing from an illness or rehabilitating from an accident and those requiring palliative or terminal cares. The vision is that Rosebank is recognised as the preferred provider of aged care services in Ashburton. The mission statement is 'Through Care to Quality of Life' and a copy of this is displayed at the front entrance (sighted). The mission also notes that they offer excellence in independent living and residential care encompassing the values of respect, hospitality and service whilst maintaining the dignity and integrity of each person.

There are nine objectives for the service into which are integrated issues such as preserving the mission and vision of the organisation, providing resident-centred care, ensuring there is a safe working environment, upholding expected ethical standards and supporting cultural appropriateness.

Rosebank Residential Limited is managed by a person who has suitable qualifications and experience in that she is a registered nurse with an annual practising certificate that is valid until March 2014, has been in her current role for seven years, has a Master’s degree in management (sighted) and previously managed an aged care facility in another town for ten years. She is maintaining her professional development in both clinical and managerial topics.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

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

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

The business plan for 2012 to 2013 was reviewed and developed into one dated 2013 to 2014 (sighted). The plan has an executive summary and covers operating performance, human resources and quality and risk management. There is also a quality and risk management plan, which shows a diagram of the quality structure. This includes a continuous quality improvement plan that has an organisational statement of commitment to quality, a set of key elements, guiding principles, key performance indicators, a list of nine objectives and ways in which these will be monitored and measured. All quality issues are being discussed at the monthly staff meetings and at the separate registered nurse meetings where wider organisational concerns and information are also discussed (minutes sighted). Quality improvement and infection control meetings are held every two months with the last one being 15 August 2013. There are six members on the continuous quality improvement committee, which consists of the manager, the clinical manager, the rest home team leader, the team leaders from kitchen and from the laundry and the staff educator. The manager informs she reports a summary of the minutes from these meetings to the board.

There is a set of quality manuals on a range of topics from general policy and procedures to human resources and health and safety, for example. A policy and procedure on document control details the distribution of these quality manuals, information about documents and data control and states policies and procedures have a two yearly renewal and review timeframe. Document control covers forms, documents related to the quality system, the control of external documents, the controller of quality records including organisational wide policies and procedures, staff files, client files, contract documents, audit and survey reports, meeting minutes and accounting records. Policies and procedures are reviewed according to a checklist within the internal audit system. Reviews are presented at the following continuous quality improvement committee meeting.

The measuring and monitoring programme includes procedural audits and document reviews on resident care; service risks (including incidents); financial and budgeting issues; organisational, legal and management processes; and environmental aspects; analyses of risks and exception reporting. A quality internal audit schedule for 2013 to 2014 is sighted and includes restraint, procedure manuals, resident satisfaction survey, resident clinical documentation, security, medication audit, staff education evaluation form, uniform, plate wastage, and care plans. Infection control has its own audit checklist for cleaning, kitchen, pantry, temperatures for delivered meats, temperatures for hot food at meal times, hand washing and refrigerator temperatures. Every order listed has a delegated staff person who is responsible for ensuring the audit is undertaken on time and the results provided to the continuous quality improvement coordinator. Examples of completed audits are sighted and summary sheets note the date of completion, who undertook the audit and who finally signed it off. Each has a quality assurance summary and states whether no corrective actions were required or details the actions that need to be taken to meet the standards. There is evidence of follow-up and review for each audit. Similarly there is evidence of analysis, evaluation and review for quality improvement data. This information contributes to the manager's report to the board.

The risk management plan has a set of guidelines, risk related definitions, ways of managing risks within a variety of contract and identifies risks for a range of aspects of the organisation. Contributions to the management of risks come from focus groups, incident analysis, concerns, complaints, health and safety reports, internal and external audit results, feedback from the multidisciplinary team, feedback from referrers, individual staff reviews, corrective action reports and the overall collection of quality improvement data. Risks are categorised and ways of mitigating the identified risks are included in the plan. Risk management processes as described by the manager include declining new residents if they do not believe they can adequately meet their needs, only employing staff who they believe are safe to do the job, providing staff training, undertaking annual staff performance appraisals, using disciplinary processes when an issue of concern arises, the presence of house rules and maintaining policies and procedures. Reviews and management of risks reportedly also occur at occupational health meetings which are held every two months, through the internal audit system, the monthly key performance indicators, the budget and the financial audits of accounts at the end of the year.

Results from the 2013 annual residents' satisfaction survey are sighted. A copy is sent to family members if a resident is not able to complete the survey. In some instances one of the volunteers may assist residents who require help to complete it. Results are collated, comparisons are made with previous years and a summary is provided to the continuous quality improvement committee.

The continuous quality improvement coordinator has recently retired and the organisation is currently seeking a new employee for this role. Seven staff confirm during a group interview that they are kept well-informed on quality improvement issues through the staff meetings and through information posted on the noticeboard in the staff room. They also confirm that they may be asked to undertake an internal audit at times.

**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

There is evidence during interview with the manager that she is fully conversant with statutory and reporting obligations. Examples provided included reporting any infectious outbreak to the medical officer of health and the contractor; that there are contractual obligations to notify the funder and the Ministry of Health should the manager leave; if anything serious happens to the building or a resident(s) that the funder and the Ministry of Health are to be advised; that any enquiry from the Health and Disability Commission, such as for a serious complaint, needs to be responded to immediately and that the funder is to be contacted if any reason they are unable to meet their contract.

And incident reporting form is used for any type of an adverse event involving a resident, staff or property. Copies of these are retained and filed according to the different areas of the facility. The number of these forms and the completeness of the data indicates that there is a good culture within the service for using this reporting system. Data on incidents is collated monthly by area and by cause. For example, data on falls, incidence of wandering and medications are analysed according to the time of day, the resident and all staff involved and possible causes. Patterns are sought, risks are identified and interventions are reviewed. All forms sighted are complete, show that follow-up undertaken at the clinical level is appropriate and all have been signed by a reviewer with comments from the team leader or the clinical manager.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Professional qualifications and annual practising certificates are validated and records are being retained by the manager - sighted records for registered and enrolled nurses, general practitioners and pharmacists.

Staff are observed to be professionally presented in uniform and during staff interviews all speak of their enjoyment in their work and that Rosebank is a good place to work. Prior to employment staff complete an application form and this is kept in the twelve of the twelve staff files reviewed. Seven of the twelve files checked also have a curriculum vitae on file. The manager informs that police checks are not required for employment in this service, although one would be done if there was any concern. As a number of staff have immigrated from other countries the manager informs she is satisfied with the rigour of the work permit and visa check process and as a result does not always contact referees. This is not differentiated on staff files and only four of the twelve staff files checked show that a referee check(s) has been undertaken. Notes from initial interviews are in only four of the twelve staff files reviewed. A post-employment interview is undertaken at one month, a review at three months and a performance appraisal is undertaken annually.

An orientation programme is undertaken by new staff. Sighted signed orientation checklists in all except one long term staff person's file. The checklists match to a comprehensive orientation manual that includes information on required competencies and additional job specific checklists are available for different roles. The programme covers emergencies, education, infection control, managing incidents, hazard identification, protective equipment, manual handling, complaints, restraints/enablers, the competency assessment programme (CAP) and standards of employment.

All staff who administer medications have a current medication administration competency. All registered nurses have a current first aid certificate, which addresses an area for improvement that was raised under criterion 1.4.7.2 at the previous certification audit. Staff education sessions are generally added to the end of staff meetings. These have been on hold for four months while a new staff educator was being employed. The new person has been in the role for one month. An electronic spread sheet is used to record staff education and training and participation in Aged Care Education (ACE) modules. It lists both mandatory training topics and optional extras and notes the date of attendance against the staff member's name. There are many gaps against some mandatory education topics, including health and safety, emergency response, infection control, safe food handling (kitchen staff) and it is difficult to see exactly where caregivers are at with their ACE training. A required improvement is to ensure staff complete at least the designated mandatory training within the designated timeframes and for all caregivers to undertake the ACE programme, as required in the aged related residential care (ARRC) contract. An area for improvement identified at the certification audit (criterion 1.4.2.7) around the need for activities staff to have a first aid certificate remains open as their first aid certificates have expired and they are both involved in transporting residents off-site. At the time of the certification audit it was also noted that volunteers do not have first aid certificates. The manager and activities staff confirm that this is not applicable as volunteers are never alone without Rosebank activities staff.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

A process of prospective employees completing an application form, accompanied by a curriculum vitae, an initial interview and follow-up with two referees is in place. Police checks are not undertaken unless indicated and the work permit and visa application process is considered sufficiently rigorous to ensure suitability for employment. There is evidence that staff who have been employed more recently have more pre and peri-employment information in their staff file, however few files show evidence that these processes are being recorded in a consistent manner. Performance review processes are being maintained.

**Finding Statement**

Although there is no evidence that service providers are not appropriate to safely meet the needs of the residents, there are inconsistencies in the documentation retained in the staff records. Not all staff records include evidence of initial interviews, or of referee checks that demonstrate these safety mechanisms are in place.

**Corrective Action Required:**

That evidence of initial interviews and of referee checks having been made is retained in staff files for all employees.

**Timeframe:**

Six months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Staff education and training records and participation in ACE training modules are being maintained electronically. A set of compulsory topics is identified within the spread sheet, as is 'optional extras'. The date of attendance is noted against the staff member's name. There are many gaps against some topics, and it is difficult to see exactly where caregivers are at with their ACE training. An area for improvement identified at the certification audit (criterion 1.4.2.7) around the need for activities staff who transport residents to have a first aid certificate remains open, as their certificates have expired.

**Finding Statement**

The electronically maintained staff training records show that a significant number of staff have not completed, or attended updates, on education topics that have been identified as compulsory. Examples include infection control, emergency response, health and safety and safe food handling (kitchen staff). Neither do the records clearly indicate caregivers' levels of attainment in the ACE programme. The diversional therapist and the assistant activities coordinator transport residents off site. Neither person has a current first aid certificate.

**Corrective Action Required:**

1) That all staff complete and/or update on the mandatory staff training topics and that caregivers participate in the ACE programme as per the ARRC contract. 2) That staff responsible for residents when transported off site have a current first aid certificate.

**Timeframe:**

Six months

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

A staff numbers and skill mix policy is sighted. This lists a set of factors that need to be taken into account when allocating staff, examples of which include: staff skill levels, safety and security needs of both staff and residents, the ability to meet residents' rights, the need for a review whenever core business changes occur, organisational goals, residents' selection criteria and cultural needs. The rosters are completed by the clinical manager and the team leader with the overall mandate being the responsibility of the manager. A formula (sighted) is used to ensure minimum staffing levels align with occupancy rates and adjustments are then made to reflect complexity and additional needs of residents.

Staff inform during interview that staffing levels are adequate with some commenting that at times it can become exceptionally busy if a person falls, or a person becomes unwell. The manager and a registered nurse both report that a registered nurse is available on-call for such instances.

The rosters (sighted) show that at least one registered nurse is on duty over 24 hours on seven days of the week. On the morning shift there is a registered nurse in the hospital and in the rest home and most afternoon shifts also have a rest home based registered nurse, which is a current goal of the service. The swing beds in the rest home are covered by the hospital based registered nurse. The clinical coordinator (mostly hospital based), the team leader (rest home based) and the overall manager are also all registered nurses. Five staff in total cover the night shift from 11pm to 7 am with three based in the hospital and two in the rest home. There are eight staff in the hospital wings on the morning shift and six on the afternoon shift. The rest home area has six in the morning and four in the afternoon. Shift timeframes vary from 6.45 am to 3.15 pm, 7 am to 1.30 pm, 7 am to 1.30 pm, 7 am to 12 noon, 8 am to 12 noon and 8 am to 1 pm. Afternoon shift timeframes vary from 2.45 pm to 11.15 pm, 2.45 pm to 10.15 pm, 3.45 pm to 10.15 pm, 4pm to 11.30 pm, 4 pm to 11pm and 4.30 pm to 11.30 pm.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

The overall responsibility for the care of the residents is provided by the Nurse Manager (interviewed) who is a NZ qualified registered nurse (RN). There is a RN on duty in the hospital wing over 24 hours (roster sighted). The RN (interviewed) is supported by care staff who undergo training as well as attending in-service education specific to the needs of the elderly (training records sighted).

Ten residents' care plans are reviewed (the sample size has been increased from seven to ten to verify consistency), six hospital wing and four rest home wing residents' files. Each resident has an admission profile developed and initial assessment completed prior to, or at entry to the facility by a RN (ten of ten records sighted). Residents have an assessment carried out by the Needs Assessment and Service Co-ordination (NASC) team prior to entry. Initial care plans are completed, based on the assessment information, within 24 hours and long-term care plans within three weeks of admission by a RN - verified in all care plans reviewed.

Long-term care plans sighted are reviewed at least six monthly by a RN, however there is no evidence of resident or family involvement and this area still requires improvement. Short term care plans are developed when an issue arises, for example urinary tract infection, wound or chest infection, and these have detailed interventions and are reviewed regularly.

Rosters indicate that there is a team mix for care provision on each wing. Handover takes place between shifts (confirmed by care staff and observed onsite) and RN input in care provision occurs.

Tracer 1 Hospital level resident

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

Tracer 2 Rest home level of care resident

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

The ARRC requirements D3.1c; D9.1; D9.2; D16.3a; D16.3l; D16.5b; D16.5c ii are met. D16.3e; D16.5e are not met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Ten residents' files are reviewed, and all have assessment prior to entry to the facility by a NASC team. The facility also completes assessments and develops the long term care plan within three weeks of admission. Evaluations and reviews are completed at least six monthly, or more regularly if an issue arises, as sighted in four of four short term care plan reviews. However medical records sighted (five of ten) have three monthly GP reviews, but do not have evidence that three monthly reviews are recommended.

Residents' care plans reviewed do not have evidence of family or resident input. Family and residents interviewed (three of three family and five of five residents) also verify they do not have input into care plan development, or view care plans, but all state that they are happy with the level of care provided.

**Finding Statement**

Ten resident care plans are reviewed (the sample size has been increased from seven to ten to verify consistency). Six hospital wing and four rest home wing residents. Residents files reviewed have GP routine reviews however four of six files in the hospital wing, and one of four files in the rest home wing have three monthly GP reviews, but do not have evidence that the GP indicates the resident is clinically stable and a three month review (rather than one month) is recommended.

Residents' care plans reviewed do not have evidence of family or resident input. Family and residents interviewed (three of three family and five of five residents) also verify they do not have input into care plan development, or view care plans, but all state that they are happy with the level of care provided.

**Corrective Action Required:**

1) Documented evidence is required that the GP recommends the resident is clinically stable and requires three monthly reviews, rather than monthly as per ARRC agreement. 2) Resident care plans are developed and updated with documented evidence of resident and family input.

**Timeframe:**

Three months

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

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

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

The RN is interviewed in the hospital wing and the rest home wing. There is a consistency of care plan documentation in both areas. There are current hardcopy assessments completed for initial nursing assessment, falls risk, skin integrity in all ten files (six hospital and four rest home) reviewed. Continence assessment occurs as required and is sighted in three files reviewed, consistent with the resident's continence status. The residents' needs are identified through the assessment process and included as interventions on the long term or short term care plans (sighted).

Care plan interventions are detailed on the resident's short term care plan (for example in one of one file where the resident has a skin lesion), but this is not always the case for long term care plans and this area requires improvement. For example a resident with bilateral below knee tubigrip applied during the day and taken off at night, has makeup applied daily by staff, attends the hairdresser weekly, and attends specific meetings and activities, does not have these support needs included in the interventions on her care or activity plan.

Family members (three of three interviewed) verify they have input into assessment processes and interventions required, and this feedback is consistent with residents (eight of eight) who confirm they are consulted and have autonomy in making decisions about their care provision.

**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:** Low

The residents' needs are identified through the assessment process and included as interventions on the long term or short term care plans (sighted). Care plan interventions are detailed on the resident's short term care plan (for example in one of one file where the resident has a skin lesion), but this is not always the case for long term care plans. For example a resident with bilateral below knee tubigrip applied during the day and taken off at night, has makeup applied daily by staff, attends the hairdresser weekly, and attends specific meetings and activities, does not have these support needs included in the interventions on her care or activity plan.

**Finding Statement**

Ten care plans are reviewed. Six in the hospital and four in the rest home. There is not sufficient documented detail in the care plan interventions of those reviewed. For example a resident with bilateral below knee tubigrip applied during the day and taken off at night, has makeup applied daily by staff, attends the hairdresser weekly, does not have these support needs included in the interventions on her care plan. Two residents with oxygen concentrators and one who has a xxxxxxx that care staff attend to, do not have the support detail included for staff to manage these interventions on a daily basis. One resident who has specific activity preferences does not have this included on her activity plan.

**Corrective Action Required:**

Care plans and activity plans include the detailed interventions that are consistent with the resident's identified needs and outcomes.

**Timeframe:**

Six 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 co-ordinator is a divisional therapist (interviewed and qualification sighted) who works full time and is supported by an activities person to review the residents' activity programme and plans, and organise the diverse range of activities provided.

Activities are planned and a group programme is developed and provided that includes entertainment (observed on the day of the audit) reading activities, sing-a-long, scrabble, rummikin, knee housie, exercises, scallywag, word games, outings, craft and baking and one to one for those who do not wish to attend the groups.

Family verify they have input into activity plan development on admission and are encouraged to assist in on-going external activities, for example one resident who attends a monthly meeting in the community. Activity plans do not always include activities (interventions) specific to each resident (refer CAR 1.3.6.1).

A church service is held weekly in the chapel and is attended by those who choose to do so. Individual clergy visits also occur. Family and residents interviewed are complimentary of the variety and appropriateness of activities provided.

The ARRC requirements D16.5c.iii, D16.5d are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

The nurse manager and a RN are interviewed. A RN will undertake an initial evaluation of the care plan within three weeks of admission to the facility. On-going reviews are documented on the resident's care plan, at least every six months (sighted in all ten of ten reviewed). Short term care plans are reviewed as indicated by the degree of risk noted during the assessment process and closed out when resolved or transferred to the long term care plan if on-going (for example one resident recently had a sacral pressure area that required wound care and this is now resolved).

Families are involved throughout the review as verbal discussion will take place (indicated in progress notes) in conjunction with the resident and is appreciated and complimented on by family members interviewed, as it keeps them fully informed. If issues arise and progress is not as expected, and the care is reviewed sooner than six monthly, they are advised in a timely manner.

Documentation is detailed in the short term care plans (three of three reviewed) and includes the degree of progress toward meeting the residents' needs, however long term care plans do not have the level of detail or indicate progress toward meeting the identified outcomes, and this is an area requiring improvement. For example two residents who have an indwelling catheter in place, have "catheterised" as the evaluation, and two other residents who require assistance to mobilise have "no change" as the evaluation. The long term care plan is not always updated to reflect a resident's changed needs, and this is an area requiring improvement.

The ARRC requirements D16.3c is met. The requirements D16.3d, D16.4a are not met.

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

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

A RN will undertake reviews and documents all care plan evaluations, at least every six months (sighted in all ten of ten care plan evaluations reviewed). Short term care plans are reviewed as indicated by the degree of risk noted during the assessment process and closed out when resolved or transferred to the long term care plan if on-going (for example, one resident recently had a sacral pressure area that required wound care and this is now resolved). Families and residents (interviewed) are involved throughout the review process. Documentation is detailed in the short term care plans (three of three reviewed) and includes the degree of progress toward meeting the residents' needs, however long term care plans do not have the level of detail or indicate progress toward meeting the identified outcomes.

**Finding Statement**

Ten care plans are reviewed. In all those reviewed the evaluations does not indicate the achievement toward the resident's goals or needs. For example a resident with increased oedema does not have the decreasing level of oedema, with the use of tubigrip, included in the evaluation. Two other residents who require assistance to mobilise have "no change" as an evaluation when the progress notes indicate increased supervision with mobilisation is required. Two residents who have an indwelling catheter in place, have "catheterised" as the evaluation.

**Corrective Action Required:**

Evaluations are documented to indicate the degree of achievement of the intervention in meeting the desired outcome.

**Timeframe:**

Six months

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

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

When an issue arises or progress is not as expected the facility RN (two of two interviewed) will develop a short term care plan that is detailed and reflective of the resident's changed needs. However if the issue continues' and the resident requires the long term care plan updated to reflect these on-going changed needs, this does not always occur.

**Finding Statement**

The facility has a yellow short term care plan form that is detailed and includes interventions and evaluations. However long term care plans are not always updated on review when progress is different than expected.

**Corrective Action Required:**

Where progress is different than expected the long term care plan is updated to reflect the change.

**Timeframe:**

Six months.

**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 High

There are policies and procedures in place for all stages of medication management including self-medication. A robotic medication system is implemented in the facility. The packs are delivered fortnightly from a local pharmacy and reconciled into the facility by the RN (records sighted). Discontinued or unused medicines are returned to the pharmacy at the same time.

A prescription medication record is completed for all residents by the resident's general practitioner (GP) who visits the facility as required and at least every month initially, and then three monthly if the resident is clinically stable. Twenty medication records are reviewed (the number is extended from 14 to 20 to provide consistency), and all have been reviewed three monthly by the GP, are legible and contain the detail required to administer the medication, except for pro re nata (PRN) medications in five of twenty records reviewed.

There is also areas of required improvement identified relating to: the facility faxing the resident's medication prescription record to the GP who makes changes and faxes the record back, but does not update the original copy within 24 hours as required; medication records have been transcribed by the RN and not all are dated against each record, some are bracketed when signed by the GP; medications are crushed without any signed authority for this to occur. There have been no reported incidents relating to medication management.

RNs in the hospital wing and care staff (annual competency assessed and sighted) in the rest home administer medications from the robotic packs and check these against the prescription record (medication administration observed), and the practice meets policy and guidelines.

The RN (interviewed) confirms there are two residents who self-medicate, and the documentation and practice reflects the organisations policies and procedures Medication robotic packs and the medication file is stored in a lockable trolley and stored in the medication room that is number lock secure (sighted).

There are controlled drugs at the facility, in a double locked metal locked storage box in the facility medication room (sighted), and the previous required improvement has now been addressed. A separate storage area in the fridge stores refrigerated medications including eye drops, and medicated creams. The medication fridge temperatures are within recommended guidelines.

**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:** High

There are policies and procedures in place for all stages of medication management including self-medication. A robotic medication system is implemented in the facility. A prescription medication record is completed for all residents by the resident's general practitioner (GP) who visits the facility as required and at least every month initially, and then three monthly if the resident is clinically stable. Twenty medication records are reviewed (the number is extended from 14 to 20 to provide consistency), and all have been reviewed three monthly by the GP. RNs in the hospital wing and care staff who are assessed as competent in the rest home administer medications from the robotic packs and check these against the prescription record. The observed practice meets policy and guidelines. Not all medication management is in line with legislation and guidelines and this requires improvement.

**Finding Statement**

Twenty medication files are reviewed. Not all medication management is in line with legislation and guidelines and this requires improvement.

1. Fifteen have been transcribed by the facility Registered Nurse and signed (initialled) by the GP.

2. Six of twenty records have been bracketed when signed by the GP.

3. Eight of twenty do not have a date against each record.

4. Eight medication records are faxed records that have not had the original record signed by the GP within the next two working days (as per medication guidelines).

5. Medications (10 of 20) are crushed, but there is no signed authority for this to occur.

**Corrective Action Required:**

A medication management system is in place that is in line with legislation, protocols and guidelines.

**Timeframe:**

One 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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

Twenty medication records are reviewed (the number is extended from 14 to 20 to provide consistency), and all have been reviewed three monthly by the GP, are legible and contain the detail required to administer the medication, except for pro re nata (PRN) medications in five of twenty records reviewed.

**Finding Statement**

Five of twenty medication records reviewed do not include the reason for PRN medication, for example morphine, paracetamol, and laxatives.

**Corrective Action Required:**

Medicine management information is recorded to a level of detail, and frequency to comply with legislation.

**Timeframe:**

Six months

**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:** PA Low

Meals are prepared in the on-site kitchen. Although the main cook was absent on the day of audit the supervisor for the day informs that there has been a recent change in the menu due to alterations in the roster. A three week menu on the wall, which has not yet been reviewed by a dietitian, is sighted. It is an area for improvement that all menus are reviewed by a dietitian as previous menu reviews have only included the summer option. Four of four residents inform their meals are hot enough, they believe they are nutritious, albeit there is often repetition, and there is always sufficient to eat. The residents also say that they have other options, such as a poached egg, if they do not like what is on the menu.

A dietary profile is completed for each new resident on admission. This details preferences for breakfast and for hot drinks, any allergies, modified food consistency, food dislikes or special dietary requirements such as gluten free or diabetic diets. Copies of the profiles are sighted in a file. The information is transferred into relevant folders and on whiteboards in the kitchen (sighted). Staff inform they become familiar with special needs and food preferences and the caregivers and clinical staff double check at meal times that any special dietary requirements are being met.

Grocery items, meat and fresh fruit and vegetables are all delivered to the facility. Temperatures of the meat is checked on arrival prior to freezing or refrigerating (records sighted). All food items, including dry goods are dated for the date of arrival and the older items moved to the front. The store room is checked and there is nothing older than one month in storage. Dates are not placed on the decanted dry goods because of the frequency of use of these products in this large facility and the system of dating store room products. Systems for recording fridge and freezer temperatures at the start of the day and for dating items stored in the refrigerator or freezer with any item not used within 24 hours being discarded are in place. Goods are stored off the floor and in storage areas that ensure their integrity will be maintained. Kitchen staff have not all undertaken training in safe food handling, or are well overdue for a refresher and this is identified as part of the required improvement in criterion 1.2.7.5.

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

Meals are prepared in the on-site kitchen. Although the main cook was absent on the day of audit the supervisor for the day informs that there has been a recent change in the menu due to alterations in the roster. A three week menu on the wall, which has not yet been reviewed by a dietitian, is sighted. It is an area for improvement that all menus are reviewed by a dietitian as previous menu reviews have only included the summer option.

**Finding Statement**

The current menu that has recently changed has not yet been reviewed by a dietitian and there is no evidence to show that previous winter menus have been reviewed.

**Corrective Action Required:**

That menus are reviewed by a dietitian to ensure residents are provided with food and fluid that meets their nutritional needs.

**Timeframe:**

Six months

**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:**

**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

A February 2012 policy and procedure on restraint minimisation includes a definition of enablers and of various types of restraint that meet the requirements of the standard. This states the use of enablers is voluntary and will ensure the safety and comfort of the resident(s). The manager is able to convey the difference between restraint and enabler and informs the restraint form requires the assessor to differentiate between restraint or enabler. Similarly, during a group interview with seven staff, all are aware of the difference between an enabler and a restraint and confirm they have undertaken training on the topics. Staff training records show staff are up to date with their training on restraint minimisation and safe practice.

**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 infection control (IC) nurse has recently resigned and the nurse manager (interviewed) has temporarily assumed the role. IC control policies and procedures describe the processes for the surveillance of infections. Infection control report forms include resident's name, the date the infection is found, the type of infection, whether or not a specimen is sent, the result and the date it is received, any antibiotics prescribed, whether the infection is resolved and if any follow-up is required. All infections are recorded on these infection report forms.

The information on the form is collated once a month, analysed and action taken when required. The analysis includes comparisons with the previous month and with the same month in the previous year, the person involved and the frequency of recurrence of the type of infection. Outcomes of this process are taken to the monthly continuous quality meeting, staff meetings, and a monthly report to the board. Where necessary, any corrective actions from the collated data are discussed and trends and patterns identified and corrective processes put in place. Staff interviewed are aware of the processes of reporting infections and IC practices implemented in the facility.

One of one resident interviewed report that she is kept informed of treatment relating to her infection which is now resolved (sighted in documentation including surveillance data).

The infections for surveillance are collated as urinary tract infections, chest/sinus infections, skin, gastro-intestinal, eyes, wound and 'other'. Infection rates at Rosebank are consistent and low (eight in total in each of the past two months, five the previous month). There have been no identified patterns or trends in the past three month surveillance data, as sighted and included in reports to committees and governance.

Internal audits of the infection control programme are up to date with no corrective actions required. The infection control co-ordinator reviews reports of current nosocomial infection rates, specific surveillance studies of infections and infection potentials and the implementation of infection control policies. The information is reported to the management committee to assist with the review of infection control policies and procedures. Previous areas of required improvement are now met.

**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:**