**Whangaroa Health Services Trust**

**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**

Whangaroa Health Services provides hospital, medical and rest home level of care for up to 20 residents. On the day of the audit there were 10 rest home residents and six hospital residents.

There is an established quality and risk management programme that includes analysis of incidents, health and safety, management of risks, complaints and an implemented internal audit schedule. The service benchmarks with other like services in the region and trends are analysed.

The chief executive has considerable management experience and is well known in the community. He is supported by a stable management team and there are staff from the community appropriately employed to provide care and support for residents.

Improvements required at the last audit around interpreting services, resident assessments and plans, medication administration, hot water temperatures and restraint have been addressed.

An improvement continues to be required to performance appraisals.

This audit also identified further improvements required around corrective action plans, satisfaction surveys, documentation of frequency and completion of three monthly medication reviews by the general practitioner.

**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 Audit07-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 Audit07-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 low risk** |

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| **Continuum of Service Delivery** | Day of Audit07-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 low risk** |

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| --- | --- | --- |
| **Safe and Appropriate Environment** | Day of Audit07-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 Audit07-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 Audit07-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** |

**Whangaroa Health Services**

Whangaroa Health Services

Surveillance audit - Audit Report

Audit Date: 07-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Whangaroa Health Services |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Whangaroa Health Services | 180 Omaunu Road | RD 2, Kaeo | Northland |

|  |
| --- |
| **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** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXXX | MBA MN B Ed Adv Dip Child and Family Dip Tchg Lead auditor | 8.00 | 6.00 | 07-Oct-13 to 07-Oct-13 |
| Auditor 1 | XXXXXXXX |       | 8.00 | 6.00 | 07-Oct-13 to 07-Oct-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXXX |       |       | 2.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 14.00 | **Total Audit Hours** | 30.00 |
| **Staff Records Reviewed** | 6 of 41 | **Client Records Reviewed** *(numeric)* | 3 of 16 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 3 |
| **Staff Interviewed** | 8 of 41 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 2 |
| **Consumers Interviewed** | 3 of 16 | **Number of Medication Records Reviewed** | 8 of 16 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

I confirm that Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 29 day of October 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

# Services and Capacity

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Whangaroa Health Services | 20 | 16 |       | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Whangaroa Health Services provides hospital, medical and rest home level of care for up to 20 residents. On the day of the audit there were 10 rest home residents and six hospital residents.

There is an established quality and risk management programme that includes analysis of incidents, health and safety, management of risks, complaints and an implemented internal audit schedule. The service benchmarks with other like services in the region and trends are analysed.

The chief executive has considerable management experience and is well known in the community. He is supported by a stable management team and there are staff from the community appropriately employed to provide care and support for residents.

Improvements required at the last audit around interpreting services, resident assessments and plans, medication administration, hot water temperatures and restraint have been addressed.

This audit also identified further improvements required around corrective action plans, satisfaction surveys, documentation of frequency and completion of three monthly medication reviews by the general practitioner.

1.1 Consumer Rights

Whangaroa Health Services demonstrates its commitment to open disclosure. Information about open disclosure is provided to new residents and their family. Family members are informed at the time of an adverse event. There is documentation in resident files that families are involved in the service and informed of any incidents. The complaints policy and process meets the requirements of right 10 of the Code of Health and Disability Services Consumers' Rights. Family and residents interviewed praised the service for the information provided to them in a timely manner.

An improvement required to a policy around interpreter and translation services has been addressed.

1.2 Organisational Management

The organisation is governed by nine trustees (one is selected as a Maori representative). There are seven wards with one trustee elected for each ward. Part of their role is to foster mutual communication with the patient population in their ward. The chief executive officer regularly reports on progress against the business and strategic plans. He has been in the position for since 2005 and is supported by the clinical services manager and the coordinator primary and elderly services who are registered nurses with current practising certificates.

Quality is coordinated by the quality and human resources coordinator and a quality committee that meets monthly. The organisation monitors its quality and risk management plans through reported infections and adverse events and reports on internal and external audits, changes to policies and procedures, restraint and complaints. Staff are informed about quality processes.

There is a clearly documented and implemented process for recruitment and retention. There is a process for managing human resources that ensures that the service appropriately allocates suitably qualified, skilled, and or experienced staff to meet the needs of residents. A range of training opportunities are offered to staff including four mandatory in-service training sessions, regular in-service training and self-directed learning packages. Caregivers are encouraged to complete Aged Care Education (ACE). Records are maintained for all employees of training completed.

Improvements are required to corrective action plans, satisfaction surveys, performance appraisals.

1.3 Continuum of Service Delivery

Registered nurses are responsible for each stage of service provision. Service delivery plans demonstrate service integration. Initial, six monthly and annual multi-disciplinary assessments include input from team members including the family when able, health professionals and the resident. Care plans are reviewed six monthly, or when there are changes in health status and updated as required. Progress notes include documentation that reflects strategies and care documented in the care plan.

During the tour of facility it was noted that all staff treated residents with respect and dignity and residents and families were able to confirm this observation. Residents and family praised the service for care provided. The general practitioner interviewed states that the service provides good care with follow up as per medical instructions when these are provided.

Medicine management and administration and the food service are managed safely and in line with required guidelines.

Improvements required at the previous audit have been addressed as follows: care plans document family and resident input, assessments and care plans are dated, issues identified are described with clear strategies and interventions documented in care plans, medication administration.

An improvement is required to documentation of frequency and completion of three monthly medication reviews by the general practitioner.

1.4 Safe and Appropriate Environment

All building and plant have been built to comply to legislation. There is a current building warrant of fitness. The rest home and hospital residents are able to access the building and external environment in a safe manner with rails, wide hallways and safe paths in place. An improvement required at the last audit around hot water temperatures has been addressed. An improvement continues to be required to performance appraisals. Improvements are required to corrective action plans, satisfaction surveys and documentation of frequency and completion of three monthly medication reviews by the general practitioner.

2 Restraint Minimisation and Safe Practice

There are processes and registers in place for the use of enablers and restraint and these are implemented with a register maintained. One resident uses a safety belt and bed safety rails as enablers, by choice. All required documentation is completed. Caregivers are familiar with the number of residents on restraint, the type of restraint used and monitoring processes. Improvements required to the restraint process at the previous audit have been addressed.

3. Infection Prevention and Control

Infection control data is tabled monthly at the health and safety meetings held on a two monthly basis. Infections are documented on the infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme with benchmarking of data completed and compared with three other like organisations. Data presented at the health and safety meeting is used to improve services.

Summary of Attainment

* 1. Consumer Rights

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | 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: 0Criteria (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 | PA Low | 0 | 6 | 2 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 4 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:15 PA:2 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Low | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:5 CI:0 FA: 6 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:15 PA:1 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:7 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:3 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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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: 0Criteria (of 21): CI:0 FA:1 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 33 **CI:** 0 **FA:** 15 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 40 **PA:** 3 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Whangaroa Health Services

Type of Audit: Surveillance audit

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

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.3 | 1.2.3.6 | PALow | **Finding:**Resident and family satisfaction surveys have not been completed in the past year.**Action:**Complete a resident and family satisfaction survey on a regular basis. | 6 months |
| 1.2.3 | 1.2.3.8 | PALow | **Finding:**Corrective actions are not consistently written for areas requiring improvement**.****Action:**Write corrective action plans for areas identified as requiring improvement. | 3 months |
| 1.3.12 | 1.3.12.6 | PALow | **Finding:**There is no documentation by the GP to indicate frequency of review of medications or that medications have been reviewed at least three monthly. **Action:**Document frequency of review by the GP and completion of at least three monthly reviews of medication.  | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Whangaroa Health Services

Type of Audit: Surveillance audit

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

DAA: Health and Disability Auditing New Zealand 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

There is an open disclosure policy which describes how full information is provided to residents and families.

Full information is provided at entry to residents and family/representatives. Family state that they are involved in the initial care planning and receive and provide on-going feedback. This is confirmed through discussion with three residents (two rest home and one hospital) and two family (one whose parents are in the rest home and one who has a family member in the hospital). Regular contact is maintained with family and they are contacted if an incident or care/ medical issue arises. Contact with the family is recorded on the quality improvement report (QIR) used to record accidents and incidents (sighted in 10 of 10 quality improvement reports).

Three of three residents and two of two relatives confirm that during the admission process the agreement and information provided at entry was discussed and that all information was easy to understand.

Discussions with two of two caregivers verify their knowledge around open disclosure. They report to the registered nurse or manager who in turn makes contact with the family.

1.1.9.4 The previous audit identified that there was no policy on interpreter and translation services. The interpretation policy was developed in September 2012 and lists contact information for regional interpreter/translation services. This is an improvement from the previous audit.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The complaints policy and flowchart describe the complaints process. Residents/families who express dissatisfaction are asked if they want to make a formal complaint. The policy complies with Right 10 of the Code. A copy of the complaints policy is posted in the staff room.

The chief executive officer (CEO) is the complaints officer and maintains the complaints register. All complaints are recorded in the register. Records include the date of receipt, letters to the complainant to acknowledge the complaint and following the investigation, records of discussions related to the complaint and actions taken. The CEO reviews the register on a regular basis to check whether the complainant has responded to the letter sent following the investigation. If there is no response after a period of time the complaint is signed off.

Two of two family members confirm that they know about the complaints process. Two of two caregivers are familiar with the requirements of the complaints policy.

Complaints are discussed at the monthly quality meetings (sighted in minutes).

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

**Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

**STANDARD 1.2.1 Governance**

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

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

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

The Whangaroa Health Services Trust vision (Moemoea), purpose (Ta Matou Koronga) and aims (Te Tino Kaupapa) address the Trust’s commitment to the principles of the Treaty of Waitangi and the participation of Maori at all levels and the protection and improvement of Maori wellbeing. The organisation is governed by nine trustees (one is selected as a Maori representative and one is a Kaumatua). There are seven wards with one trustee elected for each ward. An important part of their role is to foster mutual communication with the patient population in the ward. The board meets monthly and receives reports from the CEO. Reports include progress against the business and strategic plans (sighted in board minutes).

The strategic plan and business plan describe the organisation's strategic direction, key issues and related objectives. The strategic plan is being reviewed in consultation with the community in each ward and will be completed by the annual general meeting to be held on 24 October 2013.

The organisation is managed by a CEO who has been in the position since 2005. Previous experience includes a general manager at Ngati Hine Health Trust, an executive officer at the Taupo Employment Support Trust and the New Zealand Army. He is supported by the clinical services manager and the coordinator primary and elderly services who are registered nurses with current practising certificates. Job descriptions describe their roles, accountabilities and responsibilities.

**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:** PA Low

The organisation has a quality and continuous improvement plan 2013 that describes key tasks for continuous quality improvement (CQI) and risk management planning (RMP). Responsibilities, timeframes and desired outcomes are assigned in the plan. Progress against tasks is noted in the plan. There is a risk management plan that includes a risk rating or each identified risk, a management strategy and status. The risk register was reviewed in April 2013. The plans are ratified by the quality committee.

Quality is coordinated by the quality and human resources coordinator and a quality committee that meets monthly. Membership of the quality committee includes the quality and human resources coordinator, the CEO, the clinical services manager, the coordinator primary and elderly services and coordinators of other services. There is a set agenda that includes discussion and monitoring of reported infections, health and safety, internal and external audits, quality activity, changes to policies and procedures, restraint, surveys, education and training needs and complaints. All events are reported on a quality improvement report (QIR). Reported QIR are discussed at the quality committee meetings. The organisation benchmarks key clinical and health and safety activity with three other aged care facilities in the north on a quarterly basis. A range of internal audits are completed as documented in the audit schedule 2013, including monthly medicines, patient cares, food, laundry, continence management, controlled drugs and the complaints procedure. Each audit is documented on a checklist. The use of corrective plans is inconsistently applied and resident and family satisfaction surveys have not been completed in the past year. These are areas requiring improvement.

Staff are informed about quality processes at the meetings between caregivers and registered nurses (minutes sighted), on the quality board in the staff room and through monthly quality bulletins that are emailed to all coordinators and registered nurses. Two of two care givers confirm during interview that they are informed about quality issues.

The document control policy guides document and data control. The period of review is two yearly or at times of significant change. Each policy/procedure has a title, date of issue and review and version number and is referenced to relevant legislation. Policies are available to staff in hard copy and have recently been transferred to an intranet system where policies have a hyperlink to relevant legislation or other points of reference. Policies are reviewed by the quality and human resources coordinator and the relevant service coordinator, discussed at the quality committee and signed off by senior management. Obsolete hard and electronic documents are archived.

Improvements are required to the following: corrective action plans and to satisfaction surveys

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

A range of quality improvement data is collected, analysed and evaluated. Opportunities for resident and family feedback include the complaints system and informal discussion with staff. A resident food survey was completed in March 2013. Resident meetings are held infrequently and a resident/family satisfaction survey has not been completed in the past year.

**Finding Statement**

Resident and family satisfaction surveys have not been completed in the past year.

**Corrective Action Required:**

Complete a resident and family satisfaction survey on a regular basis.

**Timeframe:**

6 months

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

A corrective action plan is written following an external audit. A corrective action plan is printed at the bottom of some, but not all, internal audit checklists. Discrepancies in the hot water temperature readings are not documented on a corrective action plan at the time they are identified.

**Finding Statement**

Corrective actions are not consistently written for areas requiring improvement.

**Corrective Action Required:**

Write corrective action plans for areas identified as requiring improvement.

**Timeframe:**

3 months

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

D19.3b; There is an accident and incident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

All events are reported on a quality improvement report (QIR). Each QIR is allocated a classification by type and includes details of the event, immediate action taken, who is notified, the investigation and final action taken. Further actions are completed by the clinical services manager or CEO and the health and safety coordinator (sighted in 10 of 10 completed QIR). The quality and human resources coordinator signs off each form. Reported QIR are discussed at the quality committee and at the bi-monthly health and safety committee meetings. The organisation benchmarks health and safety activity with three other aged care facilities in the north on a quarterly basis.

Discussion with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications, for example notifiable disease and serious harm accidents. There is an open disclosure policy and family members interviewed state they are informed of changes in health status. A review of QIR forms identifies that contact with family is documented.

The organisation has achieved tertiary level ACC Workplace Safety Management Practices to 31 May 2014.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.

Copies of current practising certificates for registered nurses and doctors are retained. The coordinator of primary and elderly services signs that she has sighted the original of each practising certificate.

All staff have an interview and at least two referees are contacted. The orientation process is comprehensive and addresses essential components of the service. Completed orientation checklists were sighted in six personnel files (one cook, four caregivers, and one manager).

A coordinator education arranges training. She was absent on the day of the audit. A range of training opportunities are offered to staff including four mandatory in-service training sessions per year to ensure all staff can attend, other regular in-service training, self-directed learning packages (for example resuscitation and advanced directives, wound management and manual handling) and external courses. Caregivers are encouraged to complete Aged Care Education (ACE). The diversional therapist and four of 15 caregivers have completed ACE training and five of 15 are currently enrolled. Records are kept by subject and staff attendance, of all training completed including self-learning packages completed. Records are kept of attendance at in-service training.

1.2.7.3 The previous audit identified that up to date performance appraisal had not been completed for all staff. The quality and human resources coordinator maintains a database of all staff and the due date for their performance appraisals. Review of the database confirms that up to date performance appraisals have been completed for those staff due a performance appraisal.

D17.7d: There are implemented competencies for registered nurses in the form of self-directed learning packages related to specialised procedure or treatment including (but not limited to) standing orders, IV knowledge and practicum and medicines.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is a roster system implemented. Current rosters confirm that staffing for the two wings (located on one level) for rest home and hospital level residents for seven days per week is as follows:

AM: One RN, three caregivers (one caregiver finishes at 1.15 pm).

PM: One registered nurse, two caregivers who start at 2.30pm; one caregiver finishes at 9.00 pm and the other at 11.00pm

Night : 1 registered nurse and one caregiver.

There is a doctor on call.

There is a clearly documented and implemented process for recruitment and retention. There is a process for managing human resources that ensures that the service appropriately allocates suitably qualified, skilled, and or experienced staff to meet the needs of residents.

Two of two caregivers who work morning and afternoon shifts, three of three residents and two of two family members confirm that there is sufficient staff on duty.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

, D16.2, 3, 4: The three files reviewed (two hospital and one rest home), identified that in all three files an assessment was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan is reviewed by a registered nurse and amended when current health changes. All three care plans evidenced evaluations completed at least six monthly with updates to the plan noted as changes occur.

D16.5e: Three of three resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly.

A range of assessment tools are completed in resident files on admission and completed at least six monthly including the following: basic and annual assessment, InterRAI assessments completed by the needs assessor, continence, pressure sore risk, pain assessments if relevant, restraint assessment if required, memory tests, quality of life assessment, interests and activities profile, diversional therapy profile, lifestyle profile.

The assessments include identification of any behaviours that challenge and plans are documented as relevant.

There is a handover between each shift and this includes detailed updates from the registered nurses around care provided and any changes (observed on the day of the audit).

Rest home - tracer methodology:

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

Hospital - tracer methodology:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

Assessments completed on admission are comprehensive and include InterRAI and the basic and annual assessment. The long-term care plan is completed within three weeks with GP involvement within 48 hours. Plans are well described and are reflected in the progress notes. Three of three resident care plans reviewed on the day of the audit provide evidence of individualised support and intervention required. Three of three residents (two from the rest home and one from the hospital) and two of two family members (one from the rest home and one from the hospital) interviewed confirm care delivery and support by staff is consistent with their expectations. All needs identified in the assessment process were included in the care plans in three of three files sampled.

Specific plans are documented when short term needs are identified. An example of this is documentation of a specific plan for agitation noting that this has been transferred onto a long term plan in the past three weeks following a prolonged period of confusion and agitation. Weight loss for one resident where 1.2kgs is noted is documented in the care plan with strategies to manage this. Other short term needs are documented on specific care plans including management of a wound for one resident with a comprehensive assessment, plan and review completed each time the dressing is redone.

The improvement required at the previous audit around documentation of interventions in the care plan has been addressed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.5.3 Service delivery plans demonstrate service integration.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

D18.3 and 4 Wound assessment and wound management plans are in place for one resident-sighted as an extra file reviewed specifically to review documentation around wound management. Dressing supplies are available and a treatment room is stocked for use. A file reviewed specifically to ensure that dressings are being completed as per assessment indicates that there is a comprehensive assessment, plan and review completed at each dressing change and the registered nurse states that there is sufficient dressing products at all times.

Continence products are available and resident files include a continence assessment, bowel management, and continence products identified for each individual as per their requirements. One file reviewed indicates that the resident is double incontinent and specific products indicate that these are individualised.

Specialist continence advice is available as needed and this could be described noting that staff has access to GP's who are part of the public hospital system.

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

The two registered nurses interviewed describe the referral process and related form should they require assistance from a wound specialist or continence nurse.

Overall the care plans are completed comprehensively. The care being provided is consistent with the needs of residents as evidenced by discussions with the two caregivers, two registered nurses, the primary and elderly service coordinator, three of three residents and two family members.

There is a specific i.e. short-term care plan that is used for acute or short-term changes in health status.

When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. This is evidence in three of three files reviewed and the GP interviewed confirms that in most instances, the registered nurses inform him of any changes in a very timely manner. The GP identifies that at odd times, the registered nurse or other staff delay informing him of a change in state however he states that these are rare and case specific with management by line managers when this occurs. He states that this is not an area of high or moderate risk with strategies in place to manage this.

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

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

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

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

An activities profile is completed along with a lifestyle profile and diversional therapy goals documented. Residents are quick to feedback likes and dislikes to the activity coordinator. The activity care plan is developed with the residents and relative (as able) and this is expected to be reviewed at least six monthly. All plans are current with the activities coordinator catching up on reviews that have had a gap in the past year.

There is an activities coordinator who is responsible for activities, identifying different needs that are appropriate to their age culture and differing health status. The activities coordinator is employed for eight hours on Monday, Wednesday and Friday and she puts a five day a week programme on the notice board with caregivers facilitating other activities on the days she is not there.

The residents at Whangaroa Health Services Trust have an activity plan that is consummate with their needs and functional capabilities. A vehicle can be accessed if required and activities are varied e.g. bingo, exercises, entertainers, involvement of the community, gardening, crafts, weaving, hand and foot massage.

Three of three residents state that they enjoy the activities.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

All initial care plans are evaluated by the registered nurse within three weeks of admission. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. Three of three files indicate that reviews occur six monthly by the registered nurses with input from the GP, the physiotherapist, the resident, the family if possible and other health professionals as engaged along with the activities coordinator.

An additional file reviewed specifically to look at wound management indicates that comprehensive review of the wound occurs at each dressing.

Relatives are notified of changes in a resident's condition (confirmed by two of two family members interviewed).

Staffs write in resident progress notes on each shift and document any changes in care/condition of residents.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

Medications are blister packed and medications are expected to be checked on arrival by the registered nurse.

Medications are kept in a locked medication room in the rest home and hospital area. Staff sign for the administration of medications on medication sheets held with the medicines. There is a list of specimen signatures on each signing sheet.

There is a locked safe and controlled drug register for the safekeeping and administration of controlled drugs in the rest home/hospital area with all controlled drugs issued from this room. These drugs are checked on arrival and after administering. There are weekly stocktakes. A check of two controlled drugs against prescribing sheets, administration sheets and the controlled drug register indicates that documentation is completed as per policy and balances in the register match the prescribed packs.

The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards.

There is a policy around self-administered medicines policy and procedure. There is one resident self-administering some of the medications and the doctor has documented competency. The resident has a drawer in his room to keep creams.

One medication round was observed in the hospital and rest home lounge during lunch and the registered nurse signs for each blister after it is given.

All staff giving medication have been assessed as competent annually - competencies sighted. Two registered nurses interviewed state that the medication competencies involve a test and they are signed off as being competent after being observed.

Three of three residents interviewed state that they receive their medication in a timely manner and are provided with information around medications.

Improvements required at the last audit around medication competencies, transcribing, signing by the doctor, administration of medications as per charts have been addressed.

D16.5.e.i.2; Eight of eight medication charts reviewed include four in the hospital and four in the rest home. The general practitioner documents notes in MedTech when the resident has been seen. There is no documentation by the GP to indicate frequency of review or that medications have been reviewed at least three monthly.

An improvement is required to documentation of frequency of review by the GP and completion of at least three monthly reviews of medication.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

The general practitioner documents any notes of consultations with residents on MedTech and the notes are printed off and glued into the resident record.

Registered nurses are responsible for administering medication and there is no evidence of transcribing with all medications signed for appropriately. Allergies are documented in the resident record and on the medication file.

**Finding Statement**

There is no documentation by the GP to indicate frequency of review of medications or that medications have been reviewed at least three monthly.

**Corrective Action Required:**

Document frequency of review by the GP and completion of at least three monthly reviews of medication.

**Timeframe:**

3 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:** FA

All food is prepared on site in industrial type kitchen. Kitchen facilities are adequate and all those involved with the preparation of food are deemed competent to do so.

Residents' food preferences are identified and this includes consideration of any particular dietary preferences or needs.

Dietician advice is sought during the development of all menus - last in June 2010.

D19.2 Staff have been trained in safe food handling with the cook interviewed stating that she has completed City and Guild Diploma (certificate sighted).

Specific dietary requirements are noted and provided with assessments completed for all residents on admission. All files reviewed included correct documentation of diet in the kitchen. The cook interviewed is able to describe how the kitchen responds to dietary needs and the white board provides an easy check for staff to refer to. The cook was seen to be firm with a caregiver who requested food for a resident that did not meet dietary requirements as documented in the profile.

Menus are provided. The cook describes meeting individual residents’ preferences and heating food that family have brought in and providing an alternative if the resident is unable to eat or does not feel like the food on the menu. This was confirmed by residents interviewed.

The six monthly resident satisfaction surveys completed include feedback on menus. Feedback surveys viewed demonstrated satisfaction with the meals provided.

Residents are supported during meal times by care staff. Any special equipment required is available. Residents were observed at lunch time during the site visit and all had appropriate utensils, plates etc.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The facility is maintained and has adequate space to promote residents' mobility and freedom of movement. Residents' rooms allow access with mobility aids and residents' personal furnishings including the two rooms being assessed to be used for either rest home or hospital level residents.

Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted monthly by an external fire safety contractor. There is a current Building Warrant of Fitness - expiry date 31/5/14.

Equipment is calibrated annually (documentation kept on premises) and hoists and electric beds are serviced annually. When an issue requiring maintenance is noticed the manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. The maintenance person routinely works 40 hours per week and is also available on an on call basis. External contractors are engaged to complete work as required.

There is a maintenance and domestic coordinator who monitors compliance.

The environment encourages residents to be independent and to access outdoor gardens and other areas. Deck areas include ramps and paths and all are safe for residents to access.

Residents and family interviewed state that they love being in the environment provided.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

One resident uses a safety belt and bed safety rails as enablers by choice. This resident's care plan lists the two enablers. A review was completed on 25 September 2013. Interview with two of two caregivers confirms that they are familiar with the number of residents on restraint, the type of restraint used and monitoring processes.

2.2.3.4 The certification audit identified that restraint monitoring is not documented.

Documentation in the file for a bedrail, used as a restraint, verifies that two hourly monitoring is recorded and signed. Restraint authority and a six monthly review and evaluation were documented and signed. This is an improvement from the previous audit.

2.2.3.6 The certification audit identified that annual training around restraint and enablers, including challenging behaviours and de-escalation, was not documented.

In-service training on restraint minimisation was completed on 30 May 2012. The management of challenging behaviour is addressed during orientation. A self-directed learning package on restraint minimisation and safe practice addresses the identification of behaviours that might typically result in restraint and de-escalation procedures. Training records verify that six of six registered nurses and caregivers who have not recently completed the orientation process have completed the self-directed learning package in either 2012 or 2013. This is an improvement completed from the previous audit

**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

Surveillance for infection is an integral part of the infection control programme and is described in Whangaroa Health Services infection control policy. Monthly infection data is collected on all infections. All infections are then entered on to an infection register. This data is monitored and evaluated, outcomes and actions discussed at the health and safety meetings two monthly. The infection control coordinator documents a monthly report that is tabled and discussed. All infection control reports and minutes are submitted to the CEO.

The infection control coordinator is responsible for ensuring effective monitoring of infection risk.

Monthly infection surveillance occurs and the service benchmarks infection control data with three other aged care services in the north in Kaitaia, Kaikohe and Kerikeri with evidence that improvements are made as a result of the analysis of data.

**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:**