**Claud Switzer Memorial Trust Board**

**Current Status:** **08-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**

Claud Switzer Residential Care provides res home and hospital level care for up to 89 beds. There are currently 83 residents in the service including 43 residents requiring rest home care and 40 requiring hospital level care.

The service is managed by an experienced general manager who is supported by three managers including a nurse manager, human resource manager and facilities manager. There are registered nurses on each shift as per the roster and caregivers with a well implemented training programme supporting on-going skills.

The service continues to implement a quality and risk programme and there are regular meetings for staff and residents that includes all aspects of the quality and risk programme i.e. health and safety, monitoring of incidents and accidents, infection control surveillance, management of complaints and implementation of an internal audit schedule.

Residents and family interviewed praised the service for quality of care provided.

Improvements identified at the previous audit around understanding of rights, advance directives, availability and review of policies for staff, complaints, corrective action planning, training, documentation in resident files, integration of files, information in resident files, medical assessments, assessments, care planning, reviews, medications, recording of weights, food services, infection control, storage of hazards, privacy in toilets and showers and restraint have been addressed.

An improvement is required to transcribing of instructions for medication, correlation of information between assessments and care plans, updating of plans as changes occur, documentation of strategies to manage slow weight loss.

**Audit Summary AS AT** **08-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 Audit08-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 Audit08-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. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit08-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 Audit08-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 Audit08-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 Audit08-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** |

Claud Switzer Residential Care

Claud Switzer Residential Care

Surveillance audit - Audit Report

Audit Date: 08-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Claud Switzer Residential Care |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Claud Switzer Residential Care | 71 South Road |       | Kaitaia |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 08-Oct-13 **End Date:** 08-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, Lead Auditor, Dip Tchg RGON | 8.00 | 5.00 | 08-Oct-13 to 08-Oct-13 |
| Auditor 1 | XXXXXXXX | OT, health audit cert | 8.00 | 4.00 | 08-Oct-13 to 08-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)* | 11.00 | **Total Audit Hours** | 27.00 |
| **Staff Records Reviewed** | 7 of 100 | **Client Records Reviewed** *(numeric)* | 6 of 83 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 6 |
| **Staff Interviewed** | 11 of 100 | **Management Interviewed** *(numeric)* | 4 of 4 | **Relatives Interviewed** *(numeric)* | 6 |
| **Consumers Interviewed** | 7 of 83 | **Number of Medication Records Reviewed** | 12 of 83 | **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 Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 1 day of November 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Claud Switzer Residential Care | 89 | 83 | 16 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Executive Summary of Audit

General Overview

Claud Switzer Residential Care provides rest home and hospital level care for up to 89 beds. There are currently 83 residents in the service including 43 residents requiring rest home care and 40 requiring hospital level care.

The service is managed by an experienced general manager who is supported by three managers including a nurse manager, human resource manager and facilities manager. There are registered nurses on each shift as per the roster and caregivers with a well implemented training programme supporting on-going skills.

The service continues to implement a quality and risk programme and there are regular meetings for staff and residents that includes all aspects of the quality and risk programme i.e. health and safety, monitoring of incidents and accidents, infection control surveillance, management of complaints and implementation of an internal audit schedule.

Residents and family interviewed praised the service for quality of care provided.

Improvements identified at the previous audit around understanding of rights, advance directives, availability and review of policies for staff, complaints, corrective action planning, training, documentation in resident files, integration of files, information in resident files, medical assessments, assessments, care planning, reviews, medications, recording of weights, food services, infection control, storage of hazards, privacy in toilets and showers and restraint have been addressed.

An improvement is required to transcribing of instructions for medication, correlation of information between assessments and care plans, updating of plans as changes occur, documentation of strategies to manage slow weight loss.

1.1 Consumer Rights

Claud Switzer Residential Care demonstrates open disclosure and informs new residents and their families about the open disclosure process. Translation and interpreter services are available. The complaints process meets the requirements of right 10 of the Code of Health and Disability Services Consumers' Rights.

Improvements required around documentation related to the Code of Rights, policies on sexuality and intimacy and resident discrimination, advanced directives, cultural assessment of Maori residents and verbal complaints have been addressed.

1.2 Organisational Management

The Claud Switzer Memorial Trust board has three trustees and an advisory group comprising nine to 10 representatives of key stakeholder organisations. The general manager reports to each meeting of the board and the advisory group on progress against strategic and quality improvement goals.

The general manager is a registered nurse with a current practising certificate. She has been in her current position for 15 years.

Claud Switzer Residential Care has achieved ISO 9001:2008 quality management system accreditation to 15 September 2015. Quality and risk management processes are robust and include processes for adverse event reporting, data analysis, resident feedback, internal audits and corrective action planning. The facility benchmarks against three other aged care facilities in the north and is working on a falls prevention project with the Northland District Health Board.

All new employees complete a recruitment and orientation process. 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 provided for staff including an annual mandatory training session. Healthcare assistants are encouraged to completed the Aged Care Education (ACE) programme . All training is recorded. Staffing levels meet ARC requirements.

Improvements required around review of policies and procedures, corrective actions, training, documentation in resident records, integration of resident files have been addressed.

1.3 Continuum of Service Delivery

Claud Switzer Residential Care has implemented systems to assess, plan and evaluate the care needs of the residents. The resident’s needs, outcomes and/or goals have been identified and these are reviewed on a regular basis with the family/resident input. A team approach to care delivery and continuity of service delivery is encouraged. Two registered nurses have had training on InterRAI and others are in training. The service is reviewing the template for documentation of care plans in line with InterRAI assessments.

Improvements are required updating of plans as changes occur, documentation of strategies to manage slow weight loss.

Medication management is safely implemented. All staff responsible for medication administration have completed medication competencies. Visual inspection of the medication systems evidences compliance with respective legislative requirements, regulations and guidelines. There is evidence of the general practitioners reviewing the medication records three monthly or more often if and when required. An improvement is required around transcribing of instructions for medication.

Food service policies and procedures are appropriate for the service setting. The menu plans have been recently reviewed by a dietician and the menus comply with legislation such as the Ministry of Health guidelines for older adults. The experienced staff in the kitchen have all completed relevant food hygiene and safe food handling courses and this is evidenced in the staff education records and on the personal staff files sighted. Special diets can be arranged on admission to the service and this is documented on the individual nutritional profiles completed during the assessment process on admission and when the personal centred care plans for residents are reviewed. The residents and families interviewed reported satisfaction with the food service.

Improvements identified at the previous audit around medical assessments, assessments, care planning, reviews, medications, recording of weights and food services have been addressed apart from the correlation of information between assessments and care plans (this improvement is still required).

1.4 Safe and Appropriate Environment

A current Building Warrant of fitness is posted in a visible location at the entrance to the facility. There have been no building modifications since the last audit and the environment is seen by residents and family as being appropriate for the levels of care identified. There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required. There are safe outside areas that is easy to access for residents and family members. Equipment is checked annually and is designed to support residents requiring hospital and rest home level care.

Improvements identified at the previous audit around storage of hazardous substances, repairs to a wet area, securing of toilet and shower doors, input by the infection control coordinator into cleaning and laundry policies have been addressed.

2 Restraint Minimisation and Safe Practice

Enablers are not in use at the time of the audit. Appropriate processes are in place to record and monitor restraint use. An improvement required around the review of restraint has been addressed.

3. Infection Prevention and Control

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There are meetings to communicate surveillance data and for staff to discuss quality improvements. An registered nurse is identified as the infection control coordinator and policies aligned to Bug Control policies and guidelines. Surveillance is monitored effectively and any trends identified are reported back to staff through meetings. The infection control programme is integrated as part of the organisations quality system. There is a benchmarking programme with other like organisations in the region and this supports on-going quality improvement.

An improvement required around the annual review of infection control and a review of the MRSA policy has been addressed.

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 | FA | 0 | 1 | 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 | FA | 0 | 2 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 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 | FA | 0 | 1 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:5 CI:0 FA: 7 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:10 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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

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| Organisational Management Standards (of 7): N/A:1 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:19 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | PA Low | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | PA Low | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 1 | 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 Moderate | 0 | 3 | 1 | 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:4 CI:0 FA: 4 PA Neg: 0 PA Low: 3 PA Mod: 1 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:12 PA:4 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 | FA | 0 | 1 | 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 | FA | 0 | 1 | 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 | FA | 0 | 1 | 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:4 CI:0 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:6 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | 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 | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 4 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:2 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 1 | 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: 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: 0Criteria (of 29): CI:0 FA:3 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 21 **CI:** 0 **FA:** 25 **PA Neg:** 0 **PA Low:** 3 **PA Mod:** 1 **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:** 52 **PA:** 4 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Claud Switzer Residential Care

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:08-Oct-13 End Date: 08-Oct-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.3 | 1.3.3.3 | PALow | **Finding:**i) A record of dressings being completed as per the plan is inconsistently recorded. ii) an assessment and instructions documented by the physiotherapist (encourage to walk to meals without oxygen) however these are inconsistent with the care plan which states the opposite. iii) The episode of vomiting and diarrhoea is referred to in the progress notes but a care plan is not documented. **Action:**i) Ensure dressings are completed as per the plan. ii) Ensure that strategies are documented consistently between health practitioner records and the long term care plan. iii) Document changes to the care plan when changes occur.  | 6 months |
| 1.3.4 | 1.3.4.2 | PALow | **Finding:**Uniting entries in the assessment documentation with updates in the care plans is at times difficult . The previous improvement remains.**Action:**Ensure that the reader can distinguish between different entries on the assessment part of the care plan and the progress notes on the care plans.  | 3 months |
| 1.3.12 | 1.3.12.6 | PAModerate | **Finding:**There is evidence of transcribing in the PRN signing sheets and the antibiotic signing sheets. **Action:**Stop the practice of transcribing.  | 1 month |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.13 | 1.3.13.2 | PALow | **Finding:** Of the six files reviewed, two showed that residents had lost 9kgs each over a year. This continues to be monitored however strategies to manage the loss are not documented or reasons for the weight loss not documented. **Action:**Document strategies to manage slow weight loss or document if the weight loss is appropriate.  | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Claud Switzer Residential Care

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:08-Oct-13 End Date: 08-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 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

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

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

The service previous audit identified that staff did not fully understand consumer rights and the welcome booklet included incorrect information about consumer rights.

Staff attended training on sexuality and intimacy in December 2012 and completed a self-learning questionnaire at that time. Staff attended training on the Code of Health and Disability Services Consumers' Rights (the Code) and complaints in October 2012. The words "Do consumer rights always apply'" have been removed from the Welcome pack. Interview confirms that five of five healthcare assistants are familiar with the Code, the complaints process and the policy on sexuality and intimacy. The family and resident satisfaction survey completed in December 2012 confirms that residents are treated with respect. This was also verified during interview with six of six family members (two rest home and four hospital) and seven of seven residents (four hospital and three rest home).This is an improvement from the previous audit.

**Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect**

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

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 service previous audit (#.1.1.3.5) identified that staff did not have an understanding of residents rights in relation to the application of the sexuality and intimacy policy.

The sexuality and intimacy policy was updated in December 2012 and an associated training package was developed. Staff attended training on sexuality and intimacy in December 2012 and completed a self-learning questionnaire. This is an improvement from the previous audit (1.1.3.1 in place of 1.1.3.5 and 1.3.6.1 which is now documented in 1.1.10.7).

**Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.4 Recognition Of Māori Values And Beliefs**

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

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

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

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

There is a cultural assessment in six of six resident files reviewed. One of six resident files was that of a Maori resident. The cultural assessment identifies this resident's wishes and needs. The family and resident satisfaction survey, completed in December 2012, confirms that the residents' cultural and spiritual needs are met. This was verified during interview with six of six family members and seven of seven residents. This is an improvement from the previous audit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

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

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

The previous audit (#1.1.7.1 now 1.1.7.3) identified that there was no specific resident directed policy relating to discrimination.

This audit identified that the code of rights policy addresses right two of the Code (right to freedom from discrimination, coercion, harassment and exploitation) and how this is implemented in the facility, including with residents. A self-directed learning package has been developed addressing the requirements of the Code. This is an improvement from the previous audit.

**Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

The policy on open disclosure describes requirements to share information, including adverse events, with residents and their family. Residents and their family are provided with a Welcome pack at entry that includes the admission agreement, information about Switzer and information about adverse events and open disclosure. Information is available in larger font if required. Contact with the family/nominated representative is recorded on the accident and incident form (sighted on 10 of 10 completed forms).

The policy on interpretation and translation services includes contact information for translation services, for example Teles, a telephone interpreting service and the list held at Kaitaia hospital. Written language mores are available to staff in a range of languages.

There are no residents currently requiring an interpreter however staff do talk to residents in te reo at times.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

In the previous audit there was a shortfall identified around advance directives in 1.1.3.6 and 1.1.10.7. This audit identified that completed advanced directive forms in the clinical files had been signed by relatives and enduring powers of attorney in some cases, not the competent resident.

If the resident is competent they sign an advanced directive (sighted in four of six resident files). When they are not competent, the general practitioner documents the resident's resuscitation status (sighted in two of six resident files). Forms used to record the resuscitative status of residents clearly state whether they are to be used for the competent of not competent resident. This is an improvement from the previous audit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

In the previous audit they identified that staff were unsure about the documentation of a verbal complaint.

This audit identified that the complaints policy and procedure was reviewed and updated in July 2013 and clearly records the process for reporting all complaints, both written and verbal. Staff completed training on complaints in July 2013. Interview with five of five healthcare assistants confirms that they understand the process when they receive a verbal complaint, that is, they encourage the complainant to write the complaint on a complaint form and report the discussion to the registered nurse if the complaint is not documented. This is an improvement from the previous audit.

Residents and their family are informed about the complaints process in the welcome pack and the admission agreement. The suggestions, compliments and complaints form is displayed in public areas.

The general manager is the complaints officer. A complaints register is maintained. This contains all documentation relating to each complaint including letters to the complainant of acknowledgement and following the investigation. A running sheet of key dates, activity and outcomes is recorded for each complaint.

A recent complaint was referred from the Health and Disability Commission to the Northland DHB. Documentation confirms that all correspondence and discussions are recorded and that the complaint is now signed off by HealthCert. Changes to the physical environment have been made to rectify the focus of the complaint.

**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 Claud Switzer Memorial Trust board has three trustees and an advisory group comprising nine to 10 representatives of key stakeholder organisations, for example Age Concern, WINZ, a staff member and the auxiliary. The strategic plan 2013 to 2016 describes seven strategic goals with identified actions and outcomes, an organisation chart and the vision, mission, philosophy and values. The board meets monthly and the advisory group meets with the board every three months. The general manager reports to each meeting of the board and the board meetings with the advisory group on progress against the strategic and quality improvement goals (sighted in board/advisory group minutes).

The general manager is a registered nurse with a current practising certificate. She has completed diplomas in education and palliative care, has previous hospice experience and has been in her current position for 15 years. Training records confirm that she has completed more than eight hours management related training in the past year. Her job description describes her level of responsibility, accountability and authority.

**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

Claud Switzer Residential Care has achieved ISO 9001:2008 quality management system accreditation to 15 September 2015. The quality manual includes a range of policies related to quality and risk management. The annual business quality and risk management plan describes quality objectives, strategies to achieve outcomes and assigned responsibility. Each objective is related to the seven strategic goals. Progress against each goal is documented in the plan. The annual business quality and risk management plan also identifies risks, applies a risk rating and describes management process to reduce risk.

The quality committee (the general manager, infection control coordinator and the management team) meets monthly. The quality committee receives reports on adverse events reported for the period, complaints, infection control, corrective action reports, internal and external audits, resident and family feedback, health and safety, benchmarking and restraint (sighted in meeting minutes). Claud Switzer Residential Care is currently involved in a falls prevention programme with the NDHB and benchmarks every quarter against three other aged care facilities in the north. Benchmarking activity includes falls, skin tears, challenging behaviour, wandering, near misses, infection, medicine errors and pressure areas.

The audit schedule for February 2013 to January 2014 is followed each month and includes cleaning, catering, medicine administration and care plans (sighted on audit sheets).

Staff are invited to provide suggestions/feedback through the improvement to our work area form. Staff are informed about quality processes through regular meetings with management and on a noticeboard in each wing. New or revised policies are posted in the nurses' station. Staff are required to sign when they have read the policy. There are monthly team communicator meetings in each wing where concerns and issues can be discussed. Healthcare assistants state that are well informed about quality related activity and appreciate the range of opportunities available to contribute to discussion (confirmed during interview with five of five healthcare assistants).

Community members and key stakeholders are represented on the board of trustees and the advisory group. Annual satisfaction surveys are offered to residents and their family. Summaries of responses are completed (sighted for December 2012). The newsletter for May 2013 thanks residents and families for participating in the annual satisfaction surveys and there is evidence that recommendations are implemented. There is a monthly residents' meeting facilitated by the diversional therapist.

Document control and control of documents policies guide policy/document control. All policies have a title, date of issue, date of review and are signed off at the authorised level. A checklist documents the date of review for all policy manuals. Policies are reviewed by the head of department, for example the catering team are consulted on the catering manual. Best practice is included in policies and policies are referenced to relevant legislation. A list of relevant legislation is held online. Obsolete policies are archived in a storeroom onsite.

In the previous audit it was identified that policies and procedures did not always reflect accepted good practice legislative and standards requirements. These have been updated and this is now met.

In the previous audit it was also identified that corrective actions are not always resolved. This audit identified that now all corrective action reports (non-conforming reports and improvements to work area forms) are filed in the corrective action log. Documentation related to action/s completed was sighted on 10 of 10 corrective action reports. All corrective actions are reviewed after six months to ensure that the action has resulted in the required change, for example a corrective action was issued in March 2013 regarding pharmacy errors. Follow up in July 2013 confirm s a reduction in pharmacy errors. Corrective actions are monitored by the quality committee. This is an improvement from the previous audit.

Health and Safety Policies are implemented and monitored by the health and safety committee meetings. A health and safety officer is appointed.

Risk management, hazard control and emergency policies/procedures are in place. Hazard identification and control is up to date with a hazard register in place.

Previous improvements required to policies and procedures and corrective action plans have been met.

**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

Claud Switzer Residential Care has been awarded ACC workplace safety management practices, to the tertiary level, to 28 February 2015. Policies on incident reporting and accident reporting and investigation procedures describe the adverse event reporting process. Accident and incident reports are investigated by the nurse manager, sighted by the general manager and signed off by the maintenance manager if no further action is required. Accident and incident reports document the event, the date, those involved, the investigation, suggested and completed actions and whether the family member has been informed (sighted in 10 of 10 accident/incident reports). An electronic data base is maintained of all reported events.

A health and safety committee meets monthly. Membership includes the maintenance manager, a registered nurse, the diversional therapist and a healthcare assistant. The meeting agenda includes health and safety performance indicators and reported accidents and incidents. A monthly safety, health and environment report by resident and staff accident/incident type is generated. Adverse events are included in benchmarking with three other aged care facilities in the north.

Health and safety is included in the mandatory in-service sessions that occur five times a year.

There is a policy on contractual adverse event reporting. The facility is aware of its notification responsibilities and holds copies of the notice of uncontrollable event form. A norovirus outbreak on 26 August 2013 was reported to the Medical Officer of Health , DHB and to the MoH.

**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 policies on orientation, recruitment and credentialing. Job descriptions are in place and describe the position, functional relationships, primary objectives, key tasks and expected results for each role. 17 of 17 registered and enrolled nurses have current practising certificates (including the general manager and the nurse manager). Recruitment processes include an application process, a documented interview, police and referee checks (sighted in seven of seven staff files including one enrolled nurse, one registered nurse, one nurse manager and four healthcare assistants).

All new employees complete a documented orientation process which includes working with a support person of the same role for up to two weeks. The orientation programme covers the essential components of the service provided. A skills competency checklist designed for each role is completed by each new registered and enrolled nurse and healthcare assistant during the orientation process.

The training coordinator is a registered nurse with a current practising certificate, is a trained HealthEd Trust assessor and a New Zealand Nursing Council preceptor. A training plan describes the in-service training for the year. Attendance records are kept. In-service training includes a one day session on mandatory topics. This is held five times a year to enable all staff to attend. 17 of 51 healthcare assistants have completed the Aged Care Education (ACE) core, advanced and dementia programmes and a further 34 are currently enrolled in ACE. Of these 24 of 34 are enrolled in the core ACE programme, three of 34 are enrolled in the advanced ACV programme and seven of 34 are enrolled in the ACE dementia programme. 12 staff (a mix of managers registered and enrolled nurses and healthcare assistants) are currently participating in a 15 session train the trainer course that addresses clinical areas of service delivery. Attendance at internal and external courses is recorded for each employee in the training database.

Healthcare assistants state that they complete an orientation process, that they begin working with residents on their own when they are confident to do so and that they appreciate the range of training provided, especially the train the trainer sessions (confirmed during interview with five of five healthcare assistants).

 A phlebotomy competency and assessment was completed on 31 January 2013 by the four registered nurses requiring this competency. This is an improvement from the previous audit.

 One database is now used to record all training by individual staff member and date of training. This allows monitoring of completed training and attendance numbers. Attendance at in-service is also recorded in hard copy. This is an improvement from the previous audit.

**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

The facility works within the guidelines of SNZ HB 8163: 2005 Indicators for Safe Aged Care and Dementia Care for Consumers. The general manager completes a monthly resident assessment of dependency levels in each wing and allocates staff numbers accordingly.

There is a fixed roster in place with staff allocated to each of five wings. The facility is located on one level. The general manager and the nurse manager work Monday to Friday. A registered nurse is rostered on duty 24 hours per day, seven days per week. An additional registered nurse or enrolled nurse is rostered on morning shifts at the weekend. The numbers of healthcare assistants rostered for each period (morning, afternoon and nights) meets ARC requirements (sighted in the roster for the current period).

Healthcare assistants describe staffing levels as adequate (confirmed during interview with five of five healthcare assistants who work on the morning and afternoon shifts).

**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:**

**STANDARD 1.2.9 Consumer Information Management Systems**

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

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

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

The previous report identified that it was not possible to verify that resident information was entered within 48 hours of admission.

Review of six of six resident files verifies that all have a documented assessment completed within 48 hours. This is an improvement from the previous audit.

Review of six of six resident files verifies that all have an assessment, care plan and reviews (refer to 1.3.3.3 and 1.3.4.2). This is an improvement from the previous audit (previously 1.2.9.4 - now in 1.2.9.1).

Review of six resident files verifies that the file for one of six residents, who has frequent weighing is integrated. This is an improvement from the previous audit.

**Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.**

**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 Low

Policy and procedures for this organisation describe that each stage of service delivery provision is undertaken or overseen by a registered nurse (RN). The current annual practising certificates (APCs) for all staff and contracted services who require an APC were sighted. Registered nurses are responsible for completing assessments, care plans and reviews along with relevant health care assistants.

Five of five health care assistants interviewed are suitably skilled and/or experienced. Staff files sighted and 11 staff interviewed during the audit included the nurse manager, two registered nurses, five caregivers, one diversional therapist, one cook indicate that all are informed of resident needs and cares that are to be provided.

The in-service education focuses on the support of the older person. Staff interviewed, two registered nurses and five health care assistants report that the staff work effectively as a team in the rest home and the hospital and continuity of care is promoted through handovers at each shift and morning briefing on a daily basis.

The resident profile, the admission assessment and the initial care plan is completed on the day of the resident`s admission to this service or within 24 hours. The long term care plan is developed within three weeks from the information gathered from the assessment, staff observation, resident and family discussion and recognised assessment tools (Waterlow, falls assessment, cultural assessment, moving and handling, skin, continence, nutrition, oral health, activities as well as a comprehensive assessment completed when the resident is admitted.

The nurse manager and two registered nurses interviewed indicate that on admission the registered nurse completes an initial assessment and develops the initial patient centred care plan which is confirmed in the six resident files sighted three rest home and three hospital. All the three rest home residents and three hospital level residents files reviewed for the continuum of care are signed by the residents and where appropriate family to evidence consultation has been sought. The (six of six) resident files reviewed have documentation to evidence that the care plans had been reviewed within the last six months. The records sighted also had details of monthly weights, blood sugar monitoring if required, blood pressure, fluid balance records, pulse and temperature (more frequently as clinically indicated).

Progress notes entries are made at each shift (confirmed in the six of six resident files) three rest home and three hospital. A verbal and written handover occurs for oncoming shifts where there is discussion in relation to any changes to the residents` conditions (observed).

The care plan is evaluated and amended either when clinically indicated or at least every six months. Medical reviews are undertaken prior to or within two days of admission and the previous requirement to ensure that this occurs is met (confirmed in six of six files reviewed).

The GP states that staff follow medical instructions and there are no issues with overall cares or quality of care provided. The GP states that there is good nursing leadership overall and has no real concerns.

All resident files now have a comprehensive assessment completed.

Tracer methodology: Rest home

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

Tracer Methodology: Hospital

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

There are documented timeframes to complete assessments and care plans. All files (six of six) show that documentation is completed in a timely manner with all having a current plan. An end of life plan is used when needed.

**Finding Statement**

i) A record of dressings being completed as per the plan is inconsistently recorded. ii) an assessment and instructions are documented by the physiotherapist (encourage to walk to meals without oxygen) however these are inconsistent with the care plan which states the opposite. iii) The episode of vomiting and diarrhoea is referred to in the progress notes but a care plan is not documented.

**Corrective Action Required:**

i) Ensure dressings are completed as per the plan. ii) Ensure that strategies are documented consistently between health practitioner records and the long term care plan. iii) Document changes to the care plan when changes occur.

**Timeframe:**

6 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 1.3.4 Assessment**

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

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

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

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

There is evidence and confirmation that all assessments are current and up to date. The schedule was explained by the clinical manager and reviewed. The resident files reviewed evidenced that recognised assessments are performed on all residents as required six monthly or more often if changes occur in the resident`s health status or wellbeing.

An improvement continues to be required to aligning assessment entries with care plan entries.

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

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

The assessment guidelines on the template (e.g. falls - low, medium, high) are updated using different colours to highlight entries documented at different times on a template (not signed or dated) however at times it is difficult to unite the colours on the assessment with the progress on the care plan (dated and signed) when these are completed. The care plan template is being redesigned to align with InterRAI.

The previous audit identified a required improvement around the assessment grid. This is now individualised and identifies the needs of the resident, however the linking of the assessment and updates to the plan continues to be a requirement.

**Finding Statement**

Uniting entries in the assessment documentation with updates in the care plans is at times difficult. The previous improvement remains.

**Corrective Action Required:**

Ensure that the reader can distinguish between different entries on the assessment part of the care plan and the progress notes on the care plans.

**Timeframe:**

3 months

**STANDARD 1.3.5 Planning**

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

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

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

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

The previous audit identified that the service delivery plan (assessment grid be updated as new interventions are identified. The assessment grid is not used as the care plan as entries are documented in a separate comments box when changes occur. Changes are made to the grid in different colours when these are identified. The improvement required has been addressed.

Some issues are still identified in relation to reading of the grid (assessment template) - refer 1.3.4.2.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

New residents are welcomed and orientated to the facility. Interviews with s residents and six of six family report the needs of the residents are effectively met and they are satisfied with the care they or their relative receive.

Six of six resident files reviewed (three rest home and three hospital level), clearly document the resident`s individual needs, goals and support requirements assessed, planned and implemented in a timely manner. There is evidence of reviews which are signed off by the registered nurse and there is evidence of resident/family input and input from other health professionals for example the physiotherapist and podiatrist.

The files of the two resident’s shows interventions are changed in response to their condition. The interventions put in place to meet residents` needs are monitored by staff (refer 1.3.3.3).

**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

The diversional activities are planned seven days a week with the programme run with assistance of activities co-ordinators, external entertainers and staff. Most of the activities programme is provided Monday to Friday with activities planned in the weekends with staff to facilitate.

There are two diversional therapists who each work eight hours a day, five days a week (64 hours in total a week).

There is a stimulating and meaningful programme which includes activities that are physical, intellectual, sensory, social and include reminiscing. All activities are well advertised in the facility. Residents are prompted to attend with notices made over the intercom - staff sighted going into resident rooms to encourage them to attend.

Weekly group activities are designed to reflect the interests of the residents that include: group activities, one to one pampering, reading the newspaper, competitions, outings and music with visiting entertainment. The recreational assessments sighted in the resident`s files include the residents` life history, favourite things, past and current and future interests and physical, intellectual, social and cultural needs. Cultural activities are encouraged. The diversional therapist interviewed is very passionate about the role and maintains attendance records. The residents and family report satisfaction with the activities offered.

There is a map of life in each room and this prompts staff to ask questions and chat with residents around things they are interested in.

Staff receive feedback about the programme through the annual satisfaction survey and through monthly resident meetings.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Nursing reviews and assessments, medical and specialist consultations and admission to hospital for specialist treatment are clearly documented in six of six resident files reviewed. Documentation reflects that evaluations of care plans are conducted at least six monthly and more often if required. Evaluation in short term care plans utilised are documented, resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the desired outcomes.

The care plans are resident focused, indicate the degree or response to the support and/or interventions, and document towards meeting the desired goals. The nurse manager interviewed stated that if a resident is not responding to the service interventions being delivered, or their health status changes, then this is discussed with their GP. The GP interviewed verified at interview that this does occur and prefers this discussion to occur.

The resident`s family are notified and this is recorded in the file.

The previous improvement identified in the certification audit has been addressed. The care plan is now updated when changes occur and at least six monthly.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

Policies and procedures on medicine management include prescribing and dispensing, self-administration, medication reconciliation and stock control, storage and disposal, staff administration, controlled drugs, staff training and competencies and monitoring medication errors.

There are three medication rooms and all have appropriately locked doors. 12 of 12 medication files were checked (four from each medication room with all aspects of the medication system checked in each).

Medicines for residents are received from the contracted pharmacy and checked on entry to the service. Any changes that the GP makes to medicine prescriptions are faxed to the pharmacy. All 12 medicine records sighted, six rest home and six hospital have a front sheet for each individual resident and a large photograph of the resident for identification purposes. Signatures of staff can be identified.

A weekly check of stored medicines is conducted which includes checking expiry dates and medication not in use is returned to the pharmacy and recorded when uplifted by the pharmacist. The controlled drugs are stored in a locked cabinet in a locked cupboard within a locked medication room. There is a current and appropriately signed drug register which has weekly stocktakes completed. The pharmacist also checks the medication records and the medication stocks.

All staff responsible for medication management have completed medication competencies and this information was evidenced and records are maintained. 12 of 12 medication records reviewed have been reviewed three monthly and this is verified by the GP.

All medication records sighted evidence the medicines are documented, dated and signed appropriately to meet legislative requirements and guidelines available.

Residents interviewed state that they receive their medicines in a timely manner.

The previous improvements required at the certification audit have been adequately addressed. There are no standing orders any more, the medication order sheet is signed by the doctor, all registered nurses have completed an annual syringe driver competency (completed in October 2012 and April 2013), all staff have medication competencies.

An improvement is required around transcribing.

**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:** Moderate

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. Weekly checks of the controlled drug register are undertaken.

**Finding Statement**

There is evidence of transcribing in the PRN signing sheets and the antibiotic signing sheets.

**Corrective Action Required:**

Stop the practice of transcribing.

**Timeframe:**

1 month

**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

A letter in August 2013 confirms input of the registered dietitian into the menu plans.

Fluids are provided with each meal, jugs of water are available in residents` rooms and morning tea, afternoon tea and supper is provided.

Any dietary requirements are identified in the dietary profile which is undertaken on admission by the RN and updated as required. A copy is kept in the individual resident`s file and the cook has a copy.

The cook interviewed explained that the kitchen staff can cater for all dietary requirements and there are instructions related to what plate to use, if food should be cut up, and the type and portion size of the meal. Dietary supplements authorised by the dietician are given out by the clinical staff as required.

The kitchen is clean and has cooking appliances for the numbers to be catered for. All food supplies are delivered on a regular basis to meet the menu requirements. Food is stored safely, labelled with contents and expiry dates are monitored. There are daily temperature recordings of the freezers and chiller and food at time of serving. Records are maintained by staff and these were available. All kitchen staff have attended food safety training and completed the necessary requirements. Records are verified by the general manager in the cooks staff file sighted.

Six family members interviewed confirmed that the food meets the approval of their family member.

Two residents have lost 9kgs over a year and staff are monitoring the weight loss with strategies being discussed with the GP. One resident lost 3 kgs in a month and gained the following month. Three other residents have a stable weight.

Residents (rest home and hospital) are now routinely weighed monthly, with residents with specific nutritional needs weighed more frequently if ordered by the GP. The previous requirement has been addressed.

Improvements required at the previous audit have been addressed. These include the following: outbreak policies are documented and reviewed and there is sufficient water on the premises to support residents in the event of a disaster. All food is disposed of when it is past the expiry date and there is no expired food on shelves. Staff were not seen to wear jewellery that is inconsistent with the policy and the food temperature gauge is calibrated.

An improvement is required to documentation of strategies to manage slow weight loss.

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

Resident weight is now monitored monthly and this is used to identify any issues with weight loss of gain. Fluids are provided with each meal, jugs of water are available in residents` rooms and morning tea, afternoon tea and supper is provided.

Any dietary requirements are identified in the dietary profile which is undertaken on admission by the RN and updated as required. A copy is kept in the individual resident`s file and the cook has a copy.

The cook interviewed explained that the kitchen staff can cater for all dietary requirements and there are instructions related to what plate to use, if food should be cut up, and the type and portion size of the meal. Dietary supplements authorised by the dietician are given out by the clinical staff as required.

**Finding Statement**

 Of the six files reviewed, two showed that residents had lost 9kgs each over a year. This continues to be monitored however strategies to manage the loss are not documented or reasons for the weight loss not documented.

**Corrective Action Required:**

Document strategies to manage slow weight loss or document if the weight loss is appropriate.

**Timeframe:**

3 months

**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 1.4.1 Management Of Waste And Hazardous Substances**

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

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 previous improvement identified that hazardous substances are left on trolleys in the hallways. The cleaner interviewed states that the trolley is with her and there are no hazardous substances left on the trolley. The trolley was observed to be with the cleaner on the day of the audit with appropriate cleaning products only on the trolley. The previous improvement has been addressed.

**Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

A current Building Warrant of fitness is posted in a visible location at the entrance to the facility and is current. There have been no building modifications since the last audit, however there have been room refurbishments.

There is a planned maintenance schedule implemented.

D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounge on the day of the audit.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programme two yearly and this is up to date.

Interviews with five of five caregivers (three rest home and two hospital) and the two registered nurses confirmed there is adequate equipment.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required.

There are safe outside areas that is easy to access for residents and family members.

A tour of the service did not identify any damp or wet rooms and there are no musty smells of mould present.

The wet area in Kauri has been repaired with the previous improvement required now addressed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities**

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

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

The previous improvement identified that some toilet and shower doors in the older section of the facility are unable to be secured for privacy. These are now able to be secured - sighted on the day of the audit and checked. The previous improvement required has been addressed.

**Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

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

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

The previous improvement identified that cleaning and laundry policies lacked input from the infection control coordinator. The policies have been reviewed and all have had input from the infection control coordinator (registered nurse) as confirmed by the general manager (registered nurse acting for the infection control coordinator on the day of the audit). The previous improvement required has been addressed (previously 1.4.6.1).

**Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The policy on restraint minimisation and safe practice defines restraint. No enablers are in use at the time of the audit. All restraint is recorded by the restraint coordinator in a restraint register. Interview with five of five caregivers confirms that approved restraint use is documented in the resident's file, they are familiar with types of restraint and restraint procedures and participate in monitoring residents where restraint is approved. The files reviewed of two of six residents (both hospital residents) contain all the required documentation related to restraint.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

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

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

The certification audit identified that there was no quality review of restraint use that covers (a) to (h) of these criteria.

Quality reviews of restraint that address criteria (a) to (h) were completed in December 2011 and 2012. This is an improvement from the previous audit.

**Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:**

 (a) The extent of restraint use and any trends;

 (b) The organisation's progress in reducing restraint;

 (c) Adverse outcomes;

 (d) Service provider compliance with policies and procedures;

 (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

 (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

 (g) Whether changes to policy, procedures, or guidelines are required; and

 (h) Whether there are additional education or training needs or changes required to existing education.

**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 3.1 Infection control management**

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

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

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

There are comprehensive infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. There are policies including infection control management with a defined and documented IC programme. There are clear lines of accountability for the infection control programme.

All aspects of the programme are documented including the scope of surveillance and the benchmarking programme.

An annual review for the infection control programme has been completed in January 2013. The previous improvement required has been met.

**Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

Surveillance frequency and type is set out in policy and determined by the organisation`s infections control policies and procedures that are reflective of the service offered at this rest home and hospital.

Surveillance data is undertaken as required in the Health and Disability Services Standards Infection and Prevention Control standards 2008. Infection control data is collected on urinary tract infections, skin infections, eye infections, upper and lower respiratory tract infections, gastrointestinal infections, wound infections and other. The benchmarking group has been running now for 16 years and includes comparable services in Kaeo, Kerikeri, Kaitaia, Kaikohe. The Bay of Islands and the Hokianga are also joining.

There are three monthly meetings with other infection control coordinators and the DHB to set annual targets for each infection area.

The general manager and the registered nurses interviewed have a good understanding of the surveillance system and significance of collecting the data.

The infection control register for 2013 is electronically documented and includes the resident name, if admitted with an infection, if antibiotics are used, date infection cleared and duration of the infection. An antibiotic usage summary is kept up to date.

The service has had an outbreak of norovirus last in August 2013 with all parties notified i.e. public health, MoH and DHB.

The MRSA policy has been updated in line with Bug Control - last reviewed in September 2013. The previous improvement required has been 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:**