**Elmswood Court Lifecare Limited**

**Current Status:** **07-Oct-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Elmswood Retirement Village is certified to provide rest home level care for up to 88 residents. On the day of the surveillance audit, there were 55 rest home residents, 54 in the rest home and one in a serviced apartment. There are documented mission, values and goals for Elmswood Retirement Village. The facility manager has been in the role for four years and is supported by a general manager, a quality manager, registered and enrolled nurses and care staff. Residents and families interviewed were supportive of the care and support provided.

The service has addressed four of the six shortfalls from their previous certification audit around clinical follow up following incidents, documenting care plan interventions, wound assessment and treatment plans, and short term care plans.

Further improvements continue to be required around medication management.

This audit identified improvements required relating to completion and sign off of corrective actions, communication of corrective actions to staff, and timely notification of outbreaks to authorities.

**Audit Summary AS AT** **07-Oct-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

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| **Consumer Rights** | Day of Audit07-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Organisational Management** | Day of Audit07-Oct-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit07-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit07-Oct-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit07-Oct-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit07-Oct-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Some standards applicable to this service partially attained and of low risk** |

**Elmswood Retirement Village**

Elmswood Court Lifecare Limited

Surveillance audit - Audit Report

Audit Date: 07-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Elmswood Court Lifecare Limited |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Elmswood Retirement Village | 131 Wairakei Road | Bryndwr | Christchurch |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 07-Oct-13 **End Date:** 07-Oct-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | RCpN, Health Auditor, AdDipBusMan, CertQA | 8.00 | 4.00 | 07-Oct-13 |
| Auditor 1 | XXXXXXXX | RN, Lead Auditor, BHSc | 8.00 | 4.00 | 07-Oct-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXXX |       |       | 1.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 9.00 | **Total Audit Hours** | 25.00 |
| **Staff Records Reviewed** | 5 of 60 | **Client Records Reviewed** *(numeric)* | 5 of 55 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 5 |
| **Staff Interviewed** | 9 of 60 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 5 of 55 | **Number of Medication Records Reviewed** | 10 of 55 | **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 5 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

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| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Elmswood Retirement Village | 88 | 55 |       | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Elmswood Retirement Village is certified to provide rest home level care for up to 88 residents. On the day of the surveillance audit, there were 55 rest home residents, 54 in the rest home and one in a serviced apartment. There are documented mission, values and goals for Elmswood Retirement Village. The facility manager has been in the role for four years and is supported by a general manager, a quality manager, registered and enrolled nurses and care staff. Residents and families interviewed were supportive of the care and support provided.

The service has addressed four of the six shortfalls from their previous certification audit around clinical follow up following incidents, documenting care plan interventions, wound assessment and treatment plans, and short term care plans.

Further improvements continue to be required around medication management.

This audit identified improvements required relating to completion and sign off of corrective actions, communication of corrective actions to staff, and timely notification of outbreaks to authorities.

1.1 Consumer Rights

 Elmswood Retirement Village is owned by a group of shareholders and is managed by a general manager who reports to a Board of directors. The organisation has a quality and risk management plan in place with annual quality activities conducted. A quality and risk management meeting is held to report and discuss quality and resident issues. Internal audits are conducted. Corrective actions are developed following quality activities to ensure identified issues are followed through, however, improvements are required whereby corrective actions are updated and signed off when complete, and staff are informed of quality activities and outcomes. Incidents, and infection rates are reported with an analysis completed monthly for the quality and risk meeting. Incident are followed up from the registered nurse and appropriate clinical management is provided. Residents and relatives interviewed confirmed they are kept fully informed of adverse events as per the open disclosure policy. There are human resource policies and procedures in place. In-service training is provided in addition to the aged care education programme (ACE). Rosters are in place. Registered nurses provide on call service after hours. The roster provides sufficient and appropriate coverage for effective delivery of care and support for the facility.

1.2 Organisational Management

Elmswood Retirement Village is owned by a group of shareholders and is managed by a general manager who reports to a Board of directors. The organisation has a quality and risk management plan in place with annual quality activities conducted. A quality and risk management meeting is held to report and discuss quality and resident issues. Internal audits are conducted. Corrective actions are developed following quality activities to ensure identified issues are followed through, however, improvements are required whereby corrective actions are updated and signed off when complete, and staff are informed of quality activities and outcomes. Incidents and accidents, and infection rates are reported with an analysis completed monthly for the quality and risk meeting. Incident and accidents are followed up from the registered nurse and appropriate clinical management is provided. Residents and relatives interviewed confirmed they are kept fully informed of adverse events as per the open disclosure policy. There are human resource policies and procedures in place. In-service training is provided in addition to the aged care education programme (ACE). Rosters are in place. Registered nurses provide on call service after hours. The roster provides sufficient and appropriate coverage for effective delivery of care and support for the facility.

1.3 Continuum of Service Delivery

Elmswood Retirement Village has implemented systems that evidence each stage of service provision is developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into care planning, care plan evaluations and that the interventions noted in the care plans are consistent with meeting residents' needs.

A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. The previous audit identified that there had been gaps around care plan interventions, short term care plans and wound care assessments and treatment plans, this has been addressed and monitored by the service. Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. There is an appropriate medicine management system in place. The previous audit identified that there had been gaps around pharmacy labels on medications and completion of medication signing sheets by staff and this has been addressed and monitored by the service, however there are areas identified for improvement around stocktake of controlled drugs, and RN annual peer competencies.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. A five week menu is implemented and residents' individual needs are identified, documented and reviewed on regular basis.

1.4 Safe and Appropriate Environment

There is a current building warrant of fitness that expires on 1st April 2014. The facility manager states there have been no alterations to the building since last certification audit.

2 Restraint Minimisation and Safe Practice

There is a restraint policy that includes definitions of restraint and enablers. There are no residents assessed as requiring restraint or enablers. Staff are trained in restraint minimisation and managing challenging behaviours.

3. Infection Prevention and Control

The infection control nurse completes a monthly infection summary which is discussed at quality and staff meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary. Improvement is required whereby outbreak notification to Public Health authority occurs in a timely manner.

Summary of Attainment

* 1. Consumer Rights

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

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 1 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA:3 PA:1 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Low | 0 | 6 | 2 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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

* 1. Continuum of Service Delivery

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 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 | 2 | 2 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Low | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 4 PA Neg: 0 PA Low: 1 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:2 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 1 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 34 **CI:** 0 **FA:** 11 **PA Neg:** 0 **PA Low:** 4 **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:** 33 **PA:** 6 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Elmswood Court Lifecare Limited

Type of Audit: Surveillance audit

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

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.13 | 1.1.13.3 | PALow | **Finding:**Details of the process management of the complaints is not recorded - including letters of follow up and response to complainants.**Action:**Maintain records of response to complainants and follow up of corrective actions taken. | 3 months |
| 1.2.3 | 1.2.3.6 | PALow | **Finding:**Quality activities are documented in the quality and risk management meeting minutes, however, internal audits are not discussed at the two monthly staff meetings and copies of the quality and risk meeting minutes are not available for employees to read.**Action:**Ensure all quality activities and outcomes are communicated to staff for implementation of corrective actions. | 3 months |
| 1.2.3 | 1.2.3.8 | PALow | **Finding:**On review of the current list of corrective actions, the last review was conducted in April 2013, did not document review or sign off of implemented actions.**Action:**Ensure correctives actions are reviewed and sign-off when implemented change completed in a timely manner . | 6 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.12 | 1.3.12.1 | PALow | **Finding:**Six monthly stocktakes of controlled drugs are not conducted.**Action:**Provide evidence of six monthly stocktakes of controlled drugs. | 3 months |
| 1.3.12 | 1.3.12.3 | PALow | **Finding:**Two RNs who oversee the administration of medicines have not completed peer medication competencies in the last 12 months.**Action:**Provide evidence the RN's who oversee the administration of medicines have completed peer medication competencies annually. | 3 months |
| 3.5 | 3.5.7 | PALow | **Finding:**A Norovirus outbreak commenced on 18-Jul-2013 affecting two serviced apartment residents, nine rest home residents and three staff. However, Public Health authority was not notified until the 25-Jul-2013. Details of those affected were faxed to Public Health to inform them of the infection at this time. **Action:**Ensure that Public Health are notified of outbreaks in a timely manner - as per MOH guidelines for management of Norovirus outbreaks - section 8 Outbreak Notification.  | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Elmswood Court Lifecare Limited

Type of Audit: Surveillance audit

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

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.9 Communication**

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

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

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

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

There is an open disclosure policy in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident forms are completed by either caregivers or registered nurses and a copy of any incident relating to individual residents is included in the clinical file. The family contact sheet records that families are informed following GP review, incidents or if there is a change in resident condition (confirmed by three relatives interviewed). Notification of next of kin for the August 2013 period of incidents sampled was confirmed through the clinical files reviewed. Copies of completed admission agreements are held in clinical files and an extensive admission booklet is given to all new residents and or family. There is an interpreter policy in place with information included in the admission booklet.

D12.1 Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet.

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

D16.4b Residents (five) and relatives (three) interviewed confirmed they are kept fully informed.

D11.3 The admission booklet is available in large print and can be read to residents if required.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 12 months was conducted. A record of outcomes is recorded within a complaints register. The complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. A complaints process form is available to record outcomes, however, this has not been utilised for the three rest home complaints received in 2013. Details of the process management of the complaints is not recorded including letters of follow up and response. Improvement is required in this area. Complaints are discussed at the monthly quality and risk management meetings and the two monthly staff meetings.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

A review of complaints received for the past 12 months was conducted. A record of outcomes is recorded within a complaints register. The complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. A complaints process form is available to record outcomes, however, this has not been utilised for the three rest home complaints received in 2013. Details of the management of the complaints is not recorded including letters of follow up and response.

**Finding Statement**

Details of the process management of the complaints is not recorded - including letters of follow up and response to complainants.

**Corrective Action Required:**

Maintain records of response to complainants and follow up of corrective actions taken.

**Timeframe:**

3 months

**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

Elmswood Retirement Village is owned by a group of shareholders. The general manager reports to the Board of Directors three times a year. A facility manager is employed to oversee the running of the rest home and serviced apartments. The facility manager (previous enrolled nurse) has been in the role for four years. The facility manager is supported by a quality manager and a full time registered nurse. Elmswood Retirement Village is certified to provide rest home level care for up to 88 residents within a 54 bed rest home and in 34 serviced apartments. On the day of the surveillance audit, there were 55 rest home residents - 54 in the rest home and one in a serviced apartment. The service has a business plan in place (2013-2018) for organisational governance and direction. There is current comprehensive quality and risk management plans in place. The quality plan and risk management plan was reviewed in February 2013. The quality plan includes objectives, policies and procedures, implementation, monitoring, quality risk, and action plans. The mission statement of the organisation is included in the admission documentation and states that "Elmswood retirement village is committed to providing residents with the highest level of care within a warm and friendly environment".

The facility manager, and general manager meet weekly as the management team. The general manager reports to the board meetings on a range of issues including occupancy, staffing, finances, complaints and incidents. There is an audit plan, education plan, incident reporting, with an analysis completed monthly for the monthly quality and risk management meeting.

D17.3di (rest home): The facility manager has been in the role for four years and is a previous enrolled nurse. The facility manager has attended in-service and external education in the past 12 months to comply with contractual requirements - including four quadrant leadership courses, three day NZACA conference and stage three ACC training.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The organisation has quality and risk management policies in place. Elmswood Retirement Village has a business plan for the service. There is a quality programme and a risk management plan. Both were reviewed in February 2013. The quality plan for 2013 contains quality goals including resident focused goals, competent staff, high quality care, high quality facilities, continuous quality improvement, collaborative care, meeting legislative and contractual requirements and sustaining a profitable business. Quality activities include internal audits, incident analysis, health and safety, education for staff, infection preventions and risk management. The risk management plan includes assessment of risk for the organisation, safety management, security management, hazardous maintenance, emergency preparedness, building management, and human resource management. Annual review of complaints, incidents, infections and resident satisfaction occurs. Benchmarking of falls and infections occurs with three other similar size rest homes.

A monthly analysis of all incidents is completed and a summary is included in the quality and risk meeting minutes. Minutes of the quality and risk meeting minutes were viewed for 20-Sept-2013. Meeting minutes contained matters arising from the previous meeting, health and safety, infection rates, restraint, staffing, training, surveys, and maintenance. There is also a separate monthly health and safety committee meeting (minutes sited for 20-Sept-13) and a two monthly infection control committee meeting (17-Sept-13). The quality and risk management team includes the general manager, quality manager, facility manager, and facility manager of sister facility. Quality activities are documented in the meeting minutes and included in staff newsletter however, these are not discussed at the two monthly staff meetings copies of the quality and risk meeting minutes are not available for employees to read. Improvements are required in this area. Staff meetings are held two monthly and minutes sighted for 27-Sept-13 included discussion around incidents, health and safety, infection prevention, training, resident issues and general business. There is a staff newsletter published for the month in between which includes the month’s health and safety, infection prevention, training, matters of note from meetings and quality information. The newsletter has a section completed by the facility manager, and general manager.

Policies and procedures are reviewed two yearly by the quality manager and content of policies reviewed reflects current and relevant standards, contracts and guidelines. Policy manuals are access via a general server file that all staff can access. Annual satisfaction surveys are conducted for residents and relatives - last completed in December 2012 with discussion of outcomes held at staff meeting, and survey results included in resident newsletter and posted on the resident notice board.

An annual audit schedule is implemented and audit results for 2013 were viewed. Audits completed include medication management, resident files, diversional therapy, privacy and confidentiality, staff files, restraint, complaints, housekeeping, health and safety, infection control, hand washing, food services, and laundry.

Results of audits, incidents, complaints, and infections are reported to quality and risk management meetings. Corrective actions are documented if issues are identified following these quality activities.

Advised that each month at the Quality and Risk committee the corrective actions are reviewed and completed activities are removed. On review of the documented list of corrective actions in the internal audit folder, the last list of corrective actions dated April 2013 did not include documented review or sign off of implemented actions.

D5.4 The service has policies and procedures to support service delivery. The content of these policies are reviewed to ensure that standards and legislative requirements are included.

D10.1 Death/Tangihanga policy and procedure which details action to be taken on a resident’s death with required certifications and documentation. D17.10e: Emergency policies are in place to guide staff in managing clinical and non-clinical emergencies.

D19.3 there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g Falls prevention strategies such as environment review, footwear, use of walking aids, supervision and assistance for residents, the use of sensor pads and falls risk assessments are in place.

D19.3 There is a hazard register that is reviewed annually. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

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

An annual schedule of quality activities is implemented (last developed February 2013). Internal audits for 2013 were viewed. Audits are conducted and discussed at the monthly quality and risk management meetings. The quality and risk management team includes the general manager, quality manager, facility manager, and facility manager from sister facility

. Quality activities are documented in the meeting minutes however, internal audits are not discussed at the two monthly staff meetings and copies of the quality and risk meeting minutes are not available for employees to read. On interview three caregivers and one enrolled nurse advised that they are not informed about audit outcomes. Staff meetings are held two monthly and minutes sighted for 27-Sept-13 and include discussion around incidents, health and safety, infection prevention, training, resident issues and general business.

**Finding Statement**

Quality activities are documented in the quality and risk management meeting minutes, however, internal audits are not discussed at the two monthly staff meetings and copies of the quality and risk meeting minutes are not available for employees to read.

**Corrective Action Required:**

Ensure all quality activities and outcomes are communicated to staff for implementation of corrective actions.

**Timeframe:**

3 months

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

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

Results of audits, incidents, complaints, and infections are reported to quality and risk management meetings. Corrective actions are documented if issues are identified following these quality activities. Advised that each month at the Quality and Risk committee the corrective actions are reviewed and completed activities are removed. On review of the documented list of corrective actions in the internal audit folder, the last list of corrective actions dated April 2013 did not include documented review or sign off of implemented actions.

**Finding Statement**

On review of the current list of corrective actions, the last review was conducted in April 2013, did not document review or sign off of implemented actions.

**Corrective Action Required:**

Ensure correctives actions are reviewed and sign-off when implemented change completed in a timely manner.

**Timeframe:**

6 months

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

There are incident reporting policies. Adverse events are reported via the incident reporting system. Senior management are aware of the statutory and regulatory obligations regarding essential reporting. Reporting responsibilities are documented. Records were viewed for incident reports completed for August 2013 which included 19 reports. An incident monthly summary is completed. All incident forms have been completed by a registered nurse with clinical follow up completed. A review of a sample of forms was conducted and included three residents who accounted for seven incident reports. Registered nurses conduct and document clinical follow up and all reports are seen by the facility manager who also reviews all incidents for investigations and corrective actions. Corrective actions are included on the incident reporting forms completed as evidenced in seven reports reviewed. Resident files reviewed relating to incident forms evidenced documentation of family contact. Five residents and three relatives interviewed confirmed they are kept fully informed of adverse events as per the open disclosure policy. Copies of relevant incident forms are held in the clinical files. All adverse events are analysed monthly and included in the quality and risk management meetings and the health and safety meetings.

There is an improvement from the previous audit around clinical follow up of residents who have sustained suspected head injury. A new observation chart is in use with space for neurological observations. Guidelines for use have been developed for staff to follow. Two residents with frequent falls both sustained a head injury. On review of the files, both residents had had neurological observations completed and had been seen by the GP. A post falls assessment is conducted for residents who have an increase in falls rate to ensure falls prevention and management is implemented.

D19.3c The organisation is aware of their reporting responsibilities to the DHB of any serious accidents.

D19.3b; There is an incident reporting policy which includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action.

**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

Elmswood retirement village has human resource policies and procedures in place which include recruitment, orientation, staff training and industrial relations. Five staff files were viewed covering designations of registered nurse, enrolled nurse, one team leader caregiver, one caregiver, and one laundry person/caregiver. The individual files contained individual, position descriptions outlining responsibilities and expected outcomes, Police checks, orientation records for the specific roles and performance appraisals signed off by the manager. Records were also viewed of reference checks and completed interview sheets. Copies of current annual practising certificates are held in the individual files. Current annual medication competencies were viewed for the team leader/caregiver and the enrolled nurse. The two registered nurses - both of whom are responsible for medication administration have not completed annual peer medication competencies. Three of three caregivers interviewed advised that they had completed the ACE qualification. The orientation programme includes fire safety, infection control, health and safety and house rules in addition to induction to the role to be undertaken.

An annual in-service training schedule is developed and implemented in addition to the aged care education programme (ACE). Advised by the education facilitator that all care staff are encouraged and facilitated to complete the ACE programme. Records were viewed for attendance at and assessment of training held for 2012 and 2013 to date. Compulsory attendance is required annually for fire safety, and manual handling. Education for 2013 includes a mix of in-service training and self-directed learning tools. Self-directed learning tools completed in 2013 include abuse and neglect, dementia and challenging behaviours, nutrition and food handling, restraint and de-escalation techniques, infection prevention and control, and open disclosure. In-service sessions for 2013 have included chemical handling, health and safety including hazards and emergency preparedness, manual handling, Maori values and beliefs, cultural responsiveness, death and dying, continence, residents rights (including informed consent, privacy, advocacy, and complaints), open disclosure, documentation, and falls prevention. The annual training programme exceeds eight hours annually. Fire and evacuation drill conducted 27-Aug-2013.

D17.7d: Medication competencies for registered nurses have not been conducted (link #1.3.12).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is a documented rostering and skill mix policy in place. A facility manager is employed for 40 hours per week. A quality manager works for 18 hours per month and also works as a registered nurse covering the serviced apartments and registered nurse relief (eight hours/week). The rest home registered nurse works 40 hours per week. Enrolled nurses and caregivers are employed across all shifts and there is a registered nurse on call after hours. In the serviced apartments area there is team leader on in the morning shift and caregivers from the rest home area provided cover also. In the rest home area there is team leader on every shift as well as caregivers who work long and short shifts. There are three activities staff, chefs and kitchen hands as well as cleaners and laundry staff. The roster allows for hand-over time. The rosters provide sufficient and appropriate coverage for effective delivery of care and support for the facility. Three caregivers, one enrolled nurse, five residents and three relatives interviewed, confirmed there are sufficient staff on duty to meet the resident’s needs.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input, according to specified timeframes and the service is coordinated to promote continuity of service delivery.

Six of six clinical staff ( two RNs, one EN and three caregivers) interviews confirm residents and/or family members are involved in all stages of service provision.

Five of five resident and three of three family interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews.

Five of five residents' files sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations. The RNs undertake the assessments on admission with the initial care plan completed within 24 hours of admission and the long term care plan is completed within three weeks of resident's admission to the facility.

The auditor evidenced verbal briefing from am to pm shift. GP interview was conducted and confirms the GP has been providing medical services for the facility for over eight years. The interview with the GP confirms that staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff.

Staff competency assessments are current, except for annual peer medication competencies for RNs (refer to CAR 1.3.12.3).

D16.2, 3, 4: The resident files reviewed, identify that an assessment was completed within 24 hours and the long term care plan was completed within three weeks of admission. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. All five care plans evidence evaluations are completed at least six monthly.

D16.5e: The resident files reviewed identify that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly.

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); pain, continence, dietary, falls, pressure area care.

Tracer Methodology:

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 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

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.

Residents' files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. GPs documentation and records are current.

Five of five residents and three of three family interviewed confirm their and their relatives current care and treatments they are receiving meet their needs.

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

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

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

Wound assessment and wound management plans are in place for 10 residents. All wound care plans were reviewed.

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

The previous audit identified that there had been gaps around care plan interventions and wound care assessments and treatment plans, this has been addressed and monitored by the service.

**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

Interview with diversional therapist (DT) confirms the DT has been employed at the facility for over four years. The DT is employed for 40 hours each week. The DT is supported by two part time activity co-ordinators. The DT states there are five volunteers, who assist with activities such as cross words, paper reading, quizzes and one on one activities. There are three activities programme at the facility; one for the rest home; one for villas and one for the studio/apartments. Rest home activities programme runs from Monday to Friday, sighted.

The DT confirms the activities programme meets the needs of the service group and the service has appropriate equipment. Activities attendance records are maintained and were sighted.

Residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.

Residents' two monthly rest home meeting minutes were sighted for February, April, June and August 2013. The residents' meetings have a set agenda that includes but not limited to; general business; health and safety; infection control; staffing and activities. There are separate meetings held for the rest home, villa and studio/ apartment residents.

Residents' files sampled demonstrate the individual activities care plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being.

Activities audit was conducted on 30-Jul-2013.

Five of five residents and three of three family interviewed confirm residents' and their family members' past activities are considered and there is a choice to participate in activities.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. Short term care plans are utilised for short term problems.

Evaluation are conducted by the RN with input from the resident, family, care givers, diversional therapist and GPs.

Family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews.

Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed.

There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. Residents' files evidence referral letters to specialists and other health professional. Multidisciplinary reviews are current.

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

The previous audit identified that there had been gaps around short term care plans and monitoring of acute issues. These have been addressed and monitored by the service.

**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

The medication area in the facility, evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs.

The controlled drug storage in the facility is secure. The controlled drug register is maintained and evidences weekly checks, however six monthly physical stock takes are not conducted and this requires an improvement.

Medication fridge temperatures are conducted and recorded. Lunchtime medication round was observed.

Residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given).

EN and care staff who administer medicines have current medication competencies, however two RN's do not hold current annual peer medication competencies and this requires an improvement.

Staff education in medicine management was conducted in January 2012 and is available to staff as a self-directed learning tool.

Ten medication charts were sampled. All ten charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs.

There is one resident at the facility that self-administers medicines. There is evidence of residents' current competency assessment to self-administer medicines and the safe storage of medicines was sighted. The medication chart sighted evidences a record the resident is self-administering medicines.

Interview with the resident who self-administers medicines was conducted and evidences the resident is competent and aware of the responsibilities with self-administration of medicines, however does not record when medicines have been taken.

Medication audit was conducted on 11-Apr-2013.

D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

The previous audit identified that there had been gaps around pharmacy labels on medications and completion of medication signing sheets and this has been addressed and monitored by the service, however, there are areas identified for improvement around stocktake of controlled drugs, and RN competencies.

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

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

The controlled drug storage in the facility is secure. The controlled drug register is maintained and evidences weekly checks including measure of liquid controlled drug, however six monthly physical stock takes are not conducted.

**Finding Statement**

Six monthly stocktakes of controlled drugs are not conducted.

**Corrective Action Required:**

Provide evidence of six monthly stocktakes of controlled drugs.

**Timeframe:**

3 months

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

EN and care staff who administer medicines have current medication competencies. There are two RNs who administer medicines, however they have not completed competency assessments.

**Finding Statement**

Two RNs who oversee the administration of medicines have not completed peer medication competencies in the last 12 months.

**Corrective Action Required:**

Provide evidence the RN’s who oversee the administration of medicines have completed peer medication competencies annually.

**Timeframe:**

3 months

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

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

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

Food service is appropriate to the service setting with a new seasonal menu being introduced six monthly. The summer and winter menus were last reviewed by a dietitian in September 2011, letter sighted. The kitchen provides food service for Elmswood Retirement village as well as Fendalton Retirement Village residents.

The chef interview confirms awareness of residents' individual dietary needs. Residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review. There are current copies of residents' dietary profiles in the kitchen. Kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the RN.

Food safety training for kitchen staff has been conducted.

Residents' files sampled demonstrate monthly monitoring of individual resident's weight. Residents interviewed were satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided.

Food temperatures are recorded, sighted. Fridge, chiller and freezer temperatures are recorded, sighted. Decanted food is not dated. and this requires an improvement.

Kitchen services audit was conducted in January 2013.

Food satisfaction survey was conducted as part of resident satisfaction survey December 2012.

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

There is an area identified for improvement around dating of decanted foods.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

Building warrant of fitness expires on 1/04/14, displayed at entrance to the facility. The facility manager states there have been no alterations to the building since last certification audit. Advised by the general manager that structural engineers have assessed the facility - post earthquakes. A formal report was sighted (dated December 2012) that advises that the facility is safe for occupancy and no structural damage is noted.

**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:**

**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

There is a restraint policy which reflects current standards. The facility manager is the restraint coordinator. There are no residents requiring restraint or enablers. There is a documented definition of restraint and enablers. Staff have received education on restraint minimisation and challenging behaviour management as part of self-directed learning tools. On interview, two registered nurses one enrolled nurse and three caregivers were knowledgeable about restraint minimisation and alternatives and in managing challenging behaviours. Restraint minimisation and challenging behaviour management is also part of the ACE training programme provided at Elmswood retirement village.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 Surveillance**

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

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

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

The infection prevention and control policy describes and outlines the purpose and methodology for the surveillance of infections. The rest home registered nurse is the Infection Control nurse for Elmswood Retirement Village. Information obtained through surveillance is used to determine infection control activities, resources, and education needs within the facility. There is close liaison with the GP's and laboratory that advise and provide feedback /information to the service.

Systems in place are appropriate to the size and complexity of the facility. A monthly infection report is compiled. Advised that infection surveillance information is recorded when signs and symptoms of infection have been identified. Infection control data is collated monthly and reported to monthly quality and risk management meetings, two monthly infection control committee meetings and the two monthly staff meetings. All infections recorded are documented on the monthly infection summary. Documentation covers a summary, investigation, evaluation and action taken. Infection control audits are conducted. Results of surveillance and audits are communicated to staff via staff meetings, at handover time and via information and graphs posted in the staff room. Support for the IC nurse is provided from the quality manager and from an infection control nurse specialist from the local DHB. The service advised that they had a Norovirus outbreak in July 2013 with two studio apartment residents, nine rest home and three staff affected. The service sought advice from an IC expert with isolation precautions implemented as well as changes to laundry and kitchen practices until after the outbreak was resolved. The outbreak commenced on 18-Jul-2013, however, public health authority was not notified until the 25-Jul-2013. Improvement is required in this area. A debrief was held on 31-Jul-2013.

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

Support for the IC nurse is provided from the quality manager and from an infection control nurse specialist from the local laboratory. The service advised that they had a Norovirus outbreak in July 2013 with two studio apartment residents, nine rest home residents and three staff affected. The service sought advice from an IC expert with isolation precautions implemented as well as changes to laundry and kitchen practices until after the outbreak was resolved. The outbreak commenced on 18-Jul-2013, however, Public Health authority was not notified until the 25-Jul-2013. A debrief was held on 31-Jul-2013.

**Finding Statement**

A Norovirus outbreak commenced on 18-Jul-2013 affecting two serviced apartment residents, nine rest home residents and three staff. However, Public Health authority was not notified until the 25-Jul-2013. Details of those affected were faxed to Public Health to inform them of the infection at this time.

**Corrective Action Required:**

Ensure that Public Health are notified of outbreaks in a timely manner - as per MOH guidelines for management of Norovirus outbreaks - section 8 Outbreak Notification.

**Timeframe:**

3 months