

Tui House Limited

CURRENT STATUS: 18-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

Tui House provides rest home and hospital services to a total of 55 residents. On the day of the audit there are 51 residents, nine of which are assessed as requiring hospital level care. Tui House has a total of 31 beds which can be used by residents requiring either rest home level care or hospital level care.

The addition of hospital level care has occurred since the last certification audit and although the organisation has responded positively by increasing the numbers and skill levels of staff, a number of areas requiring improvement are still required.

These include the prompt and proactive identification and mitigation of risk, maintaining and improving clinical documentation, maintaining better records with regard to contacts and care plans, maintaining evidence that service delivery is provided in a timely manner, ensuring all staff have the required orientation records and attend essential/mandatory training, ensuring privacy is maintained for residents who share a bedroom and ensuring all aspects of medication meet professional and legislative requirements.

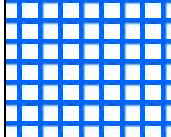
There has also been an alteration to the building which provides a larger communal area for residents to enjoy. The alteration does not require an amendment to the Building Warrant of Fitness.

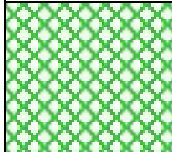
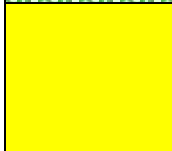


All four identified areas requiring improvement from the previous two audits have been adequately addressed.

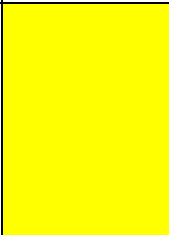
AUDIT SUMMARY AS AT 18-OCT-13

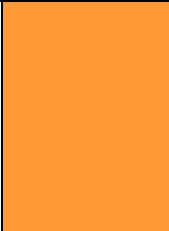
Standards have been assessed and summarised below:

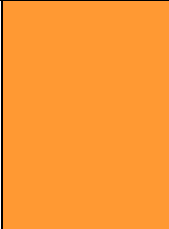
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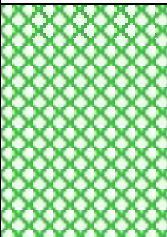
Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded

Indicator	Description	Definition
	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

Consumer Rights	Day of Audit 18-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

Organisational Management	Day of Audit 18-Oct-13	Assessment
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Continuum of Service Delivery	Day of Audit 18-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

Safe and Appropriate Environment	Day of Audit 18-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

Restraint Minimisation and Safe Practice	Day of Audit 18-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.		Some standards applicable to this service partially attained and of low risk

Infection Prevention and Control	Day of Audit 18-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

Tui House

Tui House Limited

Surveillance audit - Audit Report

Audit Date: 18-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Tui House Limited
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Premise Name	Street Address	Suburb	City
Tui House	2-4 Trentham Road	Papakura	Auckland

Proposed changes of current services <i>(e.g. reconfiguration)</i> :

Type of Audit	Surveillance audit and <i>(if applicable)</i>
Date(s) of Audit	Start Date: 18-Oct-13 End Date: 18-Oct-13
Designated Auditing Agency	Health Audit (NZ) Limited

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RN, LA, 8086	10	6	18-Oct-13
Auditor 1	XXXXXXXX	RN, NZ8086, infection preventionist	10	6	18-Oct-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX			2	30-Oct-13

Total Audit Hours on site	20	Total Audit Hours off site <i>(system generated)</i>	14	Total Audit Hours	34
Staff Records Reviewed	5 of 32	Client Records Reviewed <i>(numeric)</i>	5 of 51	Number of Client Records Reviewed using Tracer Methodology	1 of 5

Staff Interviewed	2 of 32	Management Interviewed <i>(numeric)</i>	2 of 2	Relatives Interviewed <i>(numeric)</i>	0
Consumers Interviewed	5 of 51	Number of Medication Records Reviewed	10 of 51	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	1

Declaration

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

I confirm that Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 29 day of October 2013

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

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

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

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

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

Services and Capacity

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Tui House	55	51	31	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

Tui House provides rest home and hospital services to a total of 55 residents. On the day of the audit there are 51 residents, nine of which are assessed as requiring hospital level care. Tui House has a total of 31 beds which can be used by residents requiring either rest level care or hospital level care.

The addition of hospital level care has occurred since the last certification audit and although the organisation has responded positively by increasing the numbers and skill levels of staff, a number of areas requiring improvement are still required. These include the prompt and proactive identification and mitigation of risk, maintaining and improving clinical documentation, maintaining better records with regard to contacts and care plans, maintaining evidence that service delivery is provided in a timely manner, ensuring all staff have the required orientation records and attend essential/mandatory training, ensuring privacy is maintained for residents who share a bedroom and ensuring all aspects of medication meet professional and legislative requirements.

There has also been an alteration to the building which provides a larger communal area for residents to enjoy. The alteration does not require an amendment to the Building Warrant of Fitness.

All four identified areas requiring improvement from the previous two audits have been adequately addressed.

1.1 Consumer Rights

All residents interviewed during the audit responded positively to the care and support they receive. Residents' rights are respected and all residents interviewed state the staff are 'kind', however an improvement is required to ensure privacy is maintained in shared bedrooms.

Communication channels are clearly defined and interviews and observation confirm communication is effective. Information on rights and services is provided in an appropriate manner, however not all records of family contact (following an event) have been maintained.

Resident interviews confirm understanding of their right to make complaints if necessary. The organisation takes all complaints seriously and works with the complainant toward achieving a satisfactory resolution. There have been no complaints with the Health and Disability Commission since the last audit and a complaints register is maintained.

While staff advise that open disclosure is occurring, records verifying this are not consistently available for applicable events reviewed during audit.

1.2 Organisational Management

Tui House Limited continues to be governed by Owner/Director/General Manager. The purpose, values, scope, direction and goals of the organisation are communicated and reviewed annually. Day to day operations are the responsibility of the Facility Manager who has been with the organisation for seven years. The Facility Manager is suitably experienced and qualified and is supported by the General Manager and Clinical Nurse Manager.

Tui House has a quality and risk management system in place. The required policies, procedures and work instructions are accessible. Quality and business goals are defined and achievement towards these goals is measured and monitored for effectiveness and efficiency. The service implements a quality improvement and internal monitoring programme. Corrective actions are developed where a short fall is identified. The risk management system is adequate, however a number of risks have not been included in the routine risk management process (including hazard management) and an improvement is required.

Human resource management and employment policies are in place. The orientation programme is sufficient, however evidence of completed orientation, and mandatory training, has not been consistently maintained.

Staffing is adequate to meet the needs of rest home and hospital level residents over the 24 hours with experienced advice and assistance available.

There is an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. The organisation has been proactive at ensuring all staff have the required level of skill and expertise. Staff performance is monitored.

Resident information systems are secure and maintained up to date, however not all events or communications have been documented, or entered in a timely manner, and an improvement is required.

1.3 Continuum of Service Delivery

There is a registered nurse on duty at all times. Policies and procedures are available to provide guidance for staff on the provision of care. Residents are seen by the general practitioner (GP) within 48 hours of admission. Evidence of ongoing routine GP reviews (as required to meet contractual requirements) are not consistently present in some resident files reviewed and is an area for improvement.

An initial nursing assessment is undertaken and used to develop the initial care plan. The new clinical manager has introduced a more comprehensive assessment format. A long term care plan is developed within three weeks of admission and some short term care plans are being developed. Some of the care plans reviewed are not sufficiently detailed or include all relevant aspects of care. Whilst evaluations are occurring, not all applicable components are being sufficiently documented and/or at times appropriately communicated. Verbal handovers are occurring between each shift. A written handover summary is also documented for each shift. The written handover reports do not include all relevant issues for the sampled resident files. These are areas requiring improvement.

A range of activities are provided. The activities are planned for a week at a time. Residents interviewed advise that participation is voluntary. The activities are enjoyable and meet their needs and preferences.

Policies provide guidance for staff on medication management. Medications are stored securely. Photographs are used to assist in the identification of patients. At least monthly checks of the controlled drug registers are occurring. The area identified as requiring improvement at the last audit now meets the standards. During audit a number of areas are identified as requiring improvement. These includes: ensuring the standing orders are sufficiently detailed, documenting allergies, ensuring medications are given as prescribed or noted to be withheld or refused. Where a resident has refused medications, documentation in relation to communications with the registered nurse and/or follow-up actions taken is not consistently evident. A number of practices sighted during medication administration do not meet current accepted practice.

A four week rotating menu is in use. The menu has been reviewed by a dietitian. Processes are implemented to identify and meet individual resident dietary needs and preferences.

1.4 Safe and Appropriate Environment

The facility has a current Building Warrant of Fitness. There has been a building alteration to the facility to include a larger communal/dining area.

2 Restraint Minimisation and Safe Practice

Policies and procedures provide guidance for staff on restraint minimisation and safe practice. There are currently two residents who have enablers in use. The organisations policy advises enablers are not in use at Tui House and requires review. This is an area requiring improvement.

3. Infection Prevention and Control

Tui House has an infection control surveillance programme that is appropriate to the services provided, however surveillance data has not been collated monthly and an improvement is required.

Summary of Attainment

1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	Not Applicable	0	0	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	Not Applicable	0	0	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect	PA Negligible	0	0	1	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs	Not Applicable	0	0	0	0	0	7
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	PA Negligible	0	1	1	0	0	4
Standard 1.1.10	Informed consent	Not Applicable	0	0	0	0	0	9
Standard 1.1.11	Advocacy and support	Not Applicable	0	0	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	Not Applicable	0	0	0	0	0	2
Standard 1.1.13	Complaints management	FA	0	2	0	0	0	3

Consumer Rights Standards (of 12):	N/A:9	CI:0	FA: 1	PA Neg: 2	PA Low: 0	PA Mod: 0	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Criteria (of 48):	CI:0	FA:3	PA:2	UA:0	NA: 0			

1.2 Organisational Management

		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	FA	0	1	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems	PA High	0	7	1	0	0	9
Standard 1.2.4	Adverse event reporting	FA	0	2	0	0	0	4
Standard 1.2.7	Human resource management	PA Moderate	0	2	2	0	0	5
Standard 1.2.8	Service provider availability	FA	0	1	0	0	0	1
Standard 1.2.9	Consumer information management systems	PA Moderate	0	0	1	0	0	10

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

1.3 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	PA Moderate	0	1	2	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	PA Moderate	0	0	2	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	Not Applicable	0	0	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	Not Applicable	0	0	0	0	0	2
Standard 1.3.12	Medicine management	PA High	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	FA	0	3	0	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:6	CI:0	FA: 3	PA Neg: 0	PA Low: 0	PA Mod: 2	PA High: 1
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:9	PA:5	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

		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	FA	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	FA	0	1	0	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating	Not Applicable	0	0	0	0	0	3

Safe and Appropriate Environment Standards (of 8):	N/A:5	CI:0	FA: 3	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 36):	CI:0	FA:2	PA:0	UA:0	NA: 0		

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	PA Low	0	0	1	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

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

3 Infection Prevention and Control

		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 Negligible	0	0	1	0	0	8

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

Total Standards (of 50)	N/A: 29	CI: 0	FA: 11	PA Neg: 3	PA Low: 1	PA Mod: 4	PA High: 2	PA Crit: 0	UA
Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0					
Total Criteria (of 219)	CI: 0	FA: 29	PA: 13	UA: 0	N/A: 0				

Corrective Action Requests (CAR) Report

Provider Name: Tui House Limited
Tui House

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:18-Oct-13 End Date: 18-Oct-13

DAA: Health Audit (NZ) Limited

Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.1.3	1.1.3.1	PA Negligible	<p>Finding: The curtain arrangement between beds in two of the shared bedrooms does not maximise residents' privacy.</p> <p>Action: Change the curtain arrangement in the said rooms to ensure the environment maximises privacy.</p>	6 months
1.1.9	1.1.9.1	PA Low	<p>Finding: Although there is evidence of family contact on the adverse event forms, contacts are not consistently recorded within the residents records.</p> <p>Action: Record all contacts with family within the residents records as required.</p>	6 months
1.2.3	1.2.3.9	PA High	<p>Finding: The process that addresses/treats current risks associated with service provision has not been sufficiently implemented.</p> <p>Action: Identify current risks associated with service provision and effectively manage risk through implementation of the risk management process.</p>	1 week
1.2.7	1.2.7.4	PA	<p>Finding:</p>	6 months

		Moderate	<p>Sufficient records of orientation have not been maintained/sighted.</p> <p>Action: Maintain evidence of full orientation.</p>	
1.2.7	1.2.7.5	PA Moderate	<p>Finding: There is no evidence that two permanent night staff have attended fire evacuation training.</p> <p>Action: Provide evidence that all staff complete the required training.</p>	3 months
1.2.9	1.2.9.1	PA Moderate	<p>Finding: Records sampled do not contain documentation of all appropriate events and communications. Entries are not consistently dated, timed or at times signed by the person making the entry.</p> <p>Action: Ensure documentation in resident files is sufficiently detailed, dated and timed and signed by the person making the entry.</p>	three months
1.3.3	1.3.3.3	PA Moderate	<p>Finding: i)The hospital resident audited has not been seen by the GP monthly. Nor has there been a documented assessment by the GP advising that the resident is safe and suitable for a three monthly review. One of three rest home residents had approximately three and a half months between GP reviews (the resident is noted to be suitable for a three month review). (ii) The register which identifies timeframes for resident reviews could not be located during the audit.</p> <p>Action: Ensure a system is available for nursing staff to identify and ensure residents are routinely reviewed by the GP at the frequency required to meet ARRC.</p>	Three months
1.3.3	1.3.3.4	PA Moderate	<p>Finding: While there is shift handovers occurring, and handover reports documented, the written reports do not include all relevant issues including falls, infections, elevated blood sugars. One resident is noted to have had two falls in the progress notes. The RN on duty had documented the resident is to be for reviewed by the GP the next day. A GP review did not occur and details of the falls and request for GP review is not noted on the applicable shift handover forms.</p> <p>Action: Ensure the written handover forms includes all relevant issues. Where requested GP reviews do not occur the rationale should be clearly documented in the residents notes.</p>	Three months

1.3.8	1.3.8.2	PA Moderate	<p>Finding:</p> <p>i) A resident is identified as having a pressure area and interventions are initiated. The wound care plan has not been consistently evaluated and it is unclear if the pressure area has fully resolved. ii) A pressure area risk assessment has not yet been completed for a resident who has developed a pressure area since admission. (iii) A newly diagnosed diabetic resident is having weekly blood glucose testing. The blood sugars have been noted to be between 13.2 and 15.1 mmol before breakfast (on the two occasions the blood sugars has been checked) with no evidence the RN has been informed and or followed up.</p> <p>Action:</p> <p>i) Ensure a pressure area risk assessment is completed and reviewed in a timely manner. ii) evaluations are consistently occurring and are sufficiently documented to verify residents' progress to achieving goals or aimed outcomes.</p>	Three months
1.3.8	1.3.8.3	PA Moderate	<p>Finding:</p> <p>Service plans are not always sufficiently detailed to identify the required care. For example in relation to falls prevention, diabetes and a resident at risk of wandering/absconding.</p> <p>Action:</p> <p>Ensure the residents care plans are sufficiently detailed and documented in a timely manner and identify the care required by individual residents.</p>	Three months
1.3.12	1.3.12.1	PA High	<p>Finding:</p> <p>(i) Standing orders are insufficiently detailed to clearly guide practice. (ii) Two of 10 residents have medications in three blister packs that do not align with the documented prescription. ii) The RN observed administering medications signed for administration after giving a number of residents medication, and did not consistently check the blister pack contents against the prescription chart (reported these have been previously checked by a RN). A resident who has been previously reported (via the incident reporting system) to have been hiding medications was not observed to take his medication immediately. iii) One resident admitted with three documented medication sensitivities does not have this information recorded in his GP consultation notes nor on his medication records . iv) Where a resident in the 'units' has refused medication; it is not always evident that the RN has been informed or follow-up action taken. v) Documentation does not evidence that residents respiratory inhalers are administered as prescribed or noted refused or withheld.</p> <p>Action:</p> <p>Ensure all aspects of medication management practices and documentation meet current legislative and professional standards.</p>	One week

2.1.1	2.1.1.4	PA Low	<p>Finding: The Restraint Minimisation and Safe Practice policy and procedure advises that no enablers are in use. However, there are current two residents (who are not under the aged related residential care contract) that have lap belts in place.</p> <p>Action: Update applicable policies to include the use of enablers.</p>	Six months
3.5	3.5.1	PA Negligible	<p>Finding: Surveillance data has not been collated or analysed since June 2013</p> <p>Action: Collate surveillance data monthly as required.</p>	6 months

Continuous Improvement (CI) Report

Provider Name: Tui House Limited
Tui House

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:18-Oct-13 End Date: 18-Oct-13

DAA: Health Audit (NZ) 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 1.1.3 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Negligible

The auditors are asked to follow up on residents' privacy. This issue was identified by the Programme Manager, Mental Health of the Older Person, Counties Manukau District Health Board following a routine visit and involves the placement of curtains between beds, in two of the shared bedrooms. ARRC requirement D3.1i is not fully met.

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: PA

Risk level for PA/UA: Negligible

Two shared rooms are sighted where the curtain arrangement between beds does not allow for complete privacy. There has been one documented complaint regarding privacy. This involved a staff member not knocking before entering a resident's bedroom and the complaint was appropriately addressed by management. One out the five residents interviewed during the audit is in a shared room. He is not satisfied with sharing a room, however privacy is not the issue. The resident is newly admitted and accepting that he is in a shared room until a single unit becomes available. It is expected that this will occur in the next week.

Finding Statement

The curtain arrangement between beds in two of the shared bedrooms does not maximise residents' privacy.

Corrective Action Required:

Change the curtain arrangement in the said rooms to ensure the environment maximises privacy.

Timeframe:

6 months

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: PA Negligible

Management and staff at Tui House maintain an open door policy for all residents and family members. This is evident on the day of the audit. Residents interviewed state they receive adequate information regarding services and changes. Interpreter services can be accessed if required.

There is evidence of open disclosure following an adverse event, however records of such are not consistently maintained and an improvement is required.

The ARC requirements are met.

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

There is evidence of family contact on adverse event forms; however contacts are not consistently recorded within the residents' records.

Finding Statement

Although there is evidence of family contact on the adverse event forms, contacts are not consistently recorded within the residents records.

Corrective Action Required:

Record all contacts with family within the resident's records as required.

Timeframe:

6 months

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>The complaints process is accessible to all residents. Complaints and compliment forms are displayed and formatted in a user friendly manner. The organisation is committed to hearing the concerns of residents as evident in the manner in which they encourage feedback and use the written complaints process for all verbal concerns. The local Health and Disability advocate is also welcome and visits with residents. Regular staff training on the complaints process and advocacy services is provided and was last conducted in April 2013.</p> <p>The current complaints register is sighted. There have been four documented complaints since the last certification audit. Three of these were from one resident and the other was added to the register following a resident meeting. The residents voiced concern regarding mobility equipment being left in the lounge and immediate remedial actions were implemented to the satisfaction of the residents. All complainants receive a letter detailing the outcome of the complaint and a copy is maintained within the complaint records.</p> <p>There have been no complaints made to the Health and Disability Commissioner or the District Health Board since the last certification audit. The ARRC requirements are met.</p>	

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Tui House Limited is governed by the Owner/General Manager/Director who is an experienced registered nurse. Tui House is one of two age care facilities owned by the Owner/General Manager/Director (hereafter referred to as the General Manager). The General Manager develops the annual business plan and goals with the support of the management team. The management team consists of the Facility Manager and the Clinical Nurse Manager. The General Manager is 'hands on' and is onsite five days per week Monday to Friday.

The mission, vision and goals of the organisation are displayed and included in the information booklet. They are also documented on the facility web site. New information resources are being developed to reflect the recent and planned changes in service capacity including the addition of a nine bed dementia unit. The proposed resources are sighted and project an accurate description of the services planned.

Organisational performance is monitored frequently through regular meetings with the management team, onsite observations and the annual review of business goals. The current business plan is sighted and includes the addition of hospital level care and the vision/plans to increase capacity to include the dementia unit.

Day to day operations are the responsibility of the Facility Manager. Under routine circumstances the Facility Manager is on site five days per week; however the Facility Manager is not available on the day of the audit. Adequate succession planning is in place (refer criterion #1.2.2). The Facility Manager has been in the current role for seven years and, prior to this, was a previous care giver. The Facility Manager has experience relevant to aged care and maintains at least eight hours annually of professional development activities related to the aged care sector. This includes attendance at the 2012 Aged Related Residential Care Quality Forum and four recent in-service training sessions.

The Facility Manager's job description is sighted and confirms key responsibilities and tasks. The current organisational chart is sighted and confirms authorities and reporting lines throughout the organisation.

Relevant ARC requirements are met.

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 1.2.2 Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

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 General Manager performs the role of the Facility Manager in her absence. The Clinical Nurse Manager can also perform the management role if required. On the day of the audit the Facility Manager is on leave and the General Manager and Clinical Nurse Manager are both in attendance. The documented management system includes a succession plan and business continuity plan which collectively ensure that services are provided by experienced personnel in a consistent manner. Efficiency and effectiveness of service is managed through implementation of the quality management system. The required performance monitoring is conducted and forwarded to the District Health Board as required.

Not all ARRC requirements are met. The service philosophy is commensurate with the needs of the older person, however not all safety obligations have been observed and a required improvement is documented in criterion # 1.2.3.9 - risk management.

Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA High

The documented quality and risk management system is sufficient to meet requirements. Policies and procedures are developed and updated as required. Stamps are used to verify currency of policies and the majority of documents sighted have been stamped as last reviewed in July 2013. Some policies are

currently being updated to include the provision of additional services, thus many are in draft and not yet controlled. This is an ongoing process and will require more updating once dementia services commence. Working policies are available and accessible. Obsolete documents are identified as such and removed from circulation. The original copy is maintained. Policies sighted reflect ARRC requirements.

An adequate quality programme is implemented. A Quality Improvement policy is sighted and identifies the commitment to monitor and improve services. The business plan identifies goals for the year. For example ensuring staff have the required training to meet the additional needs of residents requiring hospital and dementia care. Current issues for the business and service delivery are communicated at monthly staff meetings. The staff meeting minutes for October 2013 confirm discussions on collated quality data. This includes topics such as incidents, infections, hazards and the results of internal audits.

An internal audit schedule is implemented. Audits are scheduled at regular intervals to cover the scope of the quality system. Examples of internal audits are sighted and confirm audits are being conducted and include corrective actions where required.

Some of the risks associated with the increase in capacity and needs level of residents have been identified and addressed by the General Manager. This included up skilling of nursing staff and the addition of a displayed white board in the office in order to quickly identify the resident, needs level, risk, observations required and location. Team leaders have also been allocated with the aim to increase accountability and leadership amongst care givers. However, a number of current risks to the organisation, and residents, are identified during the audit and these have not been included in the risk management process, thus a timely improvement is required.

The remaining relevant ARRC requirements have been met with the exception of 19.3 Risk Management. The General Manager states there is an appropriate accounting system. Finances are managed by the General Manager with support from an accountant.

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: PA

Risk level for PA/UA: High

The risk management plan is stamped with a February 2013 review stamp. The risk plan has not been updated to include the additional risks associated with the increase in service capacity, the period of absence of a Clinical Nurse Manager, the increase level of needs for hospital residents, the current building/renovations on site or the proposed addition of dementia services. For example:

- (i) There is a large amount of building in progress over the three joined sites. This includes alterations to two houses to make a dementia unit and an alteration to the current building to provide a larger lounge/dining area for the hospital and rest home residents. This has involved closing in a covered deck. The auditors are advised that residents' are not accessing these areas, however no safety barriers or hazard identification/signs are sited. Residents are observed eating their evening meal in the dining/lounge construction area on the day of the audit, however it is noted that by the end of the day hazard tape has been put in place.
 - (ii) Not all clinical risks have been identified or sufficiently managed. This is evident in the number of areas requiring improvement within service delivery. In addition one resident with very recent history of a suicide attempt was admitted approximately one week ago. On entry the resident was offered the option of not having routine checks during the night. The General Manager advises this process/form should not be being offered to residents on admission, however in this example it has remained insitu.
 - (iii) The organisation had been without a Clinical Nurse Manager for six months and there is insufficient evidence that the Clinical Nurse Manager has received an orientation (refer criterion 1.2.7.4). Neither the District Health Board programme manager or HealthCERT were advised of the absence of a Clinical Nurse Manager, however the General Manager states she was filling this role during the recruitment process.
 - (iv) Capacity has increased in both bed numbers and acuity, thus increasing some demands on current staff including documentation and monitoring requirements. For example the number of residents requiring more complex and frequent interventions, additional medication supplies/needs and the number of deaths has increased.
- A high risk level is allocated based on the likelihood and consequence of an adverse event occurring.

Finding Statement

The process that addresses/treats current risks associated with service provision has not been sufficiently implemented.

Corrective Action Required:

Identify current risks associated with service provision and effectively manage risk through implementation of the risk management process.

Timeframe:

1 week

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Individual incident and accident reports are required to be completed for each incident/accident with immediate action noted and any follow up action required. The Facility Manager, General Manager or Clinical Nurse Manager are required to sign off each incident form with recommendations for improvement if required. A copy of the individual incident forms are kept in each resident file.

The service collates and graphs incidents, accidents, unplanned or untoward events monthly and provides feedback to the service and staff. Minutes of the most recent staff meeting provides sufficient evidence of discussions regarding incidents/accidents and actions taken. For example in September 2013 20 incidents are recorded. This includes 17 falls, one person climbing out of the bed and two episodes of absconding.

Incidents forms sighted are well documented and in some cases, result in the development of a short term care plan. Two recent incidents are tracked by the auditor to ensure investigation, appropriate actions and closure. One of the incidents is that of an unwitnessed fall. The required neuro observations are conducted post fall and the resident is seen by the general practitioner. The family members are contacted.

The General Manager interviewed is conversant with the required essential notifications. This includes family notifications and external notifications, however the records of family notifications are not consistently sighted in the progress notes samples and a required improvement is allocated to criterion # 1.1.9.1

The remaining ARRC requirements are met

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Moderate

There are written policies and procedures in relation to human resource management which comply with current good employment practice.

Five staff files are initially sampled. The sample is stratified and includes two registered nurses and three care givers. The sample is increased to include one permanent night staff member.

The skills and knowledge required for each position within the service is documented in job descriptions which outline responsibilities and key person specifications. Files sampled have the required recruitment screening including references. Qualifications are validated. Practising certificates are sighted.

All new staff are required to receive an orientation to the facility and to their respective job. Orientation is the responsibility of the Facility Manager. The orientation programme includes the essential components of service delivery, including emergency procedures. A work book is provided. Records of completed orientation is sighted in three out of the six staff files sampled and an improvement is required. There is an orientation review/assessment process which is conducted one month after employment in order to assess for any ongoing requirements and performance to date.

There is a planned programme of on-going education. A training plan is developed annually. Individual training records are maintained. The organisation provides a good amount of in-service training which includes the routine topics required by ARRC. In addition the registered nurses have accessed additional education. For example the Palliative Care Lecture Series, Counties Manukau District Health Board Outpatient Intravenous Antibiotic (OPIVA) training, ARRC

Education Forum Dementia/Managing Challenging Behaviours training and Preventing and Avoiding Hospital Admissions. The organisation has also recently signed up with Careerforce so that care givers can complete dementia training.

The previous improvement regarding education for the infection control coordinator has been adequately addressed. The General Manager has been in the role of infection control coordinator and has attended Bug Control training.

Performance is monitored and an annual appraisal is completed for all staff. Records of completed performance appraisals are sighted in records sampled. The remaining relevant ARRC requirements are met.

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: PA

Risk level for PA/UA: Moderate

Records of completed orientation are sighted in three out of six staff files sampled. For example:

- (i) Although the Clinical Nurse Manager reports she was orientated by the Facility Manager on commencement, no records of such have been maintained, other than a medication competency. The Clinical Nurse Manager was re-employed at Tui House three weeks ago following a period of absence for six months.
- (ii) Records of orientation for the next most senior nurse are also not sighted. This staff member has been in employ with Tui House for one month. Again, a medication competency is sighted.
- (iii) The orientation workbook for one of the care givers is sighted, however the section on emergency management/fire safety has not been completed.

Finding Statement

Sufficient records of orientation have not been maintained/sighted.

Corrective Action Required:

Maintain evidence of full orientation.

Timeframe:

6 months

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Emergency training is provided in an on-going manner. There have been two trial evacuations since the addition of hospital services. Files of two permanent night staff are included in the sample and there is no evidence that either staff member has attended the training.

Finding Statement

There is no evidence that two permanent night staff have attended fire evacuation training.

Corrective Action Required:

Provide evidence that all staff complete the required training.

Timeframe:

3 months

STANDARD 1.2.8 Service Provider Availability

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The facility employs 32 staff. This includes the Facility Manager, six registered nurses, care givers and kitchen staff. There is a documented rationale for determining service provider levels and skill mixes titled 'Roster Staffing Considerations'. The layout of the facility is considered. There is a guideline on staffing at the downstairs nurses' station.

The staffing roster is sighted and reflects the number and mix of residents, acuity of residents, residents care levels, lay out of facility, staff skills and experience. There are six caregivers on the morning shift and one registered nurse on the floor. There are five caregivers on the afternoon shift (one of whom is a floater) and one registered nurse. There are two care givers on night shift and one register nurse.

In addition the General Manager, who is also a registered nurse, and Clinical Nurse Manager are onsite five days per week during business hours.

There are no complaints/concerns from residents or staff interviewed regarding staff numbers.

Rosters sighted confirm ARRC requirements are met

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: PA Moderate

Five resident files are reviewed at audit. Entries are frequent in the progress notes (at least every shift). The records do not contain documentation of all relevant events and communications. Entries are not consistently dated, timed or at times signed by the person making the entry. These are areas requiring improvement.

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: PA

Risk level for PA/UA: Moderate

Five resident files (two hospital level care and three rest home level care) reviewed during audit. All entries are in ink. Documentation is required in the progress notes at least every shift. While this is occurring; the dates and/or times some progress notes are recorded are not consistently documented. On some occasions the entry notes the shift only (AM, PM or night). Several assessments are not signed by the person undertaking the assessment. Where there have been variances or exceptions identified these, and on occasions follow-up actions, are not consistently documented. For example a resident absconded from the facility. The CNM advises staff at the Mental Health Service Older Persons (MHSOP) was informed of this event. This is not documented in the resident notes. One resident has refused some medications. The RN interviewed advised she met with the rest home resident who was refusing medications and discussed this and came to an agreement. This is not documented. A patient is sighted to have elevated blood glucose levels. It is unclear if the RN has been informed. The resident's consents have not yet been completed over two months after the admission. The CNM advises conversations have taken place with a resident's family member in relation to enduring power of attorney. These communications are not documented in the progress notes. These are areas requiring improvement.

Finding Statement

Records sampled do not contain documentation of all appropriate events and communications. Entries are not consistently dated, timed or at times signed by the person making the entry.

Corrective Action Required:

Ensure documentation in resident files is sufficiently detailed, dated and timed and signed by the person making the entry.

Timeframe:

three months

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.3 Service Provision Requirements

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Moderate

Each stage of service provision is provided by suitably qualified staff. There is a registered nurse (RN) on duty at all times. Processes are implemented to monitor that staff and contractors have a current annual practicing certificate (APC). Refer to 1.2.7. Three of three caregivers and the RN interviewed advised

they were required to complete an orientation programme that suitably prepared them for their roles and responsibilities. Maintaining orientation related records is raised as an area for improvement in 1.2.7.4.

Initial assessments, the initial care plan and long term care plans are developed in the time frame required to meet the ARRC contract. The new clinical manager has introduced a new assessment framework that provides more detailed information to inform care planning. The frequency of ongoing routine review by the GP is not consistently occurring within ARRC (D16.5 d) required timeframes and is an area for improvement. Documentation does not consistently detail the date and time of entry and on occasions documentation is unsigned. This is raised as an area for improvement in 1.2.9.1. Whilst care plans are in place to guide caregivers, the care plans do not include all relevant components of care. This is raised as an area for improvement in 1.3.8.3. Evaluations of progress to achieve goals and the components of the care plan are occurring. Some evaluations are not documented consistently for some components of care. This is an area for improvement raised in 1.3.8.2.

There are verbal handovers between each shift and a written handover sheet is also used to document exceptions, adverse events and changes in the resident's condition. The sample sighted at audit do not include all relevant events/issues and is an area requiring improvement.

The GP is interviewed following the audit (unavailable on the day). The GP is currently satisfied with the nursing care and support being provided to residents and states they are pleased with the recent reinstatement of a clinical nurse manager.

Clause 16.3 j and k, 16.5d and D9.2a of the ARRC contract requirements are not met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Interview with the clinical manager and an RN identifies an initial assessment is undertaken on the day of admission for all new residents. The new clinical manager has introduced a new assessment framework that provides more detailed information to inform care planning. An initial care plan (basic care plan) is developed on the day of admission. A long term care plan is required to be developed within 21 days to provide guidance for staff on ongoing cares.

All residents are required to be seen within 48 hours of admission by a doctor and at least three monthly thereafter. The GP is required to document is the resident is stable and suitable for three monthly reviews and will be seen sooner if new needs arise. If the GP has not documented this exception the resident is for routinely review monthly. Five resident files reviewed during audit comprising two hospital level care residents and three rest home level care residents. Two residents (one hospital and one rest home level care resident) are not always routinely seen within the timeframes required to meet the ARRC contract and this in an area requiring improvement. For the remaining three residents they are seen by the GP within ARCC contract timeframes and sooner where indicated for infections, pain or other issues.

Hospital level care (tracer):

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

Rest home level care resident (tracer).

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

Finding Statement

i) The hospital resident audited has not been seen by the GP monthly. Nor has there been a documented assessment by the GP advising that the resident is safe and suitable for a three monthly review. One of three rest home residents had approximately three and a half months between GP reviews (the resident is noted to be suitable for a three month review). (ii) The register which identifies timeframes for resident reviews could not be located during the audit.

Corrective Action Required:

Ensure a system is available for nursing staff to identify and ensure residents are routinely reviewed by the GP at the frequency required to meet ARRC.

Timeframe:

Three months

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Four of four caregivers and two RNs interviewed advised there is verbal shift handover between ever shift occurring. The handover observed during audit for the oncoming afternoon shift included a summary of each resident's day, their participation in activity programme, elementary needs and mood/social interactions. Where a resident has refused a medication this is reported.

There is also a written report documented by staff each duty to identify changes in residents conditions, adverse/untoward events and residents on leave/in the hospital. One handover records is maintained for residents in the 'units' and another report detailed for the residents in the main hospital/rest home area. It is observed during audit that the written reports do not include all relevant issues identified in the five resident files sampled during audit including falls, infections, and elevated blood sugars. One resident is documented to have had two falls in a day as identified in the progress notes. The RN documented the resident is for review by the GP in the morning. There is no documentation that a GP review occurred and a rational for this variance is not documented. The written handover forms do not include details of the falls or request for the resident to be reviewed by the GP. This is an area requiring improvement.

Four of four care givers interviewed confirm there is a RN on duty at all times and if they are concerned about a resident's wellbeing they would advise the RN.

There are a number of GPs providing care to residents. Refer to 1.2.3.9 for a summary of the GPs interview.

Finding Statement

While there is shift handovers occurring, and handover reports documented, the written reports do not include all relevant issues including falls, infections, and elevated blood sugars. One resident is noted to have had two falls in the progress notes. The RN on duty had documented the resident is to be reviewed by the GP the next day. A GP review did not occur and details of the falls and request for GP review is not noted on the applicable shift handover forms.

Corrective Action Required:

Ensure the written handover forms include all relevant issues. Where requested GP reviews do not occur the rationale should be clearly documented in the resident's notes.

Timeframe:

Three months

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

Five resident files sampled at audit. With the exception of the issues raised as requiring improvement in 1.3.3.3, 1.3.3.4, 1.3.8.2 and 1.3.8.3 there is evidence from the sampled files that residents are seen by the GP when they are unwell. Laboratory tests have been undertaken as requested and the results noted. Treatment for infections has commenced in a timely manner. There is evidence of changes in medication and de-escalation strategies in relation to challenging behaviour. A referral to MHSOP has occurred for a resident with challenging behaviours and another resident who is identified with other risks. Wound care is documented as being provided for a resident with a wound and pressure area. A resident has commenced treatment for diabetes. A resident with frequent falls has a sensor mat in use and a soft chair is used when the resident is up.

ARRC contract requirements are met for criterion audited.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The activities co-ordinator is employed weekdays from 9 am to either 3pm or 4pm depending on the day of the week. In addition four students from a local high school assist as volunteers (two on Tuesday's and two on Thursday's) during the day and another student volunteer comes for 30 minutes three afternoons a week. Family members also assist with the activities as identified in the programme sighted. An assessment is undertaken as a component of the admission process to identify the type of activities that a resident would enjoy. This is sighted completed in four of the five resident files sampled at audit. The hospital level care resident audited did not have this completed. The clinical manager advises difficulty contacting the family member with Enduring Power of Attorney (EPOA) and the information is unable to be sufficiently obtained from the resident. Refer to 1.3.3.3 and the area identified as requiring improvement raised in 1.2.9.1.

The activities coordinator interviewed advises she has been in the role for almost four months and prior to this was employed by Tui House in another capacity. The activities programme is planned on a weekly basis and are written on the activities board present in the main reception. The resources used in planning the programme sighted. The current programme sighted includes (but is not limited to): bingo, quots, trivia, outings, exercise, DVD and off site activities. A number of residents regularly participate in activities at a local Church. There are Church services on site the first Wednesday of every month. Entertainers come on site for events. There are happy hours once a month. Special days such as father's day and residents birthdays are also celebrated. The five residents interviewed (two hospital and three rest home) confirm they participate in activities of their choice which are fun. Residents observed participating in activities programme during audit.

ARRC contract requirements are met.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Moderate

Care plans are documented in all five resident files sighted at audit and included long term care plans as well as short term care plans. The care plans are not always sufficiently detailed to identify the care required by the resident and this is an area requiring improvement. Whilst evaluations of care are occurring and this includes evaluations towards achieving the long term care plan and short term care plans, not all evaluations are sufficiently documented or the results communicated/followed up in a timely manner. This is also an area identified as requiring improvement. Not all ARRC contract requirements are met.

Clause D16.4a of the ARCC contract is not met.

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Evaluations are sighted against the goals and components of the care plan in all five resident files sampled at audit. The evaluations includes identifying if the resident has had any falls, continence needs, mobility changes and level of assistance required for activities of daily living.

Where short term care plan have been developed for wounds and pressure areas, there is inconsistent evaluation of improvements (or otherwise) being documented. One resident is noted to have a wound and a pressure area. The wound is evaluated regularly and noted to have subsequently healed. The pressure area is noted to be improving in the last assessment in the wound plan (over five weeks prior to audit). Evaluation that the pressure area has fully healed it is not clear in either the wound care plan or the resident's progress notes. The pressure area risk assessment tool is in the residents file at audit. This has not yet been completed as at the time of audit. The resident's progress notes also detail the resident has had several falls/slips. The RN has noted in one of the evaluations that the resident has not had any falls since a specific date. This is in variance to commentary in progress notes which details a number of slips/ falls as having occurred (and the frequency has reduced in recent weeks). The RN when interviewed identified the evaluation was more correctly /specifically about falls which have occurred secondary to an infection. Ensuring evaluation of progress towards achieving goals or achieving the desired outcomes is an area requiring improvement.

There are evaluations documented of the resident's improvement following commencement of antibiotics prescribed to treat all four infections (urinary or respiratory infections) as documented in the sampled files.

One rest home resident audited has been recently commenced on treatment for diabetes. Blood glucose levels (BGL) are being tested weekly as requested by the GP. The blood sugars have been noted to be between 13.2 and 15.1 before breakfast (on the two occasions the blood sugars has been checked) with no evidence communication to the RN or follow-up by the RN. This is an area requiring improvement. Two caregivers interviewed advise they are to report a BGL of above 10 mmol to the RN. Only one of the two BGL is recorded on the daily handover sheet.

Finding Statement

i) A resident is identified as having a pressure area and interventions are initiated. The wound care plan has not been consistently evaluated and it is unclear if the pressure area has fully resolved. ii) A pressure area risk assessment has not yet been completed for a resident who has developed a pressure area since admission. (iii) A newly diagnosed diabetic resident is having weekly blood glucose testing. The blood sugars have been noted to be between 13.2 and 15.1 mmol before breakfast (on the two occasions the blood sugars has been checked) with no evidence the RN has been informed and or followed up.

Corrective Action Required:

i) Ensure a pressure area risk assessment is completed and reviewed in a timely manner. ii) evaluations are consistently occurring and are sufficiently documented to verify residents' progress to achieving goals or aimed outcomes.

Timeframe:

Three months

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Service plans are not always sufficiently detailed to identify the required care for individual residents. For example one hospital level care resident audited has frequent falls. Staff report a sensor mat and reclining chair are now being effectively used as a part of the falls prevention strategy. These interventions are not documented in the falls care plan. The use of the sensor mat is noted in some of the caregivers shift reports. A caregiver interviewed advises a sensor mat is being used whenever the resident is in bed. This resident has developed a pressure area. He does not have a documented pressure area prevention care plan and a pressure area assessment has not been yet been documented (approximately six weeks later).

One rest home resident audited has recently commenced treatment for diabetes. The residents records do not include a care plan documented related to this although the residents BGL have been tested at the frequency requested by the GP. A diabetes meal is required as noted on the resident's dietary chart. Another resident is noted to have recently absconded. The clinical manager advised the MHSOP team were advised of this event (although this is not documented in the residents file). This is raised as an area for improvement in 1.2.9.1. While an updated care plan has been developed in relation to the risk of absconding, the plan is not sufficiently detailed. Missing is the frequency that staff are required to check on the resident and how the checks should be evidenced/documentated. The clinical manager advises staff are required to check on this resident every 30 minutes. The caregiver caring for the resident (who often works at night) advises the staff check the resident is in bed at the beginning of the duty and the resident is subsequently being checked every two hours. The facility owner advises a monitoring device has been sewn into a piece of the residents clothing as part of the risk management strategy. However, this has not occurred as yet as it has not been decided which garment the device should be sewn into. The clinical manager advises the resident has removed the device when being worn previously.

Finding Statement

Service plans are not always sufficiently detailed to identify the required care. For example in relation to falls prevention, diabetes and a resident at risk of wandering/absconding.

Corrective Action Required:

Ensure the residents care plans are sufficiently detailed and documented in a timely manner and identify the care required by individual residents.

Timeframe:

Three months

STANDARD 1.3.12 Medicine Management

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

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

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

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

Policies and procedures provide guidance for staff on relevant components of medication management. Controlled drugs registers are being maintained for residents in 'the units' as well as in the main rest home/hospital. All entries are in ink and have the name of the authoriser and the staff administering and checking the medication documented. A check of the balance is occurring at each occasion medication is removed from the locked box for administration. There are two residents being administered controlled medications. A check count is undertaken weekly in the main hospital/rest home and more frequently than monthly in the 'units'. The organisations policy advises a check count of the CD register must occur at least monthly. The area identified as requiring improvement at the partial provisional audit now meets the standards.

Five residents interviewed (two hospital level care residents and three rest home level care residents) confirm they are informed of medications when administered. This is observed during audit. One resident is currently self-administering medications. The medication management policy details the assessments and approval processes required. The process of self-administering medications is noted in the residents care plan and ongoing assessments. The most recent RN assessment to ensure the residents safety was undertaken on 27 September 2013. The GP has reviewed and approved the resident is safe to continue self-administering medications on the 10 October 2013.

During audit a number of areas are identified as requiring improvement. These include: ensuring the standing orders are sufficiently detailed, documenting allergies, ensuring medications are given as prescribed or noted to be withheld or refused. Where a resident has refused medications, documentation in relation to communications with the RN and/or follow-up actions taken is not consistently evident. A number of practices sighted during medication administration do not meet current accepted practice.

Staff records sampled demonstrate all six nurses who administer medications have been assessed as competent to do so. The most recent assessments occurred in October 2013 and was instigated following an identified service shortfall.

Clause D19.2 d of the ARRC contract is not met.

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: High

Policies and procedures provide guidance for staff on medication prescribing, checking, administration, storage, and documentation. A master list is maintained of the signature of the prescribers and this document is sighted. Standing orders are in place and are dated as being reviewed on 2 October 2013. The standing order is signed by several prescribers. The standing order is insufficiently detailed to clearly guide practice. For example there are three oral laxatives included (lactulose, senokot and laxsol). It is unclear which medication is to be administered first or whether a combination can be administered. There are three enemas/suppositories listed including dulcolax, microlax and glycerine suppositories. There are no instructions as to which medication the prescribers want administered first.

Ten resident medication records reviewed during audit. All medications have written in ink or are on typed summary pages provided by the pharmacy. A photo of the resident is present in all sampled records. All entries have been individually signed by the prescribers. The date medications are discontinued is noted and these entries are signed. Medication reconciliation is occurring. Two of 10 residents whose medication and records sampled at audit have medications in the resident's blister packs that do not align with the documented prescription. For one resident the medication is correct but the time the medication is being administered is incorrect. The other resident is receiving 100mg more of the prescribed medication each day. The medication is charted as 100 mgs three times a day (TDS), but being administered 200mgs twice a day. All three blister packs have been signed as being checked by the RN prior to being placed into use and the contents on each pack noted as being 'correct'. The majority of medications are documented as being given as prescribed. The exception being inhalers which are not always signed as being given as prescribed. This is an area requiring improvement.

Where a resident refuses a medication this is being documented on the medication chart and on occasions in the progress notes. Where residents are in the 'units', it is not always documented that the RN has been informed (although is often noted on the shift handover summary) not any follow-up provided (where this occurs). One rest home resident has refused oral medications on two occasions recently and has been regularly refusing inhalers. The RN interviewed is aware the resident has refused oral medications and advised to have met and discussed this with the resident including an explanation of the medication. This conversation is not documented. Documentation is also an area requiring improvement in 1.2.9.1.

The RN is observed administering medications during the lunchtime round. The RN is observed signing for the administration after giving a number of residents their medications. The RN did not consistently check the blister pack contents against the prescription chart as reported these 'have all been checked prior to being placed into use'. A resident who has been previously reported to have been hiding medications was not directly observed to take his medication. This is also an area requiring improvement and clause D19.2 d of the ARRC is not met. Medications are stored securely.

One of ten resident's records does not identify the residents known medication sensitivities. The resident is admitted and has documented medication sensitivities to three identified medications. This information has not yet been recorded in the GP consultation notes. A review of his medication records which notes pharmacy - nil known allergies or sensitivities. This is an area requiring improvement.

Finding Statement

(i) Standing orders are insufficiently detailed to clearly guide practice. (ii) Two of 10 residents have medications in three blister packs that do not align with the documented prescription. (iii) The RN observed administering medications signed for administration after giving a number of residents medication, and did not consistently check the blister pack contents against the prescription chart (reported these have been previously checked by a RN). A resident who has been previously reported (via the incident reporting system) to have been hiding medications was not observed to take his medication immediately. (iv) One resident admitted with three documented medication sensitivities does not have this information recorded in his GP consultation notes nor on his medication records. (v) Where a resident in the 'units' has refused medication; it is not always evident that the RN has been informed or follow-up action taken. (vi) Documentation does not evidence those residents respiratory inhalers are administered as prescriber or noted refused or withheld.

Corrective Action Required:

Ensure all aspects of medication management practices and documentation meet current legislative and professional standards.

Timeframe:

One week

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: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Policies and procedures are present that provide guidance for staff on food safety practices. The staff member responsible for cooking on the day of audit is covering for the two permanent cooks who have required unexpected leave. The 'cook' interviewed advises there is a four week rotating menu which is sighted on the wall. This has been reviewed by a dietitian in February 2013 and the summary report sighted. A number of recommendations have been made by the dietitian. The 'cook' was unable to identify if all the recommendations have been implemented as she is 'just filling in'. However, the dieticians report notes that 'all previous recommendations have been implemented'.

There are wall charts which details the names of residents with dietary needs or food preferences/dislikes. Three residents are noted as requiring Fortisip on a daily basis. The cook advised where the resident does not like the main food choice of the day, they are offered an alternative. This is sighted during audit. Most residents are eating fish and chips for lunch. One resident has a chicken drumstick and chips instead. Wall charts in the kitchen and nurses office provide guidance on the provision of meals and fluids to residents who required texture modified meals. Another manual sighted contains guidance for staff on special diets.

Foodstuffs sighted to be stored in the refrigerator covered and dated. Dry goods are in sealed packages or in labelled containers. The temperature of the main meal is tested prior to food service to ensure it is within required temperatures and records sighted. Monitoring of the temperature of the refrigerator and freezer is occurring. The refrigerator monitoring records sighted. The five residents interviewed verify they are provided with sufficient food and their dietary needs/preferences are met.

ARRC contract requirements are met.

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 Ma V CQ SQ STQ L

How is achievement of this standard met or not met?	Attainment: FA
The facility has a current Building Warrant of Fitness. The auditor is advised the alterations to the building do not impact on the building warrant.	

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:		

STANDARD 1.4.7 Essential, Emergency, And Security Systems

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

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

How is achievement of this standard met or not met?	Attainment: FA
The facility has an approved fire evacuation plan. There have been two fire evacuations thus far this year. One in March and one in September. The auditor is advised that the building alterations do not impact on the fire evacuation requirements.	
1.2.4 The relevant ARC requirements are met	

Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.

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: PA Low

Policies and procedures provide guidance for staff on restraint minimisation and safe practice. There are currently two residents who have lap belts (as an enabler) in use. The policy advises enablers are not in use at Tui House and requires review. This is an area requiring improvement.

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: PA

Risk level for PA/UA: Low

Policies and procedures provide guidance for staff on restraint minimisation and safe practice. The policy notes that enablers are not in use. The owner and the clinical manager advise there are currently no residents requiring restraints or enablers who are being funded under the Aged Related Residential Care (ARRC) contract. There are however, two residents who are receiving services under a different contract who have enablers in use. Ensuring the policy aligns with practice is an area requiring improvement. The owner, clinical manager and two caregivers interviewed are able to identify that enablers are voluntary. The definitions of restraint and enablers align with the requirements of these standards. The owner advises the restraint minimisation and safe practice policy is being updated in preparation for the opening of the secure

dementia unit. The annual 'restraint review' was undertaken in July 2013. The report sighted identified there are no restraints in use. Staff are provided with training on restraint minimisation and safe practice and managing challenging behaviour (refer to 1.2.7).

ARCC Contract requirements are met.

Finding Statement

The Restraint Minimisation and Safe Practice policy and procedure advises that no enablers are in use. However, there are current two residents (who are not under the aged related residential care contract) that have lap belts in place.

Corrective Action Required:

Update applicable policies to include the use of enablers.

Timeframe:

Six months

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 Negligible

Tui House has an infection control surveillance programme that is appropriate to the services provided. The previous improvement regarding the identification of multi-resistant organisms within surveillance has been adequately addressed, however surveillance data has not been collated since June 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: PA

Risk level for PA/UA: Negligible

A sufficient infection control surveillance programme is implemented. Infection statistics are collated and until June 2013 had been occurring monthly. The monthly analysis sighted is adequate to determine trends which are then communicate to staff has required. The organisation benchmarks their infection data with the other age care facility owned by the Director/General Manager. Collated data sighted confirms a generally low infection rate with a small change following the addition of hospital level care.

Finding Statement

Surveillance data has not been collated or analysed since June 2013

Corrective Action Required:

Collate surveillance data monthly as required.

Timeframe:
6 months