**Howick Baptist Healthcare Limited**

**Current Status:** **21-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**

Howick Baptist Healthcare Limited is a charitable company, with shareholders being the Baptist Union of New Zealand and the Baptist Foundation. Howick Baptist Home and Hospital care facilities provide 97 hospital and 32 rest home level care beds. On the day of audit 97 hospital and 31 rest home level care beds are occupied. The use of two additional rest home level care beds are included in this audit report and reporting against the standards audited.

The facility has a well-established management team who are led by the Chief Executive Officer (CEO) who is very well qualified for her role. The activities programme is a particular strength of the service and this standard is rated as being above that required, as continuous improvement.

The ten corrective actions from the previous certification audit are fully attained. There are no areas identified for improvement from this surveillance audit. The requirements of the provider's contract with the district health board are met.

**Audit Summary AS AT** **21-Oct-13**

Standards have been assessed and summarised below:

**Key**

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

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| --- | --- | --- |
| **Consumer Rights** | Day of Audit  21-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| --- | --- | --- |
| **Organisational Management** | Day of Audit  21-Oct-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  21-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. |  | **All standards applicable to this service fully attained with some standards exceeded** |

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| **Safe and Appropriate Environment** | Day of Audit  21-Oct-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

|  |  |  |
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| **Restraint Minimisation and Safe Practice** | Day of Audit  21-Oct-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| --- | --- | --- |
| **Infection Prevention and Control** | Day of Audit  21-Oct-13 | Assessment |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | **Standards applicable to this service fully attained** |

**Howick Baptist Home and Hospital**

Howick Baptist Healthcare Limited

Surveillance audit - Audit Report

Audit Date: 21-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Howick Baptist Healthcare Limited |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Howick Baptist Home and Hospital | 139 Union Road | Howick | Auckland |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
| Required to report on the addition of two rest home level care beds as per MOH letter dated 2 July 2012. |

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| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 21-Oct-13 **End Date:** 21-Oct-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | BA, Lead Auditor NZQA 8086, RCN. | 8.00 | 4.00 | 21-Oct-13 |
| Auditor 1 | XXXXXXXX | RN, B.Nursing, RABQSA | 8.00 | 4.00 | 21-Oct-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX | RN,MBA,NZQA 8086 |  | 2.00 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16 | **Total Audit Hours off site** *(system generated)* | 10 | **Total Audit Hours** | 26 |
| **Staff Records Reviewed** | 10 of 188 | **Client Records Reviewed** *(numeric)* | 7 of 128 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 7 |
| **Staff Interviewed** | 14 of 188 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 8 of 128 | **Number of Medication Records Reviewed** | 14 of 128 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 11 day of November 2013

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

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

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

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

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

# Services and Capacity

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Howick Baptist Home and Hospital | 129 | 128 | 0 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Executive Summary of Audit

General Overview

Howick Baptist Healthcare Limited is a charitable company, with shareholders being the Baptist Union of New Zealand and the Baptist Foundation. Howick Baptist Home and Hospital care facilities provide 97 hospital and 32 rest home level care beds. On the day of audit 97 hospital and 31 rest home level care beds are occupied. The use of two additional rest home level care beds are included in this audit report and reporting against the standards audited.

The facility has a well-established management team who are led by the Chief Executive Officer (CEO) who is very well qualified for her role. The activities programme is a particular strength of the service and this standard is rated as being above that required, as continuous improvement.

The ten corrective actions from the previous certification audit are fully attained. There are no areas identified for improvement from this surveillance audit. The requirements of the provider's contract with the district health board are met.

1.1 Consumer Rights

The residents and families report that there is a high standard of communication at the service. There is communication that reflects the services principles of open disclosure. Interpreter services are accessed as required to meet the communication needs of the residents.

Complaints are managed as described in policy and procedures. At the time of audit there are no outstanding complaints. Staff undertake correct complaints management and residents understand their right to make a complaint at any time.

1.2 Organisational Management

Organisational structures and processes are implemented by the service to ensure service delivery is planned, co-ordinated, and appropriate to the needs of the consumers. Documentation identifies that service performance is aligned with, and regularly monitored against the identified values, scope, strategic direction and goals. Quality improvements and corrective action planning is well documented. The Chief Executive Officer reports all concerns or quality deficits to the Board of Trustees as appropriate. Key components of service delivery are explicitly linked to the quality management system and are monitored to measure achievement. Incidents, accidents and untoward events are recorded and followed up as required. Risks are well documented with mitigation actions identified.

The service implements safe staffing levels and skill mixes. All shifts are covered by a registered nurse. Human resources management processes in place meet legislative requirements. Staff are fully supported by the organisation to maintain and improve their knowledge and skills through on-going education which is appropriate to their role. The Aged Related Residential Care Services Agreement requirements are met.

The previous area for improvement related to ensuring all records (electronic and paper based) are available to all staff is now addressed and an improvement implemented since the last audit.

1.3 Continuum of Service Delivery

The residents and family interviewed report satisfaction with the quality of care provided at the service. The service provides appropriate service provision for residents at rest home and hospital level of care. Each stage of service provision is undertaken by suitably qualified and experienced nursing and care staff. The assessment, planning, provision and review of care is provided in time frames that meet the residents' needs and complies with contractual requirements. The assessment, care planning, review and evaluation processes are implemented at the service. Where there are temporary changes in a resident's condition the service uses an acute care plan to document the resident's changed needs. The previous areas for improvements required related to the time frames for conducting the initial assessment and initial care plan, and ensuring the care plans reflect the assessed needs, are now addressed.

The activities programme supports the interests, needs and strengths of the residents. The residents and families interviewed express satisfaction with the activities provided. The activities programme has a number of initiatives for residents, which reflect a continuous improvement rating.

A safe and timely medicine management system is observed at the time of audit. The registered nurses and senior caregivers are responsible for medicine management and evidence competency to perform the role. The previous area of required improvement to ensure all medicines are individually signed by the prescriber is now addressed and an improvement implemented since the last certification audit.

Residents express satisfaction with the food and fluid offered at the service. The menus are appropriate to the resident group and have been reviewed by a dietitian. At the time of audit the kitchen is under renovation and the service is utilising a mobile kitchen service to prepare and cook the food onsite.

1.4 Safe and Appropriate Environment

The service has a current building warrant of fitness. Building, plant and equipment are serviced regularly to meet specific requirements.

The two additional bedrooms which were reviewed are large enough for residents to move around safely with or without assistance and they have full ensuite facilities.

All chemicals sighted are clearly labelled. This was an area identified for improvement in the previous certification audit is fully attained.

The Aged Related Residential Care Services Agreement requirements are met for the areas reviewed.

2 Restraint Minimisation and Safe Practice

The service has 20 residents with restraints and three enablers in place. The policy has a clear definition of enablers. All restraint, including enablers, are the least restrictive option. The only restraints in use are chair lap belts and bedside rails. Assessment information and monitoring requirements are identified on the resident's care plan. Two areas which required improvement in the previous certification audit are fully attained.

3. Infection Prevention and Control

The results of surveillance of infections are analysed and reported to staff and management. Where trends are identified, the service implements actions to reduce the rates of infections. The infection surveillance data is externally benchmarked.

Summary of Attainment

* 1. Consumer Rights

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

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:4 PA:0 UA:0 NA: 0 |

* 1. 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 | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 1 | 0 | 0 | 3 | 10 |

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| Organisational Management Standards (of 7): N/A:1 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:18 PA:0 UA:0 NA: 3 |

* 1. Continuum of Service Delivery

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

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| Continuum of Service Delivery Standards (of 12): N/A:4 CI:1 FA: 7 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:1 FA:15 PA:0 UA:0 NA: 1 |

* 1. Safe and Appropriate Environment

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

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| Safe and Appropriate Environment Standards (of 8): N/A: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:3 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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

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

1. Infection Prevention and Control

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

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

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| **Total Standards (of 50) N/A:** 28 **CI:** 1 **FA:** 21 **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  **Total Criteria (of 219) CI:** 1 **FA:** 44 **PA:** 0 **UA:** 0 **N/A:** 6 |

# Corrective Action Requests (CAR) Report

Provider Name: Howick Baptist Healthcare Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:21-Oct-13 End Date: 21-Oct-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

# Continuous Improvement (CI) Report

Provider Name: Howick Baptist Healthcare Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:21-Oct-13 End Date: 21-Oct-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

|  |  |  |
| --- | --- | --- |
| **Std** | **Criteria** | **Evidence** |
| 1.3.7 | 1.3.7.1 | Finding:  The achievement of providing planned activities that are meaningful to residents is beyond the expected full attainment, in relation to the sensory bags and individual reminiscence profiles for residents with cognitive impairment. A review process of the themed reminiscence bags and individual reminiscence profile programme includes analysis and reporting of findings and outcomes to the management. The analysis of the programme indicates positive results in motivation, achievement and sense of belonging and communication for the participants. The actions taken from the review of the project includes the programme could be used for a wider range and all levels of cognitive function. |

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.9 Communication**

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

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

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

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

The three of three family/whanau interviewed confirm they are kept informed of the resident's status, including any events adversely affecting the resident. The service provider communicates effectively with residents and family members, with the three of three family/whanau and eight of eight residents interviewed (three rest home and five hospital) stating that open communication is one of the strengths of the service. A family contact sheet is held in each resident's file. Evidence of open disclosure is documented in the family contact sheets, on the accident/incident form and in the residents' progress notes (evidenced in seven of seven residents' files).

The two registered nurses (RNs) interviewed reported that residents can access interpreter services if required. Access to interpreter services is documented in the interpreter service policy, which contains contact numbers for interpreter services.

The Aged Related Residential Care (ARRC) service agreement 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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

Complaints management is fully computerised and easy to follow. It is undertaken to meet policy timeframes. There are no outstanding complaints at the time of audit. Documentation identifies that all complaints have been dealt with internally to the satisfaction of complainants. All complaints are reported at Board of Trustee level on a monthly basis.

Complaints forms are located in the foyer of the rest home and the hospital. Forms are also located in the admission pack given to each resident upon entry to the service. An interview with the Chief Executive Officer (CEO) confirms that a discussion about complaints management is part of the admission process. Three of three family/whanau member interviews confirm their knowledge and understanding of the complaints process. Eight of eight resident interviews (five hospital and three rest home level care), said that although they have not had to make a complaint they understand the process and that it is their right to make a complaint if they wish. Residents report they would go to a senior staff member with any concerns.

Interviews with 12 of 12 staff and three of three members of management (one cook, the occupational therapist who is the activities coordinator, four RNs (two are in management roles), four caregivers, one physiotherapist assistant, two household staff, two maintenance staff and the CEO), confirm their understanding of complaints management to meet policy requirements. All complaints are documented and followed up accordingly. Sign off is undertaken by the CEO.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

The organisation's Strategic Plan (2013-2016), Business Plan (2013-2014), and the Quality and Risk Strategic Plan (2013) identify the vision, mission, focus, motivation and values. The proposed actions and implementation of each plan are regularly reviewed by the Board of Trustees to ensure the organisation is meeting the residents' goals. All staff are given the opportunity to have input in the service plan development. The strategic direction of the organisation shows the key activities, key players, resources implications and measures of compliance.

Interviews with eight of eight residents and three of three family/whanau members and the results of the 2012 resident satisfaction survey identify that services are delivered to meet their needs and wants.

The CEO has overall responsibility, authority and accountability for all services. She has over 20 years in management roles. She holds a Bachelor of Applied Management, a Bachelor of Divinity and a Bachelor of Arts. Her Bachelor of Divinity studies included a full year practicum working in residential care focusing on the spiritual needs of older people in care. She attends appropriate educational conferences and seminars to keep her knowledge up to date. Education sighted includes Claro New Zealand Health Sector Lawyer workshops, Counties Manukau District Health Board (CMDHB) Residential Care Quality Forums, in-service education and New Zealand Age Care Association (NZACA) local and regional conferences and meetings.

The CEO is supported by a Home and Hospital Manager (RN), In-service/Clinical Services Coordinator (RN), physiotherapist, occupational therapist, Property Services Manager, a team of RNs, an accountant and administration staff.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

The organisation identifies actual and potential risks for all aspects of service provision. The Health and Safety Committee ensure policy is implemented by monthly monitoring, evaluation and compliance with corrective actions. Measures sighted to decrease actual and potential risks include:

- Health and Safety policies, procedures and an active Health and Safety committee who keep the hazard register current and monitor all non-eliminated risks monthly

- processes to ensure plant, equipment and the environment are maintained to reflect safe practice

- staff orientation processes and on-going education which includes health and safety topics

- emergency planning and education

The organisation was a finalist in the New Zealand Aged Care Association quality initiative for the way in which it safely managed a 'new build' which occurred.

Policy and procedures are up to date and reflect current good practice and meet legislative requirements. There is a process in place to ensure policies are reviewed at least every two years with specialist input as required.

The Quality and Risk Management Plan (2013), which is overseen by the quality coordinator, is very detailed and includes the annual audit plan. Identified risks are signed off when eliminated. If a new risk is identified it is taken to the Continuous Quality Improvement (CQI) Committee and appropriate corrective actions are put in place to manage the risk. Each senior manager provides both monthly and annual reports along with oral reports to the Chief Executive Officer (CEO) who notifies the Board of Trustees of any concerns.

Staff have the opportunity to be involved in quality improvements and the organisation uses an 'Improvements to Our Work Area' form. The best idea is written up and shown at the main entrance to the building as observed on the day of audit. One quality project which all staff are involved in is related to decreasing falls. A 24 hour clock in each ward shows the name of the resident who has had a fall and the time of day it occurred. Results are analysed and corrective actions include looking at placement of staff and shift routines. There are no conclusive comparative numbers but clinical staff interviews confirm that resident falls are decreasing. This is supported by the GP during interview.

Key component of service delivery including adverse events, complaints management, infection control, health and safety and restraint minimisation are discussed at staff and management meetings as appropriate. This is confirmed during staff interviews and in meeting minutes sighted.

Key components of service delivery are monitored at facility level and analysed, and evaluated and benchmarked by independent companies. Data collected on absenteeism, manual handling injuries, pressure areas, medication errors, falls and staff and resident accidents are sent for benchmarking and results are analysed at service level. Infection control data is sent to a different agency who specialise in the benchmarking of infection control data. Results from all benchmarking agencies are used to put corrective planning in place as appropriate. Meeting minutes identify that staff and management are kept fully informed of results and corrective action outcomes.

The service is very proactive in management of risk and one example identifies that after a laundry staff member reported back strain, the incident was fully investigated and included physiotherapist input. A report was sent to the manager and after four weeks of trialling new laundry equipment, new laundry transfer trolleys with rise and fall bases were purchased. Staff report much less need to bend and twist. No further back strain has been reported since the trolleys were introduced.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

All adverse, unplanned or untoward events are recorded on incident and accident forms. This is confirmed during interview with 12 of 12 staff from all areas of the facility. Senior management staff understand their statutory obligations in relation to essential notification reporting and it is identified in policy what incidents and accidents must be notified and to whom.

The process of review for each incident and accident form includes review by the team leader at the time of the incident or accident to ensure they are completed correctly. They are then sent to the home and hospital service manager who collates the information. This is then sent to the In-service/clinical services coordinator who enters the information on to the computer. This information is analysed and discussed at the CQI meeting. Outcomes are measured against clinical indicators which are set by the group annually. For example if a resident has more than one fall in a month they are identified and discussed at the CQI committee meeting and corrective action planning is put in place to try to prevent further falls. Corrective actions include more physiotherapy input, ensuring the resident is kept in view by staff as much as possible and the use of alarm mats.

Incident and accident forms sighted show that the service informs family/whanau about any concerns in an open manner that is reflective of the principles of Open Disclosure policy. This is confirmed during three of three family/whanau and eight of eight resident (five hospital and three rest home) interviews.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Good human resources management processes are implemented. Policy identifies how current good practice and legislative requirements are met. This includes validation of practising certificates for staff that require them as sighted in staff file reviews. Practising certificates are sighted for RNs, ENs, GPs, physiotherapist, pharmacy, occupation therapist, pharmacy and podiatry staff.

The service seeks appropriate staff for each role and a comprehensive orientation process is undertaken. This includes the Code of Rights, Treaty of Waitangi, Pacific Island Client Guidelines, staff handbook, principles of hygiene, competency checklists for showing/ bed bathing/hand washing, use of personal protective clothing, dress code, professional boundaries, fire evacuation procedures, control of hazards, health and safety, manual handling, and contractual issues.

Staff are fully supported by the organisation to undertake on-going education related to their role. Education is well documented for each individual staff member. On-going education is offered both onsite and off-site on a regular basis. Staff interviews confirm the education they are offered is relevant to their roles and is presented in a professional manner. Upcoming education is notified via 'time target' and on staff notice boards.

Annual staff appraisals are up to date in 10 of 10 staff file reviews undertaken for staff from across the service (Home and Hospital manager (RN), three RNs, one EN, the occupational therapist, one cleaner and three caregivers).

Caregivers are encouraged to undertake the Aged Care Education (ACE) programme and documentation identifies that there are:

- 33 caregivers with ACE dementia care

- two are qualified Health Care Assistants

- 20 caregivers have completed stage two ACE

- 39 caregivers have completed core ACE papers.

All RNs are required to hold current first aid. All RNs and ENs have completed medication competencies within the last 12 months along with seven caregiver team leaders who work in the rest home.

Three of three family/whanau members and eight of eight resident (five hospital and three rest home) interviews confirm the services offered are delivered in a safe and effective manner to meet their needs. This is supported by the 2012 resident satisfaction survey results.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

Policy identifies that the service will ensure safe staffing levels appropriate to meet residents' needs. Staffing levels and skill mix are measures on a nurse to resident ratio and on identified resident needs. For example, on the day of audit additional staff were being rostered for a newly admitted palliative care resident.

Staff have allocated resident numbers so regardless of where residents are located they all receive the appropriate level of care. Social activities are undertaken to meet all resident needs.

Current staffing arrangements cover the extra two beds and the service staffing numbers meet contractual requirements.

A review of six weeks rosters identify that all shifts are covered by RNs.

Morning duty:

- 5 RNs for eight hours (one RN acts as a hospital coordinator on Saturdays and Sundays)

- 10 caregivers for eight hours

- 11 caregivers for six hours

Afternoon duty has:

- 4 RNs for eight hours or on some occasions 3 RNs and one EN

- 9 caregivers for eight hours

- 5 for six hours

-1 for four hours

- 5 for two hours

Night duty:

- 2 RNs for eight hours or one RN and one EN

- 8 caregivers for eight hours

Monday to Friday there is also the management team which includes but is not limited to, two RNs, a physiotherapist, activities coordinators, an occupational therapist and a social worker.

All shifts are covered by a staff member with current first aid. Staff interviews confirm extra staff are put on shifts if acuity levels increase so they always have time to complete all cares and tasks required of them.

There are dedicated laundry and cleaning staff seven days a week. Kitchen staff are contractors.

Resident and family/whanau interviews confirm they are very happy with the level of service offered and confirm staff are always visible and available when needed.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

The previous CAR at 1.2.9.10 was raised to ensure that all records pertaining to individual residents is available to all staff so they can see the integrated file information.

The eight care staff interviewed (two RNs, four caregivers, one occupational therapist and one physiotherapy aid) report that the printed care plans provide accurate and up to date information of the resident. All staff have access to the printed residents' care plan and assessments. The resident’s hard copy and electronic copies sighted have integrated information. The previous corrective action request is now addressed and an improvement implemented since the last audit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

There is a previous CAR at 1.3.3.3 to ensure that the initial assessment and care plan are consistently completed on admission. This is now addressed and sighted in the seven of seven residents' files reviewed (two rest home and five hospital). This is an improvement implemented since the previous certification audit.

Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitably qualified staff that are competent to perform their role. The seven of seven residents' files reviewed (two rest home and five hospital) confirm that the registered nurse (RN) conducts the initial assessment and initial care plan on admission to the service and develops the long term care plan within three weeks of admission. The care staff are suitably experienced and encouraged to complete the Aged Care Education (ACE) qualifications if they do not have a national qualification. Annual practicing certificates are sighted for all staff that require them.

The initial and ongoing assessments include the physical, psychosocial, cultural and spiritual needs of the resident. The additional assessment tools include falls risk, pain chart, dietary profile and continence assessment. The seven of seven residents' files evidence that the long term care plan is based on the assessed needs of the resident. The long-term care plan is recorded using an electronic resident record using the "V Care" electronic management system that is individualised to the resident's needs. The care plan identifies the need, objective, interventions and evaluation. The care plan evaluation is conducted at least three monthly and used to form part of the multidisciplinary review, confirmed in the seven of seven residents' files reviewed. The three monthly review and evaluation records a summary of any investigations, observations and assessments.

The seven of seven residents' files evidence the initial medical review is conducted within two days of admission (where required). Ongoing medical reviews are conducted monthly or at least three monthly when the resident is assessed as stable (more frequently when required for the residents changing needs). The exception for the three monthly medical review is recorded in the residents’ medical assessment form.

The service is co-ordinated in a manner that promotes continuity of care. Progress notes are updated at least daily (confirmed in the seven of seven residents' files reviewed). A handover is provided at the start of each shift, the four of four caregivers report that adequate information is provided at handover, a written handover sheet and a 24 hour book, which communicates changes in residents care.

The eight residents interviewed (three rest home and five hospital) and three family/whanau members report the residents receive care that meets their needs. The GP reports that they are 'more than satisfied' with the quality of care provided at Howick Baptist and reports that the nurses have good clinical judgement and contact the GP appropriately. The GP also reports that there is a good integration of services, with specialist input as required, to meet the needs of the residents.

Tracer example one- hospital level of care.

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

Tracer example two - rest home level of care.

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

The ARRC requirements for rest home and hospital are 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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

There is a previous CAR at 1.3.4.2 to ensure assessment processes, especially for pain and restraint use, are used to identify the resident’s needs, outcomes and goals are documented in the care plan. This is now addressed and an improvement implemented since the last audit. One hospital level of care resident reviewed has pain assessments that serve as a basis for service delivery planning. The file reviewed for the restraint minimisation standard (refer to 2.1 and 2.2) has the appropriate assessment and interventions recorded on the care plan.

The seven of seven residents' files reviewed (two rest home and five hospital) have appropriate assessments to meet the needs of the resident. Where a need is identified, interventions for this are recorded on the care plan. The files of five residents reviewed have pain identified as a need and these residents' files evidence a pain assessment, which includes the use of a pain scale. All of the files reviewed have falls risk assessments. Where there is a moderate to high falls risk, additional falls and balance assessments are conducted and specific plans developed to reduce falls. One rest home resident reviewed is assessed as high risk for falls and has interventions to minimise falls recorded on their care plan.

The eight of eight residents and two of two family/whanau interviewed report the residents receive excellent care at Howick Baptist. The GP reports that they are 'more than satisfied' with the quality of care at Howick Baptist.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

There is a previous CAR at 1.3.5.1 to ensure staff can easily access care plans and care plans are individualised, accurate and up to date. There is a previous CAR at 1.3.5.3 to ensure integration and ease of access to both electronic and hard copies of the resident’s record. Both these areas are now addressed and implemented improvements since the last audit.

The seven of seven care plans reviewed (two rest home and five hospital) have a standardised format that is individualised to the resident's assessed needs, using the electronic 'V Care' record management system. The files reviewed demonstrate integration, with one clinical file that has input from carers, activities, medical and allied health services. The sighted electronic record correlates to the printed care plan and assessments. The four of four caregivers interviewed report they receive adequate information to assist the continuity of care. All the eight clinical staff interviewed (two RNs, four caregivers, one occupational therapist and physiotherapy aid) report that can easily access the residents information. The service still has a limited number of computers and access to the electronic records, though all staff report that the printed information reflects the current needs of the residents.

The three of three family/whanau and eight of eight residents (three rest home and five hospital) report a high level of satisfaction with the overall quality of care provided at the service.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

The seven of seven long term care plans reviewed have interventions based on the residents' needs. The service has paper based and electronic assessment and care planning records. The long term care plans are individualised to the residents assessed needs. One hospital resident reviewed has recorded interventions for reducing pain, based on the assessed needs of the resident. The pharmacological and non-pharmacological interventions are recorded on the care plan. One rest home resident reviewed is assessed as high risk for falls, with the falls reduction interventions recorded on the care plan.

The four of four caregivers interviewed report the care plans provide accurate information regarding the individual needs and care required for the residents. The eight of eight residents and three of three family/whanau interviewed report satisfaction with the quality of care provided. The GP reports that they are 'more than satisfied' with the quality of care at the service, the GP reports the nursing staff have 'very good clinical judgement' and they are contacted appropriately.

The ARRC requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

The occupational therapist conducts an initial assessment of the resident's recreational, social and physical needs on admission. The initial assessment includes the resident's life history, important events that are relevant to the resident and social activities that are meaningful to the individual resident. The activities plan that is developed in consultation the with resident and family/whanau, where appropriate, sets goals and planned outcomes that are meaningful to each resident. Residents are welcome and invited to attend as many of the activities that they wish to attend. The occupational therapist and physiotherapist indicates that individual activities, physical and mental stimulation is provided for the physically frail and residents with decreased cognitive functions. Specialised activities bags are developed for care staff to use with residents with cognitive impairment to engage their interests and provide diversional strategies (eg, a 'beauty bag' that has mirrors, combs, brushes, hair curlers, a purse and a 'builder bag' that has tools and pieces of timber) and engage in reminiscence activities. Refer to criterion 1.3.7.1 for the continuous improvement rating for the projects with the sensory bags and individual reminiscence profiles.

A monthly activities plan (sighted) is developed based on the resident’s needs, interests, skill and strengths. The occupational therapist (OT) meets with the activities assistants weekly. The activities cover cognitive, physical and social needs. For variety, there is a bi-monthly theme included in the programme (theme sighted at the time of audit is 'Home Sweet Home').

The seven of seven residents' files reviewed have activities and social assessments. The goals are updated and evaluated in each resident's file at least six monthly with person centred care plan reviews and multi-disciplinary reviews. The activities co-ordinator reports where residents have a specific need, the service endeavours to provide the resources for this. Where possible residents' independence is encouraged to maintain links with family and community groups. Residents are provided with outings on a routine basis. One to one activities are planned to meet the residents' interests.

The eight of eight residents interviewed report they enjoy the range and variety of planned activities.

The ARRC 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:** CI **Risk level for PA/UA:**

The occupational therapy department has implemented a themes reminiscence bags and individual reminiscence profiles for residents with cognitive impairment. The project was commenced to provide a tactile and sensory memorabilia for residents with dementia. The project provides reminiscence opportunities and encouragement to engage and stimulate communication for residents with dementia. The assessment of the resident includes an individual reminiscence profile which includes the resident’s previous work/interests, sensory items, theme interventions, outcomes and evaluation of outcomes. The sensory stimulation themes of the individualised bags include smell, movement, touch, visual, auditory, hearing and taste. The occupational therapist reports a positive impact for residents and gave examples of a resident, with limited verbal communication, who responded well to a photo book of places in New Zealand. The resident was able to reminisce about the places, previously having had minimal communication and interaction with others, verbally responded to the activities assistant and requested that they bring their book back next time they come to see them. Another resident who has no verbal communication, responded by grinning and smiling when a auditory sensory bag was used to tap into the memories of the music that the resident enjoys to listen too.

**Finding Statement**

The achievement of providing planned activities that are meaningful to residents is beyond the expected full attainment, in relation to the sensory bags and individual reminiscence profiles for residents with cognitive impairment. A review process of the themed reminiscence bags and individual reminiscence profile programme includes analysis and reporting of findings and outcomes to the management. The analysis of the programme indicates positive results in motivation, achievement and sense of belonging and communication for the participants. The actions taken from the review of the project includes the programme could be used for a wider range and all levels of cognitive function.

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

There is a previous CAR at 1.3.8.2 to ensure that evaluations are consistently document the residents response to supports, interventions, and progress towards meeting goals. This is now addressed and an improvement implemented since the previous audit.

The seven of seven residents' care plans reviewed evidence evaluations are recorded at least three monthly, with input from the care staff, GP, the resident, the family and allied health professionals. The documented evaluations indicate the resident's progress in meeting goals, and there is a care review meeting, a re-assessment and the care plan is updated to reflect progress towards meeting goals. A summary of the last three months assessment (eg falls, pressure pain, nutrition) are summarised and reviewed as part of the evaluation and care review meeting. The seven of seven care plans sighted are individualised and personalised to the residents' needs. Any changes in the residents’ condition are written in the progress notes and discussed at the staff handover to oncoming staff (confirmed at interview with the four caregivers).

Short term or acute nursing care plans are used to documented temporary changes in the residents' condition. An acute care plan documents the problem, treatment required and the outcomes of care.

The eight of eight residents, three of three family/whanau and GP interviewed report involvement in the evaluation process and are satisfied with the care provided.

The ARRC requirements are 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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

There is a previous CAR at 1.3.12.6 to ensure all medicine ordered is individually signed by the prescriber. This is now addressed and an improvement implemented since the previous audit.

Medicines for residents are received from the pharmacy in the robotic sachet delivery system. The medicines are checked for accuracy against the resident's medicine chart at each medicine administration. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or hospital admission. A safe system for medicine management is observed on the day of audit, with the medicine round observed for the Inchinnan unit.

The medicine storage is sighted for the Inchinnan and Minerva hospital sections of the facility. Medicines are stored in locked cupboards in the locked treatment room. There is a monthly stock rotation recorded for the medicines that are not packed in the robotic sachets. The controlled drugs are stored in a locked safe, two staff sign the register at each administration and a weekly stock count is undertaken in the controlled drug register sighted. The service's medicine fridge is monitored at least weekly and temperatures are within recommended guidelines.

The 14 of 14 medicine charts reviewed are reviewed by the GP in the last three months, this is recorded on the medicine charts. All medicines ordered, sighted in the 14 of 14 medicine charts reviewed, contain the date, medicine name, dose, time of administration with any allergies highlighted in red ink. All medicine charts reviewed have each medicine individually prescribed. All signing sheets are fully completed on the administration of medicines for the past four weeks.

There are documented competencies sighted for the staff designated as responsible for medicine management, this includes all RNs, ENs and the seven team leaders in the rest home.

There is one resident in the rest home assessed as competent to self-administer their medicines. The service has a self-administration competency for residents who are able to self-administer their medicines.

The ARRC requirements are 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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence** **Attainment:** 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

The food and nutritional services are provided by an external contracted company. At the time of audit the kitchen is under renovation, with the food being prepared and cooked onsite, in a temporary mobile kitchen.

The four week rotating menu, with seasonal variations, is approved by a registered dietitian in March 2013 as suitable for aged care residents. The menu review is based on the dietitian NZ audit tool for residents living in long term care. A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. For example, the service provides diabetic and texture modified diets to meet specific residents' needs. The care staff manage the additional food supplements for the residents (eg, Fortisip). Residents are routinely weighed at least monthly (more frequently if clinically indicated) and residents with unintentional weight loss are reviewed by a dietitian. Two of the residents' files reviewed have weight loss identified, both these residents are reviewed by a dietitian, with interventions recorded based on the dietitian assessment and recommendations.

Interviews with seven of the eight residents and three of three family/whānau confirm they are overall happy with the food provided. One resident interviewed reports some minor issues with the quality of the food service.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer are in their original packaging or labelled and dated if not in the original packaging. Staff have undertaken food safety management education appropriate to service delivery.

ARRC 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 1.4.1 Management Of Waste And Hazardous Substances**

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

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

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

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

There are documented processes which are implemented by staff to ensure safe and appropriate storage and disposal of waste is maintained. This includes chemicals used at the facility. Staff interviews and observation on the day of audit identify that personal protective clothing and equipment is provided and used appropriately. Four staff cleaning trolleys identify that all chemicals are correctly labelled. Safety data sheets are available for all chemicals used. There are no specific territorial authority requirements for disposal of waste. An area for improvement identified in the previous certification audit (criterion 1.4.1.5) is now fully attained.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

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

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

All bedrooms are single occupancy. There are two bedrooms which are used for palliative care with relative areas for tea and coffee making and additional beds should they wish to stay overnight. The two additional rest home rooms that were looked at for this audit meet all requirements. Interviews with three of three family/whanau members and eight of eight residents (five hospital and three rest home) are very happy with their bedroom areas. All rooms are large enough to use mobility aids safely with the assistance of staff and are furnished to a very high standard.

**Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely manoeuvre with the assistance of their aid within their personal space/bed area.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

Restraint policies and procedures clearly identify enablers as being used voluntarily and the least restrict option to meet residents' needs. All restraint is used for safety reasons only. The restraint register identifies there are 20 restraints and three bedside rail enablers in use.

The restraints are bedside rails and chair lap belts. Some residents have both. Three file reviews were undertaken for restraint only and two for enablers only. They all show that restraint use is identified on each resident's care plan. One area identified for improvement from the previous certification audit is fully attained.

An interview with the restraint coordinator (RN) and eight clinical staff confirm their knowledge and understanding of safe restraint use including enablers.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of restraint use, the frequency of use, and monitoring requirements. This information is also shown on resident care plans as sighted on three restraint and two enabler residents' care plan reviews. One area identified for improvement in the previous certification audit (criterion 2.2.3.1) is now fully attained.

Clinical staff confirm during interview that care plans are used to guide their actions. Staff are able to verbalise their knowledge related to safe clinical management related to restraint and enabler use. Staff education is compulsory and must be undertaken annually. This is monitored by the In-service/Clinical services coordinator.

**Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:**

(a) Details of the reasons for initiating the restraint, including the desired outcome;

(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

(c) Details of any advocacy/support offered, provided or facilitated;

(d) The outcome of the restraint;

(e) Any injury to any person as a result of the use of restraint;

(f) Observations and monitoring of the consumer during the restraint;

(g) Comments resulting from the evaluation of the restraint.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 Surveillance**

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

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

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

Infection control data is collected on urinary tract infections, chest infections, wound infections, eye and ear infections and multi-resistant organisms. The monthly report of collected data is provided to senior management and presented at the quality meeting. The results are placed on staff notice boards. The surveillance data collected is based on guidelines from an aged care consultant. Infection control data is included in the quality audit programme. The service bench marks the infection surveillance results with an external company. The benchmarking results for both the rest home and hospital services are below the average for comparable aged care services. The June 2013 benchmarking results show the overall infection rate in the rest home at 4.0, which is below the average of 4.09. The hospital results for the June quarter record the overall total number of 2.6 infections per 1000 bed days, which is below the average of 5.41 infections for the same period.

The infection control coordinator reports that 2012 results indicated an increase in urinary tract infections (UTIs), with 47 recorded. The actions implemented included staff education, encouragement of fluids, with the infection control coordinator reporting that the results to date in 2013 indicating the service is on track to lower the rate of UTIs in the facility.

All staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The surveillance records show that there were eight residents with nausea/vomiting in February 2013 (confirmed as Norovirus). The Ministry of health was notified, transmission based precautions implemented for all care, cleaning and laundry staff and extra cleaning of the environment was conducted. No kitchen staff were allowed resident contact. The report sighted of the outbreak records that the serviced was able to contain the virus to eight residents in one wing of the service.

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**