**Laama Holdings Limited**

**Current Status:** **01-Nov-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**

Epsom South Rest Home is a 27 bed facility in Auckland providing rest home level care. On the day of audit there are 22 residents receiving services. In addition there are two boarders who live in the rest home. There have been no significant changes to the land, building or key personnel since the last audit.

At the last audit there were eleven areas identified as requiring improvement. Ten of these have been addressed. Ensuring all applicable electrical equipment is tested continues to require improvement. There are no new areas identified as requiring improvement at this audit.

**Audit Summary AS AT** **01-Nov-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  01-Nov-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** |

|  |  |  |
| --- | --- | --- |
| **Organisational Management** | Day of Audit  01-Nov-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  01-Nov-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. |  | **Standards applicable to this service fully attained** |

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| **Safe and Appropriate Environment** | Day of Audit  01-Nov-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  01-Nov-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  01-Nov-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** |

**Epsom South Rest Home**

Laama Holdings Ltd

Surveillance audit - Audit Report

Audit Date: 01-Nov-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Laama Holdings Ltd |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Epsom South Rest Home | 57 Pah Rd | Epsom | Auckland |

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

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 01-Nov-13 **End Date:** 01-Nov-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 | RN, infection preventionist and NZ8086 | 8.00 | 4.00 | 01-Nov-13 |
| Auditor 1 | XXXXXXXX | RN, B.Nursing, RABQSA | 8.00 | 4.00 | 01-Nov-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 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 10.00 | **Total Audit Hours** | 26.00 |
| **Staff Records Reviewed** | 4 of 9 | **Client Records Reviewed** *(numeric)* | 3 of 22 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 3 |
| **Staff Interviewed** | 3 of 9 | **Management Interviewed** *(numeric)* | 1 of 2 | **Relatives Interviewed** *(numeric)* | 2 |
| **Consumers Interviewed** | 4 of 22 | **Number of Medication Records Reviewed** | 10 of 22 | **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 12 day of November 2013

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

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

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

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

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

# Services and Capacity

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Epsom South Rest Home | 27 | 24 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Epsom South Rest Home is a 27 bed facility in Auckland providing rest home level care. On the day of audit there are 22 residents receiving services. In addition there are two boarders who live in the rest home. There have been no significant changes to the land, building or key personnel since the last audit.

At the last audit there were eleven areas identified as requiring improvement. Ten of these have been addressed. Ensuring all applicable electrical equipment is tested continues to require improvement. There are no new areas identified as requiring improvement at this audit.

1.1 Consumer Rights

Interpreters can be accessed when required. There is evidence of timely and open communication with residents and family members. Policies and procedures provide guidance for staff on complaints management processes. A complaints register is being maintained and includes evidence of actions undertaken in response to complaints. The area identified as requiring improvement at the last audit now meets the standard.

1.2 Organisational Management

Epsom South Rest Home has a documented business plan and quality plan which details the organisation’s mission, values and goals and objectives for care. The director (owner) is responsible for staff rosters, building management and maintenance and business operation. The nurse manager, is an experienced registered nurse with a current practising certificate. The nurse manager works three days a week on site and is otherwise on call and is responsible for ensuring the care needs of residents are met.

The organisation has a quality and risk management programme which includes resident satisfaction surveys, internal audits, quality indicators, complaints management and risk and hazard identification and management. The numbers of residents with infections and use of restraint is also monitored. Quality improvement data is analysed and compared (trended) with the previous audit results. Corrective action planning is occurring. Adverse events and incidents are being reported by staff and addressed in an open manner. The area identified as requiring improvement at the last audit now meets the standards. Policies and procedures are developed by an external consultant and are localised to meet the needs of the rest home.

The annual practising certificates (APCs) of applicable staff and contractors is being monitored and all are current. Copies of designated staff drivers licences are also held on file. The area identified as requiring improvement at the last audit now meets the criterion. There are documented processes related to recruitment and human resources management which are implemented. All staff complete an orientation programme. A system is in place to identify, plan, facilitate and record ongoing education which is well attended by staff.

There is a documented policy in place relating to staffing levels and skill mix. This policy is sighted to be implemented at audit. The area identified as requiring improvement at the last audit now meets the standard.

1.3 Continuum of Service Delivery

The residents and family interviewed report satisfaction with the quality of care provided at the service, with comments that they feel like they are part of a family at Epsom South Rest Home. The service provides appropriate service provision for residents requiring rest home 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 care plans reflect the assessed needs of the residents. 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 activities programme supports the interests, needs and strengths of the younger and older residents. The residents interviewed express satisfaction with the activities provided and report they also access activities in the community independently.

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. All staff who manage medicines are assessed as competent to do so.

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.

1.4 Safe and Appropriate Environment

The building has a current warrant of fitness (WOF) and ongoing checks to maintain the building WOF are maintained. Clinical equipment undergoes performance monitoring tests. Whilst electrical safety testing is being undertaken, not all applicable equipment is included and/or showing a current test and tag label. This remains as an area requiring improvement. The temperature of hot water in resident areas is being monitored and is within required temperatures and now meets the standards. The two wall mounted shower stools that were no longer 'fit for purpose' have been removed and now meets the standards. All staff involved with residents' care (including the cook) have a current first aid certificate. This also now meets the requirements of the standards.

2 Restraint Minimisation and Safe Practice

The service has no recorded enabler use. If enablers are to be used, the staff have clear knowledge that these would be voluntary and the least restrictive option for the resident. The service has two residents assessed for restraint use (bed rails), which is used to ensure resident safety. The previous audit identified two areas for improvement to ensure that the education includes the use of restraint and that competency assessment is conducted in relation to the use of restraint. The education records sighted evidence that the restraint minimisation and safe practice education includes the services policies and enabler use. The training records evidence that all care staff have attended the restraint education and have a current competency in relation to restraint minimisation and safe practice. The areas for improvement are now addressed and have been an improvement implemented since the last audit.

3. Infection Prevention and Control

Surveillance for residents with infections is occurring. The surveillance is appropriate to the service setting and the results are communicated in a timely manner with staff. Education on infection prevention and control topics is occurring. Staff are evaluating the contents of the education provided. The area identified as requiring improvement at the last audit now meets the standard.

Summary of Attainment

* 1. Consumer Rights

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | Not Applicable | 0 | 0 | 0 | 0 | 3 | 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: 3 |

* 1. Organisational Management

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

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 5 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:17 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | 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:6 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 51): CI:0 FA:14 PA:0 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | PA Low | 0 | 0 | 1 | 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 | 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: 2 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 36): CI:0 FA:0 PA:1 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 | 0 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 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:1 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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

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| Infection Prevention and Control Standards (of 5): N/A: 3 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 30 **CI:** 0 **FA:** 19 **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  **Total Criteria (of 219) CI:** 0 **FA:** 38 **PA:** 1 **UA:** 0 **N/A:** 3 |

# Corrective Action Requests (CAR) Report

Provider Name: Laama Holdings Ltd

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:01-Nov-13 End Date: 01-Nov-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.4.2 | 1.4.2.1 | PA  Low | **Finding:**  A number of electrical appliances have not undergone electrical safety testing or it is overdue.  **Action:**  Ensure electrical appliances undergo test and tagging in a timely manner. | Six months. |

# Continuous Improvement (CI) Report

Provider Name: Laama Holdings Ltd

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:01-Nov-13 End Date: 01-Nov-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.9 Communication**

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

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

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

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

The two of two 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 two of two family/whanau and four of four residents interviewed confirming this. Evidence of open disclosure is documented in the family contact sheets, on the accident/incident form and in the residents' progress notes (evidenced in three of three residents' files).

The nurse manager interviewed reports 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

The complaints policy and procedure is dated as reviewed on 11 March 2013. The policy details the complaints management process and timeframes to meet the Health and Disability Commissioner (H&DC) requirements.

The nurse manager (NM) advises Epsom South Rest Home (ESRH) is committed to an effective and fair complaints process. A complaints folder is maintained by the nurse manager. A complaints tracking form documents the date the complaint was received and details relating to the initial response, complaint investigation and feedback/results. All complaints lodged are signed off by the manager (sighted). A review of three complaints selected at random from the six complaints received in 2013 (as per the complaints register) verify all have been investigated and responded to in a timely manner. The complaints reviewed related to food services, and other residents challenging behaviour. Records of all actions undertaken are noted on the complaints response form attached to the complaints register. The area identified as requiring improvement at the last audit now meets the standards.

Complaints forms are currently held in the office (and sighted). Staff offer the forms to residents who want to make a complaint or advise during interview they fill the form on the residents behalf. The NM advises these forms are kept in the office as there is a wandering resident who removes all forms and paper towels which are in public areas.

The four residents and two family members interviewed report they would tell the nurse manager or the director if they have any concerns or complaints. All residents and family members confirm they have happy with the services being provided.

Three staff interviewed, comprising two caregivers and the cook, are able to identify their responsibilities when a resident or family member makes a complaint. The staff advise they are informed of complaints and actions undertaken at the monthly staff meetings.

The requirements of the ARRC contract are met.

**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 business plan sighted is dated 8 October 2013. The document includes (but is not limited to) the following areas: business strategy, marketing, and the management structure. The organisation has a business, quality and risk management plan. The organisation's quality improvement statement is noted. A mission statement and philosophy is identified. The mission statement is to provide a 'warm loving environment where care is individualised, flexible and genuine where goals can be achieved and dreams realised through support, empathy and experience'. The organisation's philosophy includes assisting residents to maintain independence, is recovery focused, culturally sensitive, and encourage residents to be actively involved with decision making. There are documented nursing objectives and organisation goals and objectives. The nurse manager advises he reviewed this document in October 2013. The nurse manager reports the director (who is also the owner) was also involved with reviewing the business plan.

The NM advises communication with the director occurs verbally when on site and also via email. Examples of emails sighted for the period 30 August 2013 to 30 October 2013 demonstrates regular email communications on topics including (but not limited to): staff name badges, repairs and maintenance, updates on individual residents changing care needs (including admission to hospital), required supplies/consumables for ordering enquiries, photographing a new resident for the medication profile. The nurse manager reports that monitoring of the organisation's performance also occurs via the internal audit process.

The NM advise the director is on site most days (including weekends). The owner is responsible for developing the staff roster, payroll, and ensuring maintenance is undertaken as required. The director is unable to be interviewed at audit as she has taken urgent unscheduled leave. The nurse manager confirms working with the director ensuring implementation of the quality and risk programme and ensuring the day to day care needs of residents are being met.

The nurse manager is a registered nurse. He trained as a RN in 1994 in the Philippines and qualified as a registered nurse in New Zealand in 2007. The nurse manager holds a current practising certificate with an expiry of 30 June 2014 (sighted). The nurse manager is employed Monday, Tuesday and Thursdays and is employed for 25 hours per week. The NM is also on call 24 hours a day and 7 days a week (24/7). The two caregivers and cook interviewed confirm the NM is on call and is contactable when required. The nurse manager has worked in aged care facilities since November 2009 and has held the role of clinical manager and charge nurse prior to employment at ESRH.

The nurse manager attends relevant ongoing education including the managers training day held at Waitemata DHB on 13 August 2013 and the ADHB aged related care forum on 23 April 2013. The NM has attended training on interRAI, 'urology 101', infection prevention and control, 'first do no harm' and the Privacy Code in the last year. The requirements of the ARRC contract 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 1.2.3 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

There is a documented quality and risk plan which includes a quality policy statement and goals and objectives. Efficiency, effectiveness, safety, responsiveness and accessibility are identified as being essential to the quality and risk programme. The goals relate to consumer focus, certification/contractual requirements, staff education/training, human resource management, performance monitoring and risk management. The policy includes the process for managing, implementing and evaluating the effectiveness of corrective actions.

There is a summary of plans/aims for the 2013 year. These include replacing the lounge television, purchase of a new medication trolley, upgrading lounge chairs and purchasing new clinical equipment. These have all been signed as being achieved.

The risk management plan documents the organisation's risks and notes mitigation plans for each risk. The identified risks include clinical/care related risks, documentation risks, security events, incidents / accidents, infections, medication events, legislative compliance, natural disasters, loss of data. staff competency, low occupancy, industrial action, risk to reputation and financial risk. The risk register is noted as being last reviewed on 9 October 2013 by the NM. The NM advises this revised document has been discussed with the director.

There is a control of documents and records policy. This document states the required features for document control. It lists the six manuals that comprise the quality manual system. All policies held in the manuals are reviewed annually by the external consultant. All required policies and procedures required to meet the ARRC contract are present. Changes to policies and procedures are emailed from the external consultant to the NM who then reviews the ESRH manual and makes the changes. The manual review form present at the front of each folder is signed off and identifies the changes made. The NM advises staff are informed of changes to policies and procedures via staff meeting and staff are required to review and sign the documents to verify they have been reviewed. This process is sighted to be implemented during audit. As an example six staff have signed they have reviewed the revised quality and risk plan. The obsolete policies have documentation across the entire page noting the policy has been updated and the old policy is folded in half. The NM advised these folded (obsolete policies) will be filed in a separate folder at the end of each year.

A resident satisfaction survey has been undertaken in October 2013. All residents were offered the survey and the residents and known family members. To date there have been eight responses and the survey is still in progress. The NM has started to analyse the feedback received to date and activities, food services and the standard of cleaning are areas where the residents are suggesting improvements can be made. The family member who has completed the survey provides a very positive response about services provided The NM identified he will discuss these issues and the follow-up plan at the staff meeting scheduled for November 2013. At audit the four residents and the two family members interviewed advised they are satisfied with all aspects of services provided and no concerns are raised.

There is an organisation audit calendar which identifies the audits to be undertaken each month for 2013. All required audits have been noted on the calendar as having been completed and a summary of the results noted for quick reference. There are documented targets for compliance which are noted as quality indicators. A review of the following audits identified:

- resident admission audit (April 2013): 100% compliance

- complaints (May 2013):100% compliant. Notes new forms have been developed.

- resident care (June 2013): 95.23% complaint

- medication (July 2013): 95.45% compliant

- food service (August 2013): 99.4% compliant

Corrective action plans are developed where areas for improvement are identified and are implemented. There is a comparison summary which notes the changes (positive or negative) since the past audit and likely rationale.

Staff meetings are held monthly and minutes of meetings held in August 2013, September 2013 and October 2013 demonstrates discussion has occurred on individual residents changing care needs, new staff, cleaning of resident’s rooms, infections, documentation, audit results, use of restraints, complaints, occupancy, and reported events. Three staff interviewed confirm they get feedback every month on these quality and risk issues. The staff are able to identify the residents with restraints in use and the residents who are at risk of falling.

ARRC contract requirements are met.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

The accidents and incidents policy is dated as last reviewed 9 August 2013. This policy details what accidents or incidents are the reporting responsibilities as well as follow up actions required.

Three staff interviewed (two HCAs and one cook) and the NM are able to identify their responsibilities in relation to the reporting, investigating and management of incidents. Staff are able to provide examples of the type of events that are to be reported. Staff are responsible for completing incident forms and giving them to the NM. Where a resident has been injured the nurse manager (NM) must be advised. Two of two care staff interviewed confirm the NM is responsive to calls and will come and assess residents if necessary.

All incident reports are reviewed by the NM. Incident reports sighted related to timing of administration of insulin, episodes of challenging behaviour, resident falls, and a resident absent without notifying staff verifies that these events have been reported, investigated and corrective action plans implemented. One resident has been discharged from the facility due to ongoing challenges with managing behaviour.

There are monthly incident summary reports sighted which detail the number of reported events via category (accident/injury, wandering, challenging behaviour, skin tears, falls and medication events). The time incidents occur are also noted and there are no consistent timeframes in the three months data sighted. Episodes of challenging behaviour are the most frequently reported events. One resident had five falls in September a review of the resident's file demonstrates care plans have been reviewed and updated in response to these events.

The number and types of incidents are communicated to care staff on at least a monthly basis via staff meeting and verified in meeting minutes sighted (August 2013, September 2013 and October 2013). The staff at interview confirm that where events/incidents occur, these are documented in the residents notes and also handed over to the next shift during handover. The NM advises reporting of incidents is routinely occurring with relevant events being reported in a timely manner. At audit there is no evidence that events are not reported. The area identified as requiring improvement at the last audit now meets the criterion. The staff advise the residents family must also be informed. Two of two family members advise staff always phone and advise them of any incidents in a timely manner.

The NM advises there have been no essential notifications since the last audit with the exception of resident admissions, discharges and deaths being routinely reported to the Ministry of Health. The NM is able to identify that outbreaks, significant complaints, unexpected deaths of residents and serious harm events would be reported as an essential notification.

ARRC contract 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:** FA

There are documented policies and procedures which provide the framework for recruitment and human resources managements. All four staff files reviewed at audit contain job descriptions, a signed code of conduct and evidence of completing the organisation's orientation programme. Records related to interviews and reference checks are sighted in all the staff files. The nurse manager has a practising certificate on file. There is a copy of the annual practising certificate of the two general practitioners, two pharmacists, podiatrist and two physiotherapists. The drivers licence for the three staff that drive the facility are on file and are current. The area identified as requiring improvement at the last audit now meets the criterion.

There is a staff induction/orientation programme. The document is a competency based programme included with checklists for sign off by the NM and orientation buddy. The document describes a procedure to be followed and states that minimum allowance for buddy time is 14 hours. One caregiver interviewed commenced employment four months prior to audit. The caregiver states her orientation was initially with the NM and included an orientation to the facility, each resident and the resident's care needs, policies and procedures and emergency procedures. The caregiver then works buddied shifts with a senior caregiver for each shift they will be working. The caregiver confirms being satisfied the orientation safely prepared for the role and responsibilities. Records verifying staff have completed the orientation programme sighted in all four staff files reviewed at audit.

There is a staff in-service education policy which is dated as reviewed in May 2013. The policy has five stated objectives for staff training and includes:

- providing resources and opportunities for staff in an environment that encourages good practice

- ensuring staff are fully conversant with the contents of the quality assurance manuals

- to ensure staff understand their responsibilities and duties.

- to enhance staff ability and give staff confidence to deliver good care

- ensuring staff caring for residents have specific education in relation to the care of the older person

There is a two yearly training plan which includes a list of training required to meet the requirements of the Health and Disability Service Standards and the Aged Related Care Contract. the education required for 2013 has been identified and scheduled with in-services occurring each month. These are a component of the staff meeting. The following are examples of some of the education provided at ESRH in 2013:

- February 2013 - managing challenging behaviours: nine staff attended

- March 2013 - restraint minimisation and infection prevention and control: nine staff attended

- April 2013 - Documentation: eight staff attended

- May 2013 - Sexuality and intimacy: ten staff attended

- June 2013 - Medication: ten staff attended

- July 2013 - complaints, client rights, and abuse and neglect: eight staff attended

- August 2013 - Fire evacuation: eight staff attended

- October 2013 - Epidemic / pandemic and civil defence emergencies: Six staff attended.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

The organisation has a 'good employer policy' which has been reviewed in 2013. This policy details staffing numbers and skill mix and details the requirements of the ARRC contract. The roster sighted is dated for the period 14 October 2013 to 27 October 2013. The current roster could not be located at audit. The two caregivers interviewed confirm the roster for the previous week has been rolled over to the current week. The HCA advises she had been phoned and informed by the director earlier in the week and is on site working a shift that is not part of the HCA's normal shift allocation.

The roster identifies there registered nurse (RN) is rostered to be on site three days a week and is on call when not on site. The director (owner) is also rostered on site every day for a minimum of three hours but HCAs advise is often present longer.

The activities coordinator is on site two days a week. There are dedicated hours for the cook each day.

There is a minimum of one HCA on duty at all times. There is a second HCA on duty for peak morning and afternoon periods and includes night staff working until 9.00 am (working a 10 hour shift). All caregivers have a current first aid certificate and these are sighted.

The two HCAs interviewed confirm the staffing is sufficient for their roles and responsibilities and the HCAs work as a team. The area identified as requiring improvement at the last audit now meets the standards. Caregivers are responsible for undertaking all cleaning activities and laundry services.

ARRC contract 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:**

**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

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 three of three residents' files reviewed 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. Caregivers provide most of the direct care guided by the care plan and under the direction of an RN. The care staff are suitably experienced and encouraged to complete the Careerforce qualifications if they do not have a national qualification. The nurse manager/registered nurse (RN) is a Careerforce assessor. Annual practicing certificates are sighted for all staff that require them.

The initial and ongoing assessments include bowel, mobility, sleeping, personal cleansing and dressing, skin, pain, falls risk, mental function, behaviour, communication, social, leisure, activities and interests, spirituality and culture, sexuality, medication reconciliation. The additional assessment tools include falls risk, pain chart, dietary profile and continence assessment. The three of three residents' files evidence that the long term care plan is based on the assessed needs of the resident. The ongoing long-term care plan is recorded on a standardised template that is individualised to the resident's needs. The care plan identifies the need, assistance required, special instructions and goals. The ongoing care plan evaluation is conducted at least six monthly and used to form part of the multidisciplinary review, confirmed in the three of three residents' files reviewed.

The three of three residents' files evidence the initial medical review is conducted within two days of admission (where required). Ongoing medical reviews are conducted at least monthly, as confirmed in the three of three residents files reviewed.

The service is co-ordinated in a manner that promotes continuity of care. Progress notes are updated at least daily (confirmed in the three of three residents' files reviewed). A handover is provided at the start of each shift, the two of two caregivers interviewed report that adequate information is provided at the verbal handover, on the written handover sheet and in resident progress notes.

The four of four residents interviewed and two family/whanau report the residents receive care that meets their needs. The residents and family members interviewed all commented that it is like being part of an extended family home.

Tracer example: Rest home resident

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

The ARRC requirements for rest home level of care 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 1.3.6 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 three of three long term care plans reviewed have interventions based on the residents' needs. The service has paper based assessment and care planning records. The nurse manager has completed InterRAI training. The ongoing care plan records the identified need, level of assistance required and desired outcomes or goals that are individualised to the resident’s needs. One resident file reviewed has the appropriate interventions for skin management, pain and pressure relieving interventions recorded on the care plan. One of the other resident's file reviewed has an additional nursing care plan for alcohol-related issues. The interventions related to resident safety, safety of others, depression/anxiety and the use of the phone are recorded on the care plan.

The two of two caregivers interviewed report the care plans provide accurate information regarding the individual needs and care required for the residents. The four of four residents and two family/whanau interviewed report satisfaction with the care provided.

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:** FA

The nurse manager reports that the activities coordinator has recently resigned, with the nurse manager (RN) and caregivers running the activities programme in the interim. The activities attendance sheets evidence that the activities programme has continued since the absence of the activities coordinator. Activities assessments are sighted in the three of three residents' files reviewed. The activities assessments and plans are incorporated in to the long term care plan, as sighted in the residents' files reviewed, evidence shows they are up to date and reflect individualised needs of the residents. The activities assessments include social pursuits, intellectual interests, creative pursuits, physical activity and outdoor interests. The goals are updated and evaluated in each resident's file at least six monthly with care plan reviews and multi-disciplinary reviews. The nurse manager reports where residents have a specific need, the service endeavours to provide the resources for this. There is a group of male residents who have a weekly coffee club outing. The service also has a weekly friendship group from a community group that meets at the service for recreational activities with the residents.

The activities are individualised and developed in conjunction with the resident and where appropriate their family. A monthly activities plan (sighted) is developed based on the resident’s needs, interests, skill and strengths. The activities cover cognitive, physical and social needs. For variety, there is a theme for each month with community events that are occurring locally included in the programme. The service has a number of residents who independently access activities in the community. Residents are also able assist with the grounds maintenance, (eg, raking), with the resident interviewed who was raking leaves at the time of report stating that they get great enjoyment and satisfaction from doing 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. There are volunteers who visit the residents for one to one socialisation.

The four of four residents interviewed report they are satisfied with the range and variety of planned activities. All the four residents report that they also go to activities in the community, with one reporting that one of the staff is taking a group of the residents to the local Indian festival.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

The three of three residents' care plans reviewed evidence evaluations are recorded at least six monthly by the manager (RN), with input from the GP, the resident, the family and care staff. The documented evaluations indicate the resident's progress in meeting goals, and there is a multidisciplinary review, a re-assessment and the care plan is updated to reflect progress towards meeting goals. The three of three 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 two 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. One resident file reviewed has a short term care plan for an infection.

The four of four residents and two of two family/whanau interviewed report involvement in the evaluation process and are satisfied with the care provided. All commented on feeling like part of a family.

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

Medicines for residents are received from the pharmacy in the Douglas Pharmaceutical Medico Pak delivery system. The signing sheet that records the medicines are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or hospital admission. The pharmacist conducts a six monthly reconciliation of the medicines, this is last conducted in October 2013. A safe system for medicine management is observed on the day of audit.

Medicines are stored in locked medicine trolleys and in the locked treatment room. There is a monthly stock rotation recorded for the medicines that are not packed in medico packs (record sheet sighted). The service's medicine fridge is monitored at least weekly and temperatures are within recommended guidelines. There are no residents on controlled drugs.

The 10 of 10 medicine charts reviewed are reviewed by the GP in the last three months, this is recorded on the medicine charts. All prescriptions sighted contain the date, medicine name, dose and 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. One of the first six medicine files reviewed had a medicine chart with some medicines ordered not individually signed by the GP (addressed at the time of audit), with the previous medicine chart recording that all the medicines are signed. This is a one off incident and not indicative of a systemic issue. The sample size was increased to 10 medicine charts, with all of the nine medicine files having all medicines ordered signed by the GP.

There are documented competencies sighted for the staff designated as responsible for medicine management. The medicine competencies include insulin administration.

The nurse manager reports that no residents are 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 (sighted).

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 three week rotating menu, with seasonal variations, is approved by a registered dietitian in August 2012 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 cook also reports that the menu is also flexible, with resident input. The cook reports that at times the residents request special meals or have recipes that they would like cooked and this is worked into the menu where possible.

Interviews with four of four residents confirm they are overall happy with the food provided.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. The cooks have current food safety qualifications. Fridge and freezer recordings are observed daily and recorded at least weekly, the sighted readings are within food safe guidelines. All foods sighted in the freezer are in their original packaging or labelled and dated if not in the original packaging.

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 1.4.2 Facility Specifications**

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

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

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

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

There is a building warrant of fitness with an expiry date of 29 September 2013. The ongoing checks to maintain the building warrant of fitness are being undertaken and records sighted. The responsibility for these checks have been contracted out to an external company.

Biomedical equipment has evidence of performance monitoring. Electrical safety test and tagging remains an area requiring improvement.

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

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

There is a building warrant of fitness with an expiry date of 29 September 2013. The ongoing checks to maintain the building warrant of fitness are being undertaken and records sighted. The responsibility for these checks have been contracted out to an external company.

Biomedical equipment has evidence of performance monitoring and is last done in October 2013. The NM advises the external company will be undertaking rechecking of these devices in the next two weeks. The need for biomedical testing is noted on the NM office whiteboard on arrival for the audit. A new tympanic thermometer and new electronic blood pressure machine have been purchased in 2013 and both are sighted. Electrical safety test and tagging remains an area requiring improvement. There are a number of pieces of equipment including heaters, lamps, entertainment equipment which are noted to be overdue for electrical test and tagging or this has not been completed.

**Finding Statement**

A number of electrical appliances have not undergone electrical safety testing or it is overdue.

**Corrective Action Required:**

Ensure electrical appliances undergo test and tagging in a timely manner.

**Timeframe:**

Six months.

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The previous CAR at 2.1.1.5 was made to ensure education covers the services enabler use policy and procedures. This is now addressed and an improvement since the last audit. The education records sighted evidence that the restraint education conducted in March and May 2013 covers the services enabler use policy and procedures. The two of two caregivers interviewed demonstrate knowledge of enabler use.

The service has no residents assessed as requiring enabler use and two residents assessed as requiring restraint use (bed rails). The two of two caregivers interviewed confirmed there are no enablers in use at the time of audit, and the two residents with bed rails requires this for their safety. The nurse manager and two of two caregivers confirm that if enablers are used, these will be voluntary and the least restrictive options to meet the need of the resident.

The service has a key coded lock at the front door that the residents have consented to have in place. The code for the door is displayed at the key code panel and residents are observed at the time of audit to freely come and go through the front door using the key coded lock. There are multiple other entrances and exits for the building. The four of four residents interviewed report they are free to come and go from the building and that the key coded front door does not restrict their freedom.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.5 Surveillance**

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

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

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

The nurse manager identifies the surveillance for residents with infections is occurring. The surveillance programme includes:

- respiratory tract infections

- urinary tract infections

- skin and wound infections

- eye infections

- gastroenteritis

- scabies

- monitoring the use of antibiotics.

Two of two HCAs interviewed confirm being required to report to the NM any concerns they have about a resident developing an infection. This includes changes in the appearance of wounds, discharge, offensive or discoloured urine, skin rashes and changes in behaviours and mental status.

The caregiver advises when infections are confirmed this information is provided to oncoming staff at the next shift and noted in residents' progress notes. Short term care plans are developed as required. This is verified by the second auditor in a review of the resident's file. Another resident is noted to have short term care plan developed for cellulitis of the leg, possible scabies and dysuria. All care plans have subsequently been evaluated verifying the effectiveness of the provided treatment.

Infection rates are reported by the NM monthly at staff meetings as verified in the staff meeting minutes sighted for August 2013, September 2013 and October 2013. The reported infections for August 2013 include conjunctivitis, one urinary tract infection and three wound infections. The reported infections for September 2013 include a wound infection, three fungal infections and two residents with a urinary tract infection. The reported infections for October 2013 include five residents with respiratory infections, and one other resident infection. The cluster of respiratory infections is noted in the evaluation and commentary noted on potential contributing factors.

The surveillance programme is appropriate to the organisation's size and service setting.

**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:**