**Beetham HealthCare Limited**

**Current Status:** **03-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**

Beetham Healthcare provides rest home, hospital and dementia level care for up to 42 residents with an occupancy of 34 on the day of the audit (5 dementia,13 hospital and 16 rest home level care residents).

This audit identified that the service has addressed shortfalls identified at previous certification audit around the complaints register, the hazard register, initial staff appraisals, staff education, advanced directives, providing dementia specific information, staff orientation, medicine management, hot water temperature monitoring, provision of seating and shade outdoors and a staff member being on duty with a current first aid certificate. Also resolved are meeting timeframe targets around initial assessments (including GP assessments), development of initial care plans, GP reviews, review of risk assessments and long and short term care plans, long term care plans including all relevant issues, activities plans, wound dressings and reviews, restraint and infection control practices.

There continues to be improvements required around notifying families of events, communicating quality data to staff and development of care plans.

This audit identified that improvements are required around, assessments, completion of care plans and their evaluation, evaluation of short term care plans, medication management, communication with family, staff orientations, staff appraisals, corrective actions plans and restraint documentation.

**Audit Summary AS AT** **03-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  03-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Organisational Management** | Day of Audit  03-Oct-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit  03-Oct-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit  03-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  03-Oct-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Infection Prevention and Control** | Day of Audit  03-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** |

**Beetham Health Care**

Beetham Health Care Limited

Surveillance audit - Audit Report

Audit Date: 03-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Beetham Health Care Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Beetham Health Care | Margaret Place | Lytton West | Gisborne |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 03-Oct-13 **End Date:** 03-Oct-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXXX | RN, Auditor Certificate | 8.00 | 5.00 | 03-Oct-13 |
| Auditor 1 | XXXXXXXX | RN, Auditor certificate | 8.00 | 4.00 | 03-Oct-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX |  |  | 2.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 16.00 | **Total Audit Hours off site** *(system generated)* | 11.00 | **Total Audit Hours** | 27.00 |
| **Staff Records Reviewed** | 6 of 30 | **Client Records Reviewed** *(numeric)* | 6 of 34 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 6 |
| **Staff Interviewed** | 7 of 30 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 4 |
| **Consumers Interviewed** | 5 of 34 | **Number of Medication Records Reviewed** | 12 of 34 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

# Declaration

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

I confirm that Health and Disability Auditing New Zealand Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 14 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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Beetham Health Care | 42 | 34 |  | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Beetham Healthcare provides rest home, hospital and dementia level care for up to 42 residents with an occupancy of 34 on the day of the audit (five dementia,13 hospital and 16 rest home level care residents).

This audit identified that the service has addressed shortfalls identified at previous certification audit around the complaints register, the hazard register, initial staff appraisals, staff education, advanced directives, providing dementia specific information, staff orientation, medicine management, hot water temperature monitoring, provision of seating and shade outdoors and a staff member being on duty with a current first aid certificate. Also resolved are meeting timeframe targets around initial assessments (including GP assessments), development of initial care plans, GP reviews, review of risk assessments and long and short term care plans, long term care plans including all relevant issues, activities plans, wound dressings and reviews, restraint and infection control practices.

There continues to be improvements required around notifying families of events, communicating quality data to staff and development of care plans.

This audit identified that improvements are required around, assessments, completion of care plans and their evaluation, evaluation of short term care plans, medication management, communication with family, staff orientations, staff appraisals, corrective actions plans and restraint documentation.

1.1 Consumer Rights

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service, continually, and as required. Information specific to the dementia unit is included in the information pack provided to residents an families. Family are involved in the initial care planning, at care plan review and receive and provide on-going feedback. Regular contact is maintained with family including when a change in residents health status occurs. However this audit identified that there a continuing improvement required around informing families following an incident/event. Advance directives were evidenced to have been completed correctly.

There is a complaints register which is current. The service has documented complaints and there is evidence of follow up.

1.2 Organisational Management

The quality process being implemented includes regularly reviewed policies, an internal audit programme, education programme and a health and safety programme that includes hazard management. The service uses a quality programme provided by an external quality consultant who provides regular updates. Review of policies and procedures is completed by the quality coordinator on consultation with the CEO, clinical services manager, staff and external quality consultant. Quality data gathered includes the use of comprehensive forms. Data is collated monthly and trends identified. Corrective action plans, implementation of plans and solution occur when trends are identified. This audit identified improvements required around discussion of quality data and corrective action plans. Therefore there are improvements required in these areas. There is an implemented annual education programme for all staff. Staff training records are maintained. There are comprehensive human resource/ management policies and staff files reviewed evidence completed reference checks, job descriptions, evidence of orientation and training, employment agreements and initial and annual appraisals. This audit identified that an improvement is required around staff orientations and staff appraisals being completed in annual timeframe. There is an current hazard register.

Staff and residents interviewed report that staffing levels are sufficient.

1.3 Continuum of Service Delivery

Beetham Health Care has a comprehensive information pack that is given to all inquiring residents and their families. Since the previous audit, Beetham Health Care reviewed their information pack and included dementia specific information. The packs are provided to current and potential consumers.

Assessments and care plans are developed by registered nurses and they are competent to perform their role. The Clinical services manager oversees the coordination of the services and there is a registered nurse cover 24 hours a day/ 7 days a week. Registered nurses support the dementia unit. Progress notes are recorded for all shifts. Corrective actions required around initial assessments and timeframes of service delivery plans have been addressed but there are still improvements requiring around care planning and care plan evaluations. Resident and families interviewed were complimentary of care received at the Beetham Health Care and confirmed their input in the development of care planning. There is documented evidence of a GP review at least three monthly and on an as required basis. There was evidence of an initiation of a short term care plan where there were changes in the residents health status and the required interventions were implemented. There is an improvement required around the evaluation of short term care plans.

Medication is checked on delivery by the night staff and stored in the medication rooms. Registered nurses and medicine competent health care assistants administer medication. Although corrective actions from the previous audit were addressed, there are further improvements required around medication management system.

The main kitchen is clean and well maintained. There is a daily cleaning schedule, food temperatures fridge / freezer temperatures, and delivery checklists. Resident and families interviewed praised the food services and variety of food served.

1.4 Safe and Appropriate Environment

The building has current warrant of fitness that is valid until 9 July 2014.

Hot water monitoring occurs regularly and maintained around 45°C. This is an improvement from the previous audit. Staff records including staff with current first aid certificate and the roster reviewed showed that there is a staff member on duty at all times with a current first aid certificate.

2 Restraint Minimisation and Safe Practice

There are implemented policies and procedures related to restraint minimisation and safe practice. Staff receive on-going training on restraint minimisation and safe practice, and have current restraint competencies.

There are currently six residents requiring the use of a restraint (bedrails). There are four residents who have requested the use of an enabler (bedrail).

Completed assessment, consent forms for the use of restraint/enabler and monitoring forms were evidenced completed in residents files reviewed. There is an improvement required around the use of restraint being documented in resident care plans.

3. Infection Prevention and Control

Infection surveillance is an integral part of the infection control programme and is described in Beetham Health Care’s infection control and surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. Infections are discussed at monthly health and safety meetings, monthly quality meeting and bi monthly staff and clinical meetings

Summary of Attainment

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* 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 | PA Moderate | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 1 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:9 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 1 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:1 UA:0 NA: 0 |

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Moderate | 0 | 6 | 2 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 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: 3 PA Neg: 0 PA Low: 1 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:14 PA:3 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 | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | PA Moderate | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | PA Moderate | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Moderate | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Moderate | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:4 CI:0 FA: 3 PA Neg: 0 PA Low: 0 PA Mod: 5 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:11 PA:5 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 1 | 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:6 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 36): CI:0 FA:4 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 | PA Low | 0 | 0 | 1 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 1 CI:0 FA: 4 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:0 FA:5 PA:1 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 | 2 | 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:4 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 25 **CI:** 0 **FA:** 16 **PA Neg:** 0 **PA Low:** 2 **PA Mod:** 7 **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:** 42 **PA:** 10 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Beetham Health Care Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:03-Oct-13 End Date: 03-Oct-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.9 | 1.1.9.1 | PA  Moderate | **Finding:**  Five of seventeen incident accident forms reviewed did not document family had been informed of the incidents/accidents. There was no evidence of family contact being documented in progress notes or on family communication charts in five files reviewed. As this was a shortfall identified at previous certification audit the risk rating has been increased to reflect that continuing improvement in this area is required.  **Action:**  Ensure family notification is recorded following a resident event. | 3 months |
| 1.2.3 | 1.2.3.6 | PA  Low | **Finding:**  Meeting minutes reviewed did not consistently evidence discussion of corrective actions arising from completed internal audits.  **Action:**  Ensure meetings minutes include discussion around corrective actions identified from completed audits. | 3 months |
| 1.2.3 | 1.2.3.8 | PA  Low | **Finding:**  Signed close off of corrective actions identified from completed audits were not consistently documented.  **Action:**  Ensure that corrective actions are signed and dated when completed. | 3 months |
| 1.2.7 | 1.2.7.3 | PA  Low | **Finding:**  Completed orientation programmes were not evidenced in two of seven files reviewed. (ii) one staff appraisal had not occurred within the annual timeframe.  **Action:**  Ensure completed orientation for staff are held on file. (ii) ensure that staff appraisals are completed within the agreed timeframe. | 6 months |
| 1.3.3 | 1.3.3.3 | PA  Moderate | **Finding:**  Six files reviewed on the day of audit evidenced timeframes for re- assessments and the completion of long term care plans are not adhered to. Initial assessments are completed on admission but six monthly re assessments are not completed /documented. Three out of six files reviewed showed that long term care plans are not developed within specified timeframes. These three residents did not have a care plan in place. A further two hospital files checked showed that long term care plans are not developed within three weeks of admission. These shortfalls were identified in the previous audit but have not been addressed.  **Action:**  Ensure long term care plans are developed within three weeks of admission and reviewed six monthly or sooner if clinically indicated | immediately -one month |
| 1.3.5 | 1.3.5.2 | PA  Moderate | **Finding:**  The results obtained from completed assessments were not reflected in the interventions documented in care plans.  **Action:**  Ensure the results of assessments completed are reflected in resident care plans and interventions meet resident needs. | 3 months |
| 1.3.6 | 1.3.6.1 | PA  Moderate | **Finding:**  1) Two files reviewed (one dementia and one hospital) evidenced that care plan interventions were not consistent with residents assessed needs particularly around mobility and falls risk interventions. Beetham Health Care uses computer generated care plans that are generic. The care plan format prompts staff to consider several options however this is required to be deleted if it is not appropriate. The care plans reviewed evidenced interventions documented were not specific for example; (1) it was not clear if a resident required a walking frame or wheelchair or hoist transfer only. 2) None of the files reviewed had a documented multidisciplinary review. These are planned to take place annually.  **Action:**  Ensure that care plan interventions are clear and meets the residents assessed needs.2) Ensure that multidisciplinary reviews take place as scheduled. | 3 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.8 | 1.3.8.2 | PA  Moderate | **Finding:**  Evaluations were not completed in two of six care plans reviewed. Evaluations of short term care plans were not evidenced completed.  **Action:**  Ensure that care plan reviews/evaluations are completed. (ii) Ensure that short term care plans are evaluated to assess effectiveness of meeting the goal/outcome. | 3 months |
| 1.3.12 | 1.3.12.1 | PA  Moderate | **Finding:**  There are several issues that identified required improvements. 1) On arrival to the service, one of the auditors observed that the RN was administering morning medications and left the medication trolley unattended and unlocked for a considerable period of time. 2) All residents maintain their own GPs and this creates challenges around prescribing. Most medication charts are faxed several times to the GP clinics and a faxed copy is kept in the medication folder. 10 out of 15 charts reviewed was a faxed copy and three of these charts were very difficult to read. 3) Expired medication were kept on site. 4) Past residents medications were kept on site. 5) Robotic sachets that belong to two residents were opened and one resident had two drugs and the other one had one drug replaced and sachets were sealed with a sticky tape. The replacement of drugs were evident for the rest of the sachets for several days. The RN and the clinical services manager stated that these changes were initiated and completed by the pharmacist.  **Action:**  1 )Ensure the medicine trolley is not left un-attended when administering medication. 2) Ensure medication charts are legible.3) Ensure expired medications are returned to the pharmacy. 4) Ensure deceased/discharged residents medications are returned to the pharmacy. | immediately-one month |
| 2.1.1 | 2.1.1.4 | PA  Low | **Finding:**  One of three care plans reviewed of residents requiring the use of a restraint did not document the need for restraint and interventions to guide staff in the delivery of care. However and assessment, risk questionnaire and restraint/enabler consent form were evidenced in place for this resident and staff were monitoring the restraint when in use therefore the risk to the resident was reduced and the risk rating has been assessed as low. The care plan was updated on the day of audit to reflect the residents needs around the use of restraint.  **Action:**  Ensure the use of restraint and appropriate interventions to guide staff are documented in residents care plans. | immediately- one month |

# Continuous Improvement (CI) Report

Provider Name: Beetham Health Care Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:03-Oct-13 End Date: 03-Oct-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.9 Communication**

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

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

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

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

The audit team were requested by Health Cert to review pain management and effective communication, as issues were identified in the letter dated 24 May 2013.

Discussions with five residents and four family members all stated they were welcomed on entry and were given time and explanation about services. Resident/relative meetings occur bi-monthly (Minutes of meetings sighted).

E4.1biii.There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

The clinical services manager and quality coordinator have an open-door policy.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

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

D16.4b Four relatives stated that they are always informed when their family members health status changes. However a review of incident forms from September 2013 identified that relatives are not consistently informed of resident events, therefore an improvement is required.

D 13.3 Six files reviewed included completed admission agreements.

Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry.

D11.3 The information pack is available in large print and advised that this can be read to residents.

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs.

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

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

Twelve incident/accident forms documented family notification of the events.

**Finding Statement**

Five of seventeen incident accident forms reviewed did not document family had been informed of the incidents/accidents. There was no evidence of family contact being documented in progress notes or on family communication charts in five files reviewed. As this was a shortfall identified at previous certification audit the risk rating has been increased to reflect that continuing improvement in this area is required.

**Corrective Action Required:**

Ensure family notification is recorded following a resident event.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

Resuscitation forms reviewed in six resident files. Resuscitation forms in two hospital and one rest home residents’ files were evidenced to be signed by the resident. Three dementia files evidenced the GP had signed that residents were not competent to make an informed decision regarding resuscitation; the residents are therefore for resuscitation.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

D13.3h.The service has complaints management policies and procedures in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack.

D13.3g: The complaints procedure is provided to relatives on admission as confirmed by five family interviewed.

Staff including the two registered nurses (RNs), three health care assistants, one cook and diversional therapist interviewed are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau.

Residents and family confirm they are aware of the complaints process and they would make a complaint to the clinical services manager if necessary.

E4.1biii.There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

There is a complaints register in place. The previous audit identified that close out dates of complaints were inconsistently recorded. This shortfall has been addressed as the complaints register reviewed documented actions taken and close out dates of complaints.

The service has received seven complaints to date in 2013. Seven complaints tracked indicate that the issues and responses are addressed as per timeframes in the policy. A letter from HDC dated 14-May-13 was sighted and stated further action not substantiated regarding a complaint received.

**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 philosophy is documented and this is included in the welcome pack.

There is a Business, Strategic and Quality Plan for 2013. Beetham is managed by a CEO (qualified RN). The CEO has previously owned an aged care service and has significant experience in the strategic management of aged care facilities. The CSM (RN) has been in this role since 2012 and reports to the CEO. The CSM is supported by a quality coordinator (RN) who has previous experience in clinical and facility management roles. The reporting structure includes CSM to the CEO who in turn reports to the Board.

There are two monthly management meetings and operational meetings.

The service provides rest home, hospital and dementia level care for a potential 42 residents with an occupancy of 34 on the day of the audit which included five dementia,13 hospital and 16 rest home level care residents.

ARC,D17.3di (rest home, hospital), The Clinical Services Manager has maintained more than eight hours annually of professional development activities related to managing the service.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that there are service operational management strategies and an implemented quality and risk programme which includes individually appropriate care.

The previous audit found that the policies and procedures which has been purchased from an external aged care management consultant (which were newly implemented at that time) had not been personalised to reflect the actual practices which were occurring at Beetham. This shortfall has been addressed and policies and procedures have been reviewed to reflect current practice at Beetham.

The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning and these are reviewed annually to two yearly with updates being provided by the external management consultant. All policies are current. There is a document control process in place for all policies.

D5.4 The service has the following policies/ procedures to support service delivery; continence, challenging behaviour, pain management policy and procedure, personal grooming and hygiene policy, skin, wound care policy and procedures. transportation of subsidised residents policy and procedure includes costs, resident, and staff safety.

D10.1 There is a death policy and procedure that outlines immediate action to be taken upon a resident death and that all necessary certifications and documentation is completed in a timely manner.

D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies. There is a member of staff on duty on each shift who holds a current first aid certificate.

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

D19.2g Falls prevention strategies such as low beds, use of hip protectors, exercise programme, sensor mats and increased supervision are used in the service as described by the clinical service manager, two registered nurses and three health care assistants interviewed. Individual risks are identified in care plans.

The three health care assistants interviewed state that any new health care assistant receives an orientation that includes reading of the policies and orientation records signed off in five of seven staff files reviewed. (link to #1.2.7.3)

Beetham is implementing an internal audit programme with corrective actions being documented on the audit sheet. Signed close out of corrective actions completed was not consistently documented in two of eleven audits reviewed. Meetings minutes reviewed did not consistently evidence discussion of corrective actions arising from internal audits. Continuing improvements are required as these shortfalls were also identified at previous certification audit.

There is a meeting structure that enables communication. The staff meetings and clinical meetings alternate monthly. There are monthly health and safety/infection control meeting and a monthly quality meeting. There is a restraint approval meeting six monthly. The set agenda ensures that all aspects of the quality and risk programme are discussed i.e. infections and infection control, complaints, incidents and accidents, staff, resident issues.

There is a maintenance schedule completed annually and this includes documentation of maintenance completed in 2013.

There is a risk management register and hazards documented. A review of these indicate that these are signed off when resolved. A list of current hazards is kept with actions implemented to proactively prevent accidents. This is an improvement implemented following a finding at certification audit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

An internal audit programme is occurring. The internal audit programme includes monitoring of: hand hygiene, manual handling, clinical documentation, restraint, orientation, complaints, client rights, laundry and managing waste. Audit recommendations are documented on the audit sheet - there is inconsistency in terms of closing out resulting corrective actions (refer 1.2.3.8). Trends are reported back to staff via the quality, clinical meetings and staff meetings.

**Finding Statement**

Meeting minutes reviewed did not consistently evidence discussion of corrective actions arising from completed internal audits.

**Corrective Action Required:**

Ensure meetings minutes include discussion around corrective actions identified from completed audits.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

There is an internal audit schedule. A range of audits have been undertaken in 2013 including: resident admission procedure, care plans, consent, education and training, fire safety, activities, cleaning, laundry, food service, wound care and complaints. There is a form recording corrective actions which is completed in two of eleven internal audits completed. Signed close out of corrective actions is not evidenced to be consistent.

**Finding Statement**

Signed close off of corrective actions identified from completed audits were not consistently documented.

**Corrective Action Required:**

Ensure that corrective actions are signed and dated when completed.

**Timeframe:**

3 months

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

D19.3b; There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

Incidents/accidents are investigated and analysis of incidents trends with graphs documented occurs monthly. There is a discussion of incidents/accidents in staff meetings, clinical meeting, management meetings and quality meetings.

Seventeen incident forms for September 2013 were reviewed which included 4 falls with injury, 7 unwitnessed falls, 1 skin tear, 2 challenging behaviour and three other e.g. resident not happy with breakfast. Incident/accident forms document any emergent treatment (where appropriate), RN assessment and any preventative measures that could be implemented to prevent reoccurrence. However incident/accident forms do not identify if contact with family has been made to advise of the event. (link to #1.1.9.1)

Discussions with the clinical service manager and quality coordinator (RN) confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

There is an open disclosure policy and family members interviewed stated they are informed of changes in health status.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

D17.7d: There are implemented competencies for all registered nurses around medication and evidence in an registered nurse file reviewed that these have been completed.

Current practicing certificates are sighted for the registered nurses, (including CSM), doctors and podiatrist.

Seven of seven staff files include a signed contract, application form, references, evidence of training and job description.

The HR policy has been reviewed to reflect that a staff appraisal is completed three months following commencement of employment and annually thereafter. This is an improvement implemented following a shortfall identified at certification audit. However there is still an improvement required around the completion of staff appraisals within the agreed timeframes.

Five of seven staff files reviewed indicate that staff have completed an orientation programme that is relevant to support for people using rest home, dementia, and hospital level care. Therefore there is an improvement required around the completion of orientation documentation.

Discussion with the quality coordinator. clinical services manager, two registered nurses and three health care assistants confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements.

There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Education completed in 2013 includes; Fundamentals of palliative care series (hospice), infection control, approach to dementia care, loss and grief, managing complaints, medication management, manual handling, continence management, pressure area care, Elder abuse, diabetes, dementia education, fire training and wound dressing training. Training records include date, session topic and content and names of attendees. Those staff who do not attend training are provided with the hand outs of the education session.

There are nine health care assistants who work in the dementia unit. Two staff have completed the required dementia unit standards and six are currently completing dementia unit standards. Two of the six staff currently completing dementia unit standards have commenced employment within the last six months.

Registered nurses and health care assistants are funded to attend external training.

The clinical service manager and quality coordinator have completed at least eight hours training a year (training records sighted).

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

Five of seven staff files reviewed evidenced completed orientation programmes. Staff appraisals are completed in six of seven files reviewed.

**Finding Statement**

Completed orientation programmes were not evidenced in two of seven files reviewed. (ii) one staff appraisal had not occurred within the annual timeframe.

**Corrective Action Required:**

Ensure completed orientation for staff are held on file. (ii) ensure that staff appraisals are completed within the agreed timeframe.

**Timeframe:**

6 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There are policies, systems and a roster in place that meets the requirements of the contract and supports safe staffing levels for service delivery. There are HR policies in place that outlines staffing responsibilities, staff levels and skill mix.

There is a roster in place that meets the contract requirements - sighted with evidence that staff are replaced if off sick.

There is a registered nurse on each shift 24 hours a day. The CSM is on call 24/7.

Staff interviewed confirm that the roster provides adequate cover.

Both residents and family interviewed confirm there are sufficient staffing levels to meet resident’s needs.

The registered nurses are aware of when to call emergency services.

Roster’s reviewed identified the member of staff on duty on each shift who holds a current first aid certificate.

**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 1.3.1 Entry To Services**

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

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

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

The service has a comprehensive information pack that is given to all inquiring residents or their families. Entry criteria and the access process are clearly defined in the policy and the resident information pack. Since the previous audit, Beetham Health Care reviewed their information pack and included dementia specific information. The packs are provided to current and potential consumers. Therefore the required corrective action from the previous audit has been addressed.

**Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

Assessments and care plans are developed by registered nurses and they are competent to perform their role. The RNs have completed training around the use of clinical assessments such as palliative care, continence management, mobility, wound care, de-escalation and pressure care.

Corrective actions required around initial assessments and medical care provided within identified timeframes are addressed but risk assessments are not reviewed six monthly and long term care plans are not developed within three weeks of admission therefore improvements in these areas continue to be required from the previous audit.

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

A range of assessment tools were completed in resident files on admission (but not limited to); a) falls, b) pressure areas, c) continence, d) nutrition e) pain and f) behaviour assessments.

Staffing level is appropriate. Full verbal hand over between shifts occurs - evidenced on the day of the audit. The clinical services manager oversees the coordination of the services. There is a RN 24 hours a day 7 days a week. There is RN support in the dementia unit. Progress notes were recorded for all shifts. There are discharge letters from the local hospital following a number of different visits – both out-patient and in-patient. Staff interview with two hospital and one dementia health care assistants, and two RNs confirmed that the staff are responsive to residents’ changing health needs. Two files reviewed from the dementia unit included reporting escalation of behaviours of residents and any concerns that they found. Two RNs provided evidence of faxing, emailing and contacting specialist for advice and support when it was appropriate. GP responses were timely. All residents (three rest home and two hospital) and all families interviewed (two dementia and one hospital and one rest home) stated that they were kept informed of changes and actions taken. GPs were not available for an interview on the day of audit.

Tracer Methodology:

Dementia resident

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

Hospital resident

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

Rest home resident

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

D16.2, 3, 4: The six files reviewed (two from each area, rest home, hospital and dementia), identified that in all six files an assessment was completed within 24 hours. Initial care plans are developed within 24 hours of admission. All residents are seen by the GP at least three monthly. Residents are assessed by the GP within 48 hours of admission. These are improvements implemented from the previous audit. Information is gathered from residents, families, GPs, specialists, clinical assessments and referring agency.

**Finding Statement**

Six files reviewed on the day of audit evidenced timeframes for re- assessments and the completion of long term care plans are not adhered to. Initial assessments are completed on admission but six monthly re assessments are not completed /documented. Three out of six files reviewed showed that long term care plans are not developed within specified timeframes. These three residents did not have a care plan in place. A further two hospital files checked showed that long term care plans are not developed within three weeks of admission. These shortfalls were identified in the previous audit but have not been addressed.

**Corrective Action Required:**

Ensure long term care plans are developed within three weeks of admission and reviewed six monthly or sooner if clinically indicated

**Timeframe:**

immediately -one month

**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 1.3.5 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:** PA Moderate

Six resident care plans are reviewed (two dementia, two rest home and two hospital). Care plans include issues/problem and corresponding goals and interventions.

All six files had completed an activities plan. Therefore the corrective action required from the previous audit has been addressed.

Five residents (two hospital and three rest home) and four families (two hospital and two dementia) interviewed were complimentary of care received at the Beetham Health Care and confirmed their input in the development of care planning. This audit identified an improvement required around the results of completed assessments being reflected into the long term care plan interventions.

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

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

Clinical risk assessments tools are completed. All six files had completed an activities plan. Therefore the corrective action required from the previous audit has been addressed.

**Finding Statement**

The results obtained from completed assessments were not reflected in the interventions documented in care plans.

**Corrective Action Required:**

Ensure the results of assessments completed are reflected in resident care plans and interventions meet resident needs.

**Timeframe:**

3 months

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

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

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.- May 2013.

There is no resident requiring wound care in the dementia unit. Wound assessment and wound management plans are in place for seven residents. One of these wounds is a pressure sore which is a chronic wound. The resident was admitted to the service with the wound present. The resident file contains information around specialist input and on-going support from the district health nurses. All wound assessments and wound charts are kept in the separate folder until the wound is healed and then transferred to the individual resident's file. The wound folder reviewed and showed that all wound management plans are up to date including on-going assessments. District health nurse's wound care plan is recorded on the wound management chart and followed up. All wounds are reviewed/dressed within the appropriate time frame. Progress notes also includes notes around specialists reviews and wound healing progress, therefore the corrective action required from the previous audit around wound care management has been addressed.

The RNs (two) and clinical services manager interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurses.

All of the five residents (two hospital and three rest home) and four families (two hospital and two dementia) interviewed were complimentary of care received at the Beetham Health Care. The audit identified an improvement required around documentation of interventions.

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

Care plans are not up to date and do not describe interventions consistent with meeting resident's assessed needs and desired outcomes. However all staff interviewed (three heath care assistants - two hospital and one dementia - and two RNs) were knowledgeable of resident's current needs and they could elaborate on appropriate interventions for each residents but these are not always documented. When residents' condition alters, the clinical services manager and RNs initiates a review and if required GP or specialist consultation.

This finding is discussed with the clinical services manager on the day of audit. A Care Plan Compliance audit was conducted in February 2013 but outcome of the audit was not communicated to staff and the required corrective actions were not completed. Refer to 1.2.3.6.and 1.2.3.8.

**Finding Statement**

1) Two files reviewed (one dementia and one hospital) evidenced that care plan interventions were not consistent with residents assessed needs particularly around mobility and falls risk interventions. Beetham Health Care uses computer generated care plans that are generic. The care plan format prompts staff to consider several options however this is required to be deleted if it is not appropriate. The care plans reviewed evidenced interventions documented were not specific for example; (1) it was not clear if a resident required a walking frame or wheelchair or hoist transfer only. 2) None of the files reviewed had a documented multidisciplinary review. These are planned to take place annually.

**Corrective Action Required:**

Ensure that care plan interventions are clear and meet the residents assessed needs.2) Ensure that multidisciplinary reviews take place as scheduled.

**Timeframe:**

3 months

**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

Two activity coordinators were interviewed who develop and deliver the activities programme at Beetham Healthcare. The activities team work a total of 75 hours per fortnight. Activities are provided Monday-Friday by the activity staff and then at the weekends by the health care assistants. Both activity coordinators hold a current first aid certificate.

One of the activity officers is a retired RN and the other has completed care giving and dementia specific education and is working towards a Diversional Therapy qualification.

The activity coordinators complete an assessment on admission on consultation with the resident and family (where appropriate). This assists the activity coordinator in developing a personalised activity care plan that meets the residents interests and needs. The activity plan is completed within three weeks of admission as evidenced in six resident files reviewed,

The residents receive a weekly copy of the programme; this is delivered on a Friday afternoon to advise residents and families of activities happening the following week. A copy of the programme is also displayed on the notice boards around the facility.

The service does not have its own van but uses the "sunshine club" bus for outings.

Church services are held on the last Wednesday of each month with a morning and evening service, providing an opportunity for residents and family to worship together.

Local community groups use the facility’s large activity area as a venue for meetings, dancing practice, music practice, church services and other aged care facilities utilise the venue for training, and activities.

Residents are encouraged to attend events occurring in the community. Residents interviewed described going to the "stroke club, RSA, church services, going out for tea and morning coffee and to events happening in the town.

The activity programme includes entertainers, ballroom dancing, walking group, exercise class, baking, crafts, "big days out', happy hour, quizzes, games and indoor bowling.

Residents from the dementia unit have an escort with them if attending a group activity in the rest home/hospital area. This was observed by the auditors on the day of audit.

There is a focus on spending one on one time with residents who are unable or prefer not to join in group activities.

Dementia residents have an activity plan developed that covers a twenty four hour period. Residents in the dementia unit were observed assisting to set the dinner table at meal times, folding items of linen and having someone on one time with an activity coordinator and staff.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. Residents and family members interviewed spoke positively of the activities at the facility and reported there was a great sense of "community and fun".

Residents meetings occur bi-monthly and feedback regarding suggestions made by the residents documented in minute meetings sighted is fed back to the activity team and evidenced implemented where possible.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

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

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

D16.4a Six patient files (two from each area) are reviewed showed that care plans evaluations are not completed. This improvement continues to be required from the previous audit.

There is documented evidence of GP review at least every three months and on an as required basis, for all six files reviewed. There was evidence of initiation of short term care plan in the three resident files where there were changes in the residents health status and required interventions are implemented. On the day of audit, in the dementia unit, a mobility assessment is completed by a physiotherapist following a referral. Staff interview

(two caregivers who work in the unit) confirmed current knowledge around the new interventions and risk management plan around falls prevention. The Dementia unit is small therefore staff are able to provide patient centred care. Family members interview (two) from the dementia unit confirmed this.

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

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

Four of six care plans evidenced six monthly review/ evaluation.

**Finding Statement**

Evaluations were not completed in two of six care plans reviewed. Evaluations of short term care plans were not evidenced completed.

**Corrective Action Required:**

Ensure that care plan reviews/evaluations are completed. (ii) Ensure that short term care plans are evaluated to assess effectiveness of meeting the goal/outcome.

**Timeframe:**

3 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

Beetham Health Care uses robotic medication dispensing system. Medication is checked on delivery by the night staff and stored in the medication rooms. All controlled drugs are kept in the rest home - hospital treatment room and weekly stocktake occurs. The controlled drug register was reviewed and was found to be correct. The medication fridge temperature is monitored daily. Registered nurses administer medications in all three areas and medicine competent caregivers in the dementia unit administer medicines on morning duties only.

There are policies and procedures around self-medication of residents and there are no residents self-medicating on the day of audit. Medication management training was last provided on July 2013 and medication management competencies are maintained.

Although corrective actions from the previous audit have been addressed, there are further improvements required around the medication management system.

D16.5.e.i.2; 15 (five from each area), medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.

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

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

Corrective actions from the previous audit have been addressed: 1) Eye drops sighted, all have been dated when they were opened. 2) 15 medication charts reviewed all have photo identification. (3) Allergies are documented in all medications charts sampled.4) medications were signed as administered.

**Finding Statement**

There are several issues that identified required improvements. 1) On arrival to the service, one of the auditors observed that the RN was administering morning medications and left the medication trolley unattended and unlocked for a considerable period of time. 2) All residents maintain their own GPs and this creates challenges around prescribing. Most medication charts are faxed several times to the GP clinics and a faxed copy is kept in the medication folder. 10 out of 15 charts reviewed was a faxed copy and three of these charts were very difficult to read. 3) Expired medications were kept on site. 4) Past residents medications were kept on site. 5) Robotic sachets that belong to two residents were opened and one resident had two drugs and the other one had one drug replaced and sachets were sealed with a sticky tape. The replacement of drugs was evident for the rest of the sachets for several days. The RN and the clinical services manager stated that these changes were initiated and completed by the pharmacist.

**Corrective Action Required:**

1 ) Ensure the medicine trolley is not left un-attended when administering medication. 2) Ensure medication charts are legible.3) Ensure expired medications are returned to the pharmacy. 4) Ensure deceased/discharged residents medications are returned to the pharmacy.

**Timeframe:**

immediately-one month

**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

Beetham Health Care employs two cooks with additional kitchen hands. The main kitchen supplies meals for the rest home, hospital and dementia unit and food is transported by insulated trolleys. Nutritional assessment is undertaken for each resident on admission, a copy is provided to the cook. The service has access to a dietician for review of the resident's nutritional status and the menu is reviewed by a registered dietician.

Residents' files sampled demonstrate regular monthly monitoring of individual consumer’s weight and nutritional needs, and the nutritional needs and interventions are identified and documented.

The main kitchen is clean and well maintained. There is a well-kept daily cleaning schedule, food temperatures fridge / freezer temperatures are monitored, and delivery checklists are maintained. Food in the pantry is stored off the floor and food is covered and dated in the fridge. The kitchen also provides food for residents from the serviced apartments. Kitchen service audits are undertaken and last completed in June 2013. All residents (three rest home and two hospital) and all families interviewed (two dementia and one hospital and one rest home) praised the food services and the variety of food served.

E3.3f, there is evidence that there is additional nutritious snacks available over 24 hours.

D19.2 Staff have Food Safety Certificates (NZQA) which is displayed on the wall in the kitchen.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

The building has a current warrant of fitness that is valid until 9 July 2014. The building is purpose built and allows space for residents to mobilise freely. There is a maintenance plan and staff report that any maintenance requested is completed promptly.

Hot water monitoring occurs regularly and maintained around 45°C. This is an improvement from the previous audit.

Seating and shade is available in the rest home/hospital area and in the dementia unit.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

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

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

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

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

Staff records and the roster reviewed showed that there is a staff member on duty at all times with a current first aid certificate. This is an improvement from the previous audit.

**Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

The restraint minimisation and safe practice policy includes restraint/enabler procedures. There is a documented definition of restraint and enablers which is congruent with the definition in the standard.

Any assessment of use of enablers is based on information in the care plan, discussions with residents and on staff observations of residents. There is a restraint and enabler register with six residents using a bedrail as restraint and four residents using a bedrail identified as an enabler.

Two residents interviewed who request the use of an enabler confirm that it is a voluntary aid and used to help them change their position independently when in bed.

Staff including the caregivers interviewed state that any use of enablers is voluntarily and is decided on by the resident.

Three of six files were reviewed of residents requiring the use of a restraint. All files evidenced a Restraint/enabler pre assessment form, risk questionnaire form and consent forms have been completed. Monitoring of restraints was documented as occurring two hourly when restraints are in use. Evaluation of the continued need for restraint occurs six monthly. An improvement is required around the documenting the use of a restraint in the residents care plan.

Completed restraint minimisation competency questionnaires for staff were sighted.

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

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

Care plans reviewed of two residents documented the need for restraint in the residents care plans.

**Finding Statement**

One of three care plans reviewed of residents requiring the use of a restraint did not document the need for restraint and interventions to guide staff in the delivery of care. However and assessment, risk questionnaire and restraint/enabler consent form were evidenced in place for this resident and staff were monitoring the restraint when in use therefore the risk to the resident was reduced and the risk rating has been assessed as low. The care plan was updated on the day of audit to reflect the resident’s needs around the use of restraint.

**Corrective Action Required:**

Ensure the use of restraint and appropriate interventions to guide staff are documented in residents care plans.

**Timeframe:**

immediately- one month

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.2 Assessment**

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

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

The previous certification audit identified that there were no assessments documented in resident’s files that met the required standard. Improvements have been implemented. Assessments are undertaken by a registered nurse on consultation with the resident and their family/whanau. Restraint/enabler pre assessments are based on information in the long term care plan, resident discussions and on observations of the staff. There is a restraint/enabler pre assessment form and restraint/enabler risk questionnaire form which is available and completed for the residents requiring the use of an enabler or restraint. Three restraint files were reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed six monthly (written evaluation sighted).

**Criterion 2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:**

(a) Any risks related to the use of restraint;

(b) Any underlying causes for the relevant behaviour or condition if known;

(c) Existing advance directives the consumer may have made;

(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

(f) Maintaining culturally safe practice;

(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

(h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

The previous certification audit identified that the restraint register did not clearly document which resident was using and enabler and which was a restraint. This audit evidenced that the restraint register sighted clearly identified residents using a restraint and those using an enabler. Therefore this finding has been addressed.

**Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

Shortfalls identified at certification audit included; that there was no on-going evidence of evaluation of restraint in place. This finding has been addressed with six monthly evaluation of the continued need for restraint evidenced occurring within this timeframe in three resident files reviewed requiring the use of a restraint.

**Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:**

(a) Future options to avoid the use of restraint;

(b) Whether the consumer's service delivery plan (or crisis plan) was followed;

(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

(d) Whether the desired outcome was achieved;

(e) Whether the restraint was the least restrictive option to achieve the desired outcome;

(f) The duration of the restraint episode and whether this was for the least amount of time required;

(g) The impact the restraint had on the consumer;

(h) Whether appropriate advocacy/support was provided or facilitated;

(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

(j) Whether the service's policies and procedures were followed;

(k) Any suggested changes or additions required to the restraint education for service providers.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

The previous certification audit identified that there was no evidence that individuals approved restraint was reviewed. Improvements have been implemented. Three of six files were reviewed of residents requiring the use of a restraint. All files evidenced a Restraint/enabler pre assessment form, risk questionnaire form and consent forms have been completed. Monitoring of restraints was documented as occurring two hourly when restraints are in use. Evaluation of the continued need for restraint occurs six monthly. Restraint/enabler evaluation forms were evidenced completed in the three restraint files reviewed which have been completed in a six monthly time frame. An annual review of restraint has been completed for 2011-12. Therefore the previous findings have now been addressed.

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.4 Education**

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

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

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

The previous certification audit identified that the infection control officer had not received training sufficient to provide knowledge to fill the role and that infection control education was not included in the orientation package and on-going staff education.

Infection control is included in the orientation package and a questionnaire on infection control is completed by new staff members as evidenced in five of seven staff files reviewed. (link to #1.2.7)

Education on infection control for staff has been conducted in August 2013 with 21 staff attending. The infection control officer (CSM) has attended education on infection control. Therefore these previous findings have been addressed.

Three health care assistants interviewed confirmed that recent training on infection control had occurred and that they had attended this education session.

**Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

Infection surveillance is an integral part of the infection control programme and is described in Beethams infection control and surveillance policy. The previous certification audit documented the following shortfalls; that infections that do not require antimicrobial treatment are not included in infection surveillance data and that infection control surveillance data is not discussed at quality meetings. These findings have been addressed.

Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. Infections are discussed at monthly health and safety meetings, monthly quality meeting and bi monthly staff and clinical meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical services manager. On interview the infection control officer (CSM) advised that infection surveillance captures all infections within the facility which was confirmed on review of monthly surveillance reports.

**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:**