# Prasad Family Foundation Limited

## Current Status: 13 August 2014

**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 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Brylyn Residential Care is privately owned and provides care for up to 22 rest home residents and ten hospital residents. On the day of audit there are 18 rest home residents and four hospital level residents. Brylyn Residential Care is managed by a registered nurse who has been in her current role for seven months. There are systems in place to provide care for residents. There is an orientation and training programme that provides staff with knowledge and skills to deliver care and support is in place.

A routine unannounced surveillance audit was undertaken in July 2013 that resulted in 17 required improvements. This current second unannounced surveillance audit was undertaken due to the 17 required improvements found in July 2013. Improvements required from the previous surveillance audit relating to privacy in communal bathrooms, ensuring informed consent processes were implemented, complaints register, timely completion of nursing assessments and call bells in the lounge/dining area were found to have been addressed.

Eleven improvements continue to be required to be addressed from the previous surveillance audit, relating to the quality and risk management system including policy review, corrective action plans, internal audits and incident reporting, food handling training, safe storage of chemicals, aspects of care planning, intervention documentation and evaluation, wound management and an area of high risk around medication management/documentation.

A partial provisional audit was completed in January 2014 in respect of adding hospital level services and resulted in eight required improvements. This current surveillance audit found improvements required at the partial provisional audit around orientation, registered nurse cover, aspects of medication management, equipment servicing, fridge temperature monitoring, menu review, and a job description for the infection control coordinator have been addressed; and improvements continued to be required around clinical risk assessments, care plan interventions, aspects of medication management and the environment.

This current surveillance audit has identified further improvements relating to recording family notification following a change in health status; evidence of formalised reporting to the director and/or reporting of progress against goals; meeting minutes having aspects of quality information being discussed such as the internal audit, complaints, infection control; training in regard to medication competencies relevant to the resident group; ensuring staff supervising resident outings are first aid qualified and kitchen staff attend food safety training; staffing to ensure sufficient staff are rostered to meet the needs of the resident group; reviewing activities plan and care plans at the same time; family involvement in care planning; evaluation of care plans; ensuring the call bell system is an effective method of summoning staff, particularly in an emergency situation; and annual review of the infection control programme.

## Audit Summary as at 13 August 2014

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 |

### Consumer Rights as at 13 August 2014

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

### Organisational Management as at 13 August 2014

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

### Continuum of Service Delivery as at 13 August 2014

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

### Safe and Appropriate Environment as at 13 August 2014

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Restraint Minimisation and Safe Practice as at 13 August 2014

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 13 August 2014

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

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Prasad Family Foundation Limited |
| **Certificate name:** | Prasad Family Foundation Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Brylyn Residential Care | | | |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 13 August 2014 | **End date:** | 13 August 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 22 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 8 | **Hours off site** | 7 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 8 | **Total hours off site** | 7 |
| **Technical Experts** | XXXXXXX | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 16 | Total audit hours | 32 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 7 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 15 | Number of relatives interviewed | 1 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Friday, 26 September 2014

## **Executive Summary of Audit**

**General Overview**

Brylyn Residential Care is privately owned and provides care for up to 22 rest home residents and ten hospital residents. On the day of audit there are 18 rest home residents and four hospital level residents. Brylyn Residential Care is managed by a registered nurse who has been in her current role for seven months. There are systems in place to provide care for residents. There is an orientation and training programme that provides staff with knowledge and skills to deliver care and support is in place.

A surveillance audit was undertaken in July 2013 that resulted in 17 required improvements, this current surveillance audit found:

Improvements required from the previous surveillance audit relating to privacy in communal bathrooms, ensuring informed consent processes are implemented, complaints register, timely completed of nursing assessments and call bells in the lounge/dining area have been addressed.

Improvements continue to be required from the 2013 surveillance audit relating to the quality and risk management system including policy review, corrective action plans, internal audits and incident reporting, food handling training, storage of chemicals, aspects of care planning, interventions, evaluations, wound management and an area of high risk around medication management/documentation.

A partial provisional audit was completed in January 2014 in respect of adding hospital level services and resulted in eight required improvements. This current surveillance audit found:

Improvements required at the partial provisional around orientation, registered nurse cover, aspects of medication management, equipment servicing, fridge temperature monitoring, menu review, and a job description for the infection control coordinator have been addressed.

Improvements continue to be required around clinical risk assessments, care plan interventions, aspects of medication management and the environment.

This surveillance audit has identified further improvements relating to family notification, formalised reporting against goals, meeting minutes, training, staffing, activities, family involvement in care planning, evaluation, call bell system and annual review of the infection control programme.

**Outcome 1.1: Consumer Rights**

There is an open disclosure policy. Appropriate informed consent processes are in place. While interviews with residents and one relative inform family are notified of their family member’s current health status including any adverse events, this is not always recorded and this is a required improvement. A complaints process is implemented.

**Outcome 1.2: Organisational Management**

There is a quality and risk management plan and aspects of the quality system are being implemented. There is an internal audit programme outlined in the quality and risk management plan to monitor outcomes. There is an appropriately qualified nurse manager who provides guidance for the service and is supported by registered nurses and experienced care staff. There is a registered nurse on every shift. There is an implemented in-service training schedule. There are required improvements around: formalised reporting, policy review, meeting minutes, internal audit, corrective action planning, training, incident reporting and staffing.

**Outcome 1.3: Continuum of Service Delivery**

Assessments, care plans and evaluations are completed by registered nurses. Risk assessment tools and monitoring forms are available for use on admission and when a residents health status changes. Care plans are individualised. Short term care plans are in use for changes in health status and evaluated at regular intervals. There are improvements required around the use of risk assessments, documented interventions, evaluations of care plans and wounds. Residents and family are complimentary about the staff and standard of care provided. The activity programme for the rest home and hospital residents is varied, interesting and involves community visitors, entertainment and outings. The programme meets the consumer group recreational requirements and preferences. There is an improvement required around co-ordinating the review of the activity plan and care plan at the same time. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have not completed annual competencies; however annual education has been attended. The GP reviews the medication chart three monthly. There are improvements required around aspects of medicine management. Meals are prepared on site. The menu has been approved by a dietitian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided. There is an improvement required around food safety training.

**Outcome 1.4: Safe and Appropriate Environment**

The service displays a current building warrant of fitness is current. There is a call bell system that does not sound an alert for staff and this is a required improvement.

**Outcome 2: Restraint Minimisation and Safe Practice**

There are restraint minimisation and safe practice policies and procedures applicable to the size and type of the service. The restraint policy includes a definition of enablers and procedures for assessment and appropriate use of enablers (that is, voluntary restraint). There are currently no enablers or restraints in use. The restraint co-ordinator is a registered nurse.

**Outcome 3: Infection Prevention and Control**

There is an implemented infection control programme that is linked to the quality system with monthly reporting of surveillance data being undertaken. The infection control programme requires annual review and this is a required improvement.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 8 | 0 | 7 | 8 | 0 | 0 |
| **Criteria** | 0 | 43 | 0 | 8 | 10 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 27 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 40 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Accident/incident forms do not have a section to indicate if family have been informed (or not) of an accident/incident. Five files reviewed did not report family notification has occurred following a change in resident health status. Interview with the nurse manager informs she notifies family, however this is not always recorded in resident notes. | Family notification following a change in health status is recorded. | 60 |
| HDS(C)S.2008 | Standard 1.2.1: Governance | The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.1.1 | The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | There is no evidence of formalised reporting to the director, and/or reporting of progress against goals. | Establish and implement a reporting structure to monitor progress against goals outlined in the various plans. | 60 |
| HDS(C)S.2008 | 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. | PA Moderate |  |  |  |
| HDS(C)S.2008 | 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. | PA Moderate | The manager is currently working through policies/procedures and updating them. There are instances where documents do not link or reference other documents/policies and related forms. The finding from the surveillance audit remains open. | Continue to work through updating policies/procedures ensuring they reflect the higher hospital level care. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | While the staff meeting minutes record the number (and type) of resident incidents occurring monthly there is no record of other aspects of quality information being discussed such as internal audit, complaints, infection control. | Quality improvement data is evaluated and discussed at the staff meetings. | 60 |
| HDS(C)S.2008 | Criterion 1.2.3.7 | A process to measure achievement against the quality and risk management plan is implemented. | PA Moderate | There is a 2013-2015 quality/risk management plan. There is an internal audit schedule included in the quality plan that includes the following audits: medication, incident/accident, complaints, infection control, restraint, personal care/hygiene, resident/family satisfaction, staff satisfaction, kitchen/food, laundry and cleaning. Six of the eleven prescribed audits have been completed. No evaluation of the overall quality plan is seen to have been completed. The finding from the surveillance audit remains open. | a) Complete an evaluation of the effectiveness of the quality plan/programme b) fully implement an internal audit programme to assist with reviewing service delivery | 90 |
| HDS(C)S.2008 | 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. | PA Moderate | While corrective action plans have been developed in the internal audits reviewed, these have not been closed out and/or progress towards meeting the required actions recorded. The annual resident satisfaction survey (results received February 2014), identified areas for improvement, however these have not been developed into a corrective action plan, and/or progress towards addressing improvements is not evident. The finding from the surveillance audit remains open. | Ensure corrective actions are documented (and closed out) as a result of identified shortfalls. Ensure meeting minutes reflect follow through of actions required | 90 |
| HDS(C)S.2008 | 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. | PA Moderate |  |  |  |
| HDS(C)S.2008 | 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. | PA Moderate | Seven incident forms were reviewed across the last three months. The following was noted:  a) Two forms did not include recording of neuro observations where the incident relating to a fall where a ‘bleeding scalp’ was reported and the second reported ‘hit head’.  b) Two instances where the minimisation strategy reported: ‘attend to resident sooner rather than later’ and ‘…age and frailty makes her susceptible for skin tears…’, | Ensure incident forms are fully completed to include strategies going forward to manage risk and identify opportunities for improvement | 60 |
| HDS(C)S.2008 | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | 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. | PA Low | The following was noted in respect of education:  a) There is annual medication education there are no competencies being completed.  b) The activities programme includes van outings which are supervised by the activities coordinator. She does not have a current first aid certificate.  c) The cook has not attended food safety training. | Develop and implement medication competencies relevant to the resident group, ensure the activities coordinator (or the staff member supervising resident outings) is first aid qualified, the cook attend food safety training. | 90 |
| HDS(C)S.2008 | Standard 1.2.8: Service Provider Availability | Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate |  |  |  |
| HDS(C)S.2008 | 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. | PA Moderate | The following was noted:  a) one registered nurse and one caregiver between 3pm and 11pm for 18 rest home and four hospital residents - two residents require sling hoist transfer and one standing hoist transfer  b) falls average 10/month across the last six months  c) there are no sensor mats in use, and the call bell system does not make alarm when activated (link 1.4.7)  d) resident feedback informs there is sometimes a ‘delay’ in answering call bells (noting the response time is not monitored)  e) staff interview informs insufficient staff, particularly in the afternoon | Sufficient staff are rostered to meet the needs of the resident group. | 30 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | There is no evidence/review of risk tool assessments for changes to the resident health status as follows; a) rest home resident with five falls since January 2014 does not have a falls risk assessment on file or completed with recent falls. There are no falls prevention strategies documented in the care plan. The same resident had a stage 1 sacral pressure area June 2014 (now resolved) however there is no review of the pressure area risk or pressure area prevention strategies documented in the care plan. b) another rest home resident with three falls since June 2014 does not have a falls risk assessment on file or completed with recent falls.  There are no pain assessments in place for a) rest home resident with XXXX reported to be expressing pain and given PRN pain relief. b) resident recently admitted from hospital following falls and on controlled drugs who is reported to be experiencing breakthrough pain XXXXXand given PRN pain relief. c) one hospital resident who is on controlled drugs for chronic pain due to XXXXX. | Ensure risk assessments are a) completed on admission b) reviewed at least six monthly c) reviewed with changes to health status and d) outcomes are documented in the long term care plan. | 30 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | 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. | PA Moderate | 1)There is no documented evidence of resident and/or family involvement in the development or review of the care planning process. 2) The care plan does not reflect current needs and management for a) hospital resident on PEG feeds since admission to hospital March 2014 and b) hospital resident with a XXXXX | 1) Ensure care plans are consumer focused with resident/family involvement. 2) Ensure care plans reflect the resident’s current needs and supports | 30 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | 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. | PA Low | 1) Four out of 11 wounds have not been evaluated at the documented frequency. 2) One rest home resident with weight loss and mini nutritional score of 4 (at risk) has not had an evaluation in June 2014 as instructed. Progress note one week ago stated the resident is not eating much. There is no evidence of food or fluid intake monitoring. The resident has had gradual weight loss in the last month. There has been no monthly weight recordings from January to June 2014 for one hospital resident with a colostomy. 3) Two rest home residents reported to have falls with head injury did not have neurological observations in place post fall. There is no evidence GP notification. 4) Progress notes record changes to resident’s status and handovers occur to ensure staff are aware of the residents support needs. | 1) Ensure wounds are evaluated at the documented frequency. 2) Ensure there is weight monitoring in place. 3) Ensure neurological observations are completed post falls with head injury and the GP is notified. 4) There are no documented interventions for one rest home resident with altered mood (confusion) as reported in progress notes. | 60 |
| HDS(C)S.2008 | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | 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. | PA Low | The activity plan and the care plan is not reviewed at the same time. | Ensure the activity plan and care plan is reviewed at the same time. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | 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. | PA Low | There is no written six monthly evaluation in one hospital and one rest home file. | Ensure written evaluations are completed six monthly. | 60 |
| HDS(C)S.2008 | 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. | PA Moderate |  |  |  |
| HDS(C)S.2008 | 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. | PA Moderate | 1) There is no evidence of six monthly pharmacy audits of controlled drugs. 2) The standing order form does not comply with Ministry of Health standing order guidelines 2012. 3) There is transcribing on three out of 10 PRN medication administration forms. 4) The fentanyl patch is being signed when applied on the regular oral medication signing sheet. There are two signing sheets in place for one resident on XXXX. One form is for three times a day and the pharmacy generated signing sheet is for four times a day. 5) Two out of 10 medication charts did not have a GP signature for discontinued medications. 6) Nine out of 10 medications charts did not have an indication for use of PRN medications. | 1) Ensure the pharmacy complete a pharmacy audit of controlled drugs six monthly. 2) Ensure the standing order form meets current guidelines 3) Transcribing is to cease. 4) Ensure correct administration signing sheets are used. 5) Ensure the GP signs for discontinued medications. 6) All PRN medications prescribed require an indication for use. | 30 |
| HDS(C)S.2008 | Standard 1.4.6: Cleaning And Laundry Services | Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.6.3 | Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. | PA Moderate | There is no barrier between the kitchen and dining room to maintain resident safety from the staff only area. The chemical cupboard in the kitchen is not lockable. | Ensure safe storage of chemicals within the kitchen. | 30 |
| HDS(C)S.2008 | Standard 1.4.7: Essential, Emergency, And Security Systems | Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.7.5 | An appropriate 'call system' is available to summon assistance when required. | PA Moderate | When activated a light appears at designated area/s throughout the facility. Response to resident calls is dependent on staff sighting the alert. There is no sound activated (or pager) call system to get assistance in an emergency (link 1.2.8). Staff interviewed confirm they are reliant on seeing that a call has been activated, and when attending to other residents a delay in response is incurred. Interviews with residents inform call bell response is sometimes delayed (also refer evidence 1.2.8). | Ensure there is an effective method of summoning staff is in place, particularly in an emergency situation. | 90 |
| HDS(IPC)S.2008 | Standard 3.1: Infection control management | There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | PA Low |  |  |  |
| HDS(IPC)S.2008 | Criterion 3.1.3 | The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | The infection control programme has an issue date of 4/4/13 and review date of 4/4/15. The infection control programme requires annual review. | Review the infection control programme annually. | 180 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

#### Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect **(**HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

**Attainment and Risk:** FA

**Evidence:**

There are policies in place to guide practice in respect of independence, privacy and respect (link 1.2.3). A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. Resident files are stored out of sight. There was a finding at the surveillance audit relating to privacy in communal bathrooms, there are locks on communal bathroom/toilets and the finding is now closed.  
D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service encourages residents to have choices and this includes voluntary participation in daily activities. Interview with two care givers describe how choice is incorporated into resident cares. Interview with residents (three rest home, one hospital) inform staff are respectful. There is an abuse and neglect policy being implemented and in-service was provided in March 2014. Interviews with residents were positive about the care provided.  
D4.1a Five resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with residents confirm their values and beliefs were considered.   
D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.  
D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files

##### **Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)**

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)**

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)**

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)**

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a policy to guide staff on the process around open disclosure and interpreter services. Accident/incident forms do not have a section to indicate if family have been informed (or not) of an accident/incident. Five files reviewed did not report family notification has occurred following a change in resident health status. Interview with the nurse manager informs she notifies family, however this is not always recorded in resident notes. This is a required improvement

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 relatives (one) stated they are informed when their family members health status changes.  
D11.3 The information pack is available in large print and this can be read to residents.

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

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

**Attainment and Risk:** PA Low

**Evidence:**

Accident/incident forms do not have a section to indicate if family have been informed (or not) of an accident/incident. Five files reviewed did not report family notification has occurred following a change in resident health status. Interview with the nurse manager informs she notifies family, however this is not always recorded in resident notes.

**Finding:**

Accident/incident forms do not have a section to indicate if family have been informed (or not) of an accident/incident. Five files reviewed did not report family notification has occurred following a change in resident health status. Interview with the nurse manager informs she notifies family, however this is not always recorded in resident notes.

**Corrective Action:**

Family notification following a change in health status is recorded.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.1.10: Informed Consent **(**HDS(C)S.2008:1.1.10)

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

**Attainment and Risk:** FA

**Evidence:**

There are policies and procedures related to informed consent. Interviews with two caregivers identify that consents are sought in the delivery of personal cares and this is confirmed by four residents who identify that they are able to make choices. Information on informed consent is included in the information pack and discussed with residents and families and admission. There is a multi-faceted informed consent form available. There is evidence of written general consents and outings in two rest home and three hospital files sampled, this is an improvement from the previous surveillance audit. Resuscitation forms have been completed and signed appropriately in five of five resident files sampled (two rest hone and three hospital), this is an improvement from the previous surveillance audit.

##### **Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)**

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

The service is able to demonstrate that written consent is obtained where required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.1.13: Complaints Management **(**HDS(C)S.2008:1.1.13)

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

**Attainment and Risk:** FA

**Evidence:**

There is a complaints policy to guide practice. The nurse manager leads the investigation and management of complaints (verbal and written). There is a complaints (and compliments) register that records activity in an on-going fashion. This is an improvement from the previous surveillance audit.

Complaints are not consistently discussed at the three monthly staff meeting (link 1.2.3). There are six complaints recorded across 2013 (two written and four verbal), and one verbal complaint recorded during 2014. This complaints is seen to have been investigated with resolved. Discussion with four residents (three rest home and one hospital) and one relative (rest home) confirm they are aware of how to make a complaint.

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

##### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **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 **(**HDS(C)S.2008:1.2.1)

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

**Attainment and Risk:** PA Low

**Evidence:**

Brylyn Residential Care provides care for up to 22 rest home residents and ten hospital residents. At the time of the audit, there are 18 rest home residents (excluding one who is in hospital), and four hospital level residents. Included in this total is one rest home level respite resident. There are no residents under the chronic health conditions contract at the time of audit. The nurse manager, who has a current practising certificate has been in post seven months and has experience in DHB and community settings. Since the partial provisional audit (January 2014), the previous nurse manager who was providing support has now left. The nurse manager currently holds a clinical load five days/week. One ‘paper’ day per fortnight has recently been agreed.

Brylyn Residential Care is privately owned. The nurse manager reports to the director/owners who in turn report to the board. The organisation has a Business Plan dated 02/05/14 and a Quality and Risk Management plan 2013- 2015. The quality management system identifies the vision, mission and objectives. The objectives include the plan to cater for hospital level residents. There is no evidence of formalised reporting to the director, and/or reporting of progress against goals and this is an area for improvement.

ARC, D17.3di (rest home): The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

##### **Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

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

**Attainment and Risk:** PA Low

**Evidence:**

Brylyn Residential Care is privately owned. The nurse manager reports to the director/owners who in turn report to the board. The organisation has a Business Plan dated 02/05/14 and a Quality and Risk Management plan 2013- 2015. The quality management system identifies the vision, mission and objectives. The objectives include the plan to cater for hospital level residents. There is no evidence of formalised reporting to the director, and/or reporting of progress against goals and this is an area for improvement

**Finding:**

There is no evidence of formalised reporting to the director, and/or reporting of progress against goals.

**Corrective Action:**

Establish and implement a reporting structure to monitor progress against goals outlined in the various plans.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Brylyn Residential Care has a quality framework that requires full implementation. The service continues to use Joanna Briggs clinical procedures as a base for operating policies. At the time of audit the nurse manager is continuing to work through updating policies/procedures and this is a recurring area of improvement from the previous surveillance audit (July 2013).

Brylyn Residential Care quality and risk management plan outlines an annual internal audit schedule, this has not been fully implemented and there is no evidence in meeting minutes that progress towards goals outlined in the quality plan are being progressed. These areas for improvement were identified at the surveillance audit (July 2013) and remain open.

Quality matters are taken to the two to three monthly staff meetings, while meeting minutes evidence incidents (aggregated monthly) are discussed, there is no record that other key components of the quality management system are reported including internal audit, infection control and complaints/compliments. This is an area for improvement.

Of the internal audits completed (medication, infection control, cleaning, care plan and kitchen), corrective action plans have been developed, however these are not signed out and this is an area for improvement recurring from the previous surveillance audit.

Resident/relative meetings take place four - six monthly. Annual resident satisfaction surveys are completed, the 2013 survey identified areas for improvement, however there is no corrective action plan to manage/monitor implementation of service improvements.

D19.3: There is an H&S and risk management programme in place including policies to guide practice. Staff accidents and incidents and monitored.   
D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls (link 1.2.4)

##### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

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.

**Attainment and Risk:** PA Moderate

**Evidence:**

The service uses Joanna Briggs clinical procedures as a base for operating documents. The nurse manager informs the institute has not/does not update. She is currently working through policies/procedures and updating them. There are a number of documents that have been signed as reviewed.

**Finding:**

The manager is currently working through policies/procedures and updating them. There are instances where documents do not link or reference other documents/policies and related forms. The finding from the surveillance audit remains open.

**Corrective Action:**

Continue to work through updating policies/procedures ensuring they reflect the higher hospital level care.

**Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

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

**Attainment and Risk:** PA Low

**Evidence:**

Staff meetings are held two to three monthly. The minutes reviewed indicate monthly resident incidents are discussed.

**Finding:**

While the staff meeting minutes record the number (and type) of resident incidents occurring monthly there is no record of other aspects of quality information being discussed such as internal audit, complaints, infection control.

**Corrective Action:**

Quality improvement data is evaluated and discussed at the staff meetings.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service has a quality risk management plan that outlines an internal audit schedule. Progress with the quality plan is monitored through two-three monthly staff meetings. Resident incidents are collected to identify trends and themes (link 1.2.4).

**Finding:**

There is a 2013-2015 quality/risk management plan. There is an internal audit schedule included in the quality plan that includes the following audits: medication, incident/accident, complaints, infection control, restraint, personal care/hygiene, resident/family satisfaction, staff satisfaction, kitchen/food, laundry and cleaning. Six of the eleven prescribed audits have been completed. No evaluation of the overall quality plan is seen to have been completed. The finding from the surveillance audit remains open.

**Corrective Action:**

a) Complete an evaluation of the effectiveness of the quality plan/programme b) fully implement an internal audit programme to assist with reviewing service delivery

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There is an internal audit schedule included in the quality and risk management plan. Six (of the 11) prescribed audits have been completed across the 2013 to current period. Corrective actions are developed where non-compliance is noted. An annual resident satisfaction survey is completed (results received February 2014).

**Finding:**

While corrective action plans have been developed in the internal audits reviewed, these have not been closed out and/or progress towards meeting the required actions recorded. The annual resident satisfaction survey (results received February 2014), identified areas for improvement, however these have not been developed into a corrective action plan, and/or progress towards addressing improvements is not evident. The finding from the surveillance audit remains open.

**Corrective Action:**

Ensure corrective actions are documented (and closed out) as a result of identified shortfalls. Ensure meeting minutes reflect follow through of actions required

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.4: Adverse Event Reporting **(**HDS(C)S.2008:1.2.4)

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

**Attainment and Risk:** PA Moderate

**Evidence:**

D19.3c: The service collects incident and accident data and reports aggregated figures to the two to three monthly staff meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of event. Family are notified by the nurse manager (link 1.1.9). Seven incident forms were reviewed. There are instances where corrective actions identified were not reported as actioned (and closed out – link 1.2.3), and minimisation strategies were not consistently developed. This was an area for improvement identified at the previous surveillance audit and remains open.   
D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.   
Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

##### **Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

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.

**Attainment and Risk:** PA Moderate

**Evidence:**

There is an incident and accident policy that defines the way they report significant incidents and accidents. Staff meeting minutes (held two to three monthly) include discussion about incident and accidents. Two caregivers interviewed confirmed that incidents were discussed with them.

**Finding:**

Seven incident forms were reviewed across the last three months. The following was noted:

a) Two forms did not include recording of neuro observations where the incident relating to a fall where a ‘XXXXX’ was reported and the second reported ‘hit head’.

b) Two instances where the minimisation strategy reported: ‘attend to resident sooner rather than later’ and ‘…age and frailty makes her susceptible for skin tears…’,

**Corrective Action:**

Ensure incident forms are fully completed to include strategies going forward to manage risk and identify opportunities for improvement

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.7: Human Resource Management **(**HDS(C)S.2008:1.2.7)

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

**Attainment and Risk:** PA Low

**Evidence:**

There are human resources policies to support recruitment practices. The nurse manager and registered nurse’s practising certificates are on file. Six staff files were reviewed (two caregivers, two registered nurses – one of which is the infection control coordinator, cook and activities coordinator) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in staff files). There is an orientation programme for registered nurses that is overseen by the nurse manager and these are seen to be completed. Interview with one registered nurse informs the orientation is sufficient, the finding from the partial provisional audit relating to orientation is considered to have been met. Two caregivers were able to describe the orientation process and believed new staff were adequately orientated to the service.

There is an education plan that includes all required sessions as part of these standards including manual handling, peg feeding, wound care (etc.). The plan is being implemented. While there is annual medication education there are no competencies being completed, only registered nurses administer medications. The activities programme includes van outings which are supervised by the activities coordinator. She does not have a current first aid certificate. The cook has not attended food safety training. These are areas for improvement.

There is a staff member with a current first aid certificate on every shift.

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

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

**Attainment and Risk:** PA Low

**Evidence:**

There is an education plan that includes all required sessions as part of these standards including manual handling, wound care, peg feeding. The plan is being implemented and attendance recorded. Interview with two caregivers informs there is sufficient education provided.

**Finding:**

The following was noted in respect of education:

a) There is annual medication education there are no competencies being completed.

b) The activities programme includes van outings which are supervised by the activities coordinator. She does not have a current first aid certificate.

c) The cook has not attended food safety training.

**Corrective Action:**

Develop and implement medication competencies relevant to the resident group, ensure the activities coordinator (or the staff member supervising resident outings) is first aid qualified, the cook attend food safety training.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.8: Service Provider Availability **(**HDS(C)S.2008:1.2.8)

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

**Attainment and Risk:** PA Moderate

**Evidence:**

A level of staffing policy defines the policies and procedures to describe the minimum requirements for the relevant positions within the service provision. There is a registered nurse on each shift, and a first aid trained member of staff on each shift. The partial provisional audit identified a finding around sufficient registered nurse cover and this finding is considered to now be met.

There is one registered nurse and one care giver on the afternoon shift, and this is an area of improvement.

##### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Staffing is as follows: one registered nurse on each shift; AM: three caregivers 7am-3pm, PM: one caregiver 3pm-11pm, ND: one caregiver 11pm-7am. The nurse manager holds a clinical load five days/week, having recently negotiated one paper day/fortnight. The nurse manger is on call 24/7.

**Finding:**

The following was noted:

a) one registered nurse and one caregiver between 3pm and 11pm for 18 rest home and four hospital residents - two residents require sling hoist transfer and one standing hoist transfer

b) falls average 10/month across the last six months

c) there are no sensor mats in use, and the call bell system does not make alarm when activated (link 1.4.7)

d) resident feedback informs there is sometimes a ‘delay’ in answering call bells (noting the response time is not monitored)

e) staff interview informs insufficient staff, particularly in the afternoon

**Corrective Action:**

Sufficient staff are rostered to meet the needs of the resident group.

**Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.3: Continuum of Service Delivery**

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

#### Standard 1.3.3: Service Provision Requirements **(**HDS(C)S.2008:1.3.3)

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy and process that describe resident’s admission and assessment procedures. D16.2, 3, 4: a registered nurse (RN) undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. Within three weeks the long term care plan is developed in the five of five resident files sampled (two hospital, three rest home including one recent admission). In all files sampled the initial admission assessment, initial care plans and long term care plans are completed, dated and signed off by a registered nurse. This is an improvement since the previous surveillance audit.

Care plans are used by nursing staff and caregivers to ensure care delivery meets the residents assessed needs. There is a handover for caregivers and registered nurses at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. Progress notes are completed each shift. All five files identified integration of allied health including general practitioner, needs assessment co-ordinator, podiatrist and dietitian. Medical assessments are completed within 48 hours of admission by the GP in five of five resident files sampled. Brylyn currently has a contracted GP who is one of three GPs at a local practice. The GP (interviewed) visits the service every 10 days and is available at other times as required. Communication is by email or fax. The GP stated the RN clinical assessments and after hours calls are appropriate. The GP is available 24/7 for palliative care residents and meets with families as arranged. There is an after hour’s clinic available. A locum is provided to cover the GP leave. The GP is continuing to provide cover until a replacement is appointed for the service due to his recent resignation. One of two hospital files sampled does not contain a written evaluation (link 1.3.8), one rest home resident has not been at the service long enough for a written evaluation. One of five resident files sampled has an InterRAI assessment completed for a rest home resident. Activity assessments, activity plans and reviews are completed by the activity co-ordinators.

Three rest home residents files sampled are 1) resident with fall and injury and previous pressure area sacrum 2) resident with weight loss and falls 3) resident admitted form hospital and on controlled drug pain management.  
Two hospital residents files sampled are 1) resident on controlled drug pain management for chronic pain and colostomy and indwelling catheter in place. 2) Resident on PEG feeds.

Tracer Methodology: hospital resident

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

Tracer Methodology: 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 (HDS(C)S.2008:1.3.3.1)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.4: Assessment **(**HDS(C)S.2008:1.3.4)

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

RNs complete an initial assessment on all residents admitted to the service as sighted in five of five files (three rest home and two hospital). Risk assessment tools available for use include continence, falls, skin management assessment, braden pressure area risk assessment, pain assessment and abbey pain scale and mini nutritional assessments. There is no evidence/review of risk tool assessment for changes to resident health status and the previous surveillance and partial provisional audits findings around clinical assessments remains.

##### **Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

RNs complete an initial assessment on all residents admitted to the service as sighted in five of five files (three rest home and two hospital). Risk assessment tools available for use include continence, falls, skin management assessment, braden pressure area risk assessment, pain assessment and abbey pain scale and mini nutritional assessments.

**Finding:**

There is no evidence/review of risk tool assessments for changes to the resident health status as follows; a) rest home resident with five falls since January 2014 does not have a falls risk assessment on file or completed with recent falls. There are no falls prevention strategies documented in the care plan. The same resident had a stage 1 sacral pressure area June 2014 (now resolved) however there is no review of the pressure area risk or pressure area prevention strategies documented in the care plan. b) another rest home resident with three falls since June 2014 does not have a falls risk assessment on file or completed with recent falls.

There are no pain assessments in place for a) rest home resident XXXXX reported to be expressing pain and given PRN pain relief. b) resident recently admitted from hospital following falls and on controlled drugs who is reported to be experiencing breakthrough and given PRN pain relief. c) one hospital resident who is on controlled drugs for chronic pain due to XXXXXXX.

**Corrective Action:**

Ensure risk assessments are a) completed on admission b) reviewed at least six monthly c) reviewed with changes to health status and d) outcomes are documented in the long term care plan.

**Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Registered nurses complete care plans and reviews occur at least six monthly or earlier due to health changes. Care plans are used by nursing staff and caregivers to ensure care delivery meets the residents assessed needs. There is an improvement required around a) ensuring the care plans reflect the residents current needs and b) are consumer focused with resident/family involvement in the development and review of care plans. This is a new finding raised at this surveillance audit.

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Registered nurses complete care plans and reviews occur at least six monthly or earlier due to health changes. Care plans are used by nursing staff and caregivers to ensure care delivery meets the residents assessed needs

**Finding:**

1)There is no documented evidence of resident and/or family involvement in the development or review of the care planning process. 2) The care plan does not reflect current needs and management for a) hospital resident on PEG feeds since admission to hospital March 2014 and b) hospital resident with a XXXXXXXXXX.

**Corrective Action:**

1) Ensure care plans are consumer focused with resident/family involvement. 2) Ensure care plans reflect the resident’s current needs and supports

**Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)**

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.6: Service Delivery/Interventions **(**HDS(C)S.2008:1.3.6)

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

**Attainment and Risk:** PA Low

**Evidence:**

The service provides services for residents requiring rest home and hospital level of care at Brylyn. Individualised care plans are completed by registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, a GP consultation as evidenced in the medical notes. The two caregivers and one RN/manager interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including hoists (checked January 2014), electric beds (hospital) , pressure relieving mattresses and cushions, shower chairs, transfer belts, wheelchairs, hospital level lazy boy chairs on wheels, chair scales, gloves, aprons and masks.

Wound assessments and dressing plans and frequency are in place for six wounds, one moderate and two large skin tears, and two heel pressure areas. There is evidence of GP involvement for non-healing wounds or large skin tears. There has been a referral to plastics for a skin graft (BCC scalp and neck). There is an improvement required around evaluations of wounds.

Continence products are available and resident files include a continence assessment as applicable that continence products identified for day and night use. There are policies and procedures to guide staff in the management of catheters and catheter care. There are adequate supplies of continent products in all areas.

Residents’ weight is recorded on admission and monitored monthly. Weight loss interventions (sighted) include mini nutritional assessments, GP notification and dietary supplements. There is an improvement required around weight monitoring. There is dietitian input for one hospital resident with enteral feeding (PEG).

Two rest home residents with falls (June and July 2014) and reported head injury did not have neurological observations completed

D18.3 and 4; Dressing supplies are available and there are adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

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

**Attainment and Risk:** PA Low

**Evidence:**

Wound assessments and dressing plans and frequency is in place for six wounds, one moderate and two large skin tears, and two heel pressure areas. There is evidence of GP involvement for non-healing wounds or large skin tears. There has been a referral to plastics for a skin graft (BCC scalp and neck). Residents’ weight is recorded on admission and monitored monthly. Weight loss interventions (sighted) include mini nutritional assessments, GP notification and dietary supplements. Accident/incident forms are completed for all resident falls. An improvement is required around neurological observations and GP notification post falls with injury. Progress notes record changes to resident’s status and handovers occur to ensure staff are aware of the residents support needs.

The previous findings from the surveillance and partial provisional audits remains.

**Finding:**

1) Four out of 11 wounds have not been evaluated at the documented frequency. 2) One rest home resident with weight loss and mini nutritional score of 4 (at risk) has not had an evaluation in June 2014 as instructed. Progress note one week ago stated the resident is not eating much. There is no evidence of food or fluid intake monitoring. The resident has had gradual weight loss in the last month. There has been no monthly weight recordings from January to June 2014 for one hospital resident with a colostomy. 3) Two rest home residents reported to have falls with head injury did not have neurological observations in place post fall. There is no evidence GP notification. 4) Progress notes record changes to resident’s status and handovers occur to ensure staff are aware of the residents support needs.

**Corrective Action:**

1) Ensure wounds are evaluated at the documented frequency. 2) Ensure there is weight monitoring in place. 3) Ensure neurological observations are completed post falls with head injury and the GP is notified. 4) There are no documented interventions for one rest home resident with altered mood (confusion) as reported in progress notes.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.7: Planned Activities **(**HDS(C)S.2008:1.3.7)

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

**Attainment and Risk:** PA Low

**Evidence:**

There is one activity co-ordinator employed for a total of 25 hours per week to plan and implement the Monday to Friday programme for the rest home and hospital residents. She has 13 years aged care experience in activities and caregiving. The activity co-ordinator attends regional diversional meetings and receives relevant information regarding educational opportunities, events and community activities. On-site in services are attended. The activity co-ordinator does not have a current first aid certificate (link 1.2.7.5). Community links are maintained with community visitors to the home such as Salvation Army, Probus, entertainers, musical entertainment and visiting Vicar weekly.

There is a weekly planner of the activity programme which includes (but not limited to); exercises (observed), walks, bingo, housie, craft, ball games, trivia, and reading. The service has a library of small and medium print books. The activity co-ordinator spends one on one time with residents who are unable to participate or choose not to participate in the group programme. The service has a disability van with wheelchair hoist and outings are arranged regularly for drives in the country, scenic drives and places of interest. The residents have input into the activity programme and outings through the three monthly resident meetings. Residents and family are involved in the resident social profile and history on admission. Activity plans and records of attendance are in place for five of five resident files sampled (two hospital and three rest home).

Residents (three rest home and one hospital) interviewed are satisfied with the content and variety of the activity programme.

D16.5d There is an improvement required around the review of the activity plan at the same time as the care plan review. This is a new finding.

##### **Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

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

**Attainment and Risk:** PA Low

**Evidence:**

Residents and family are involved in the resident social profile and history on admission. Activity plans and records of attendance are in place for five of five resident files sampled (two hospital and three rest home).

**Finding:**

The activity plan and the care plan is not reviewed at the same time.

**Corrective Action:**

Ensure the activity plan and care plan is reviewed at the same time.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.8: Evaluation **(**HDS(C)S.2008:1.3.8)

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Initial assessments and ADLs (activities of daily living) and developed within 24 hours of admission. Long term care plans are developed by a RN within three weeks of admission. The long term care plan is evaluated by the RN at least six monthly or if there is a change in health status. Written evaluations are evident in one hospital resident file and two rest home files. Short term care plans are evaluated using an evaluation progress form (sighted). There is a three monthly review by the GP or nurse practitioner.   
D16.4a; Care plans are evaluated in two of five resident files sampled. One rest home resident has not been at the service six months. There is an improvement required around the evaluation of long term care plans and this continues as a finding from the previous surveillance audit.

ARC: D16.3c; All initial care plans were evaluated by the RN within three weeks of admission

##### **Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

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.

**Attainment and Risk:** PA Low

**Evidence:**

Care plans are evaluated in three of five resident files sampled (one rest home and one hospital file). One rest home resident has not been at the service six months.

**Finding:**

There is no written six monthly evaluation in one hospital and one rest home file.

**Corrective Action:**

Ensure written evaluations are completed six monthly.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.12: Medicine Management **(**HDS(C)S.2008:1.3.12)

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy is contracted to provide the medication regular and PRN blister packs and other pharmaceuticals. There is a formal process for RN checking of medications on delivery. Returns are kept in the locked medication room. There is one central locked medication room. Contents of the medication trolley are within the expiry date. Eye drops are dated on opening. Controlled drugs are stored within a controlled drug safe. There are weekly controlled drug stocktakes. There is an improvement required around six monthly pharmacy audits of controlled drugs. Register nurses and the RN/manager administer medications and have attended annual medication education. The RNs and RN manager have not completed a medication competency (link 1.2.7.5). Standing order supplies are listed on the standing order form. This is an improvement from the previous partial provisional audit. The standing order form requires improvement.

The one rest home resident who self-medicates supplementary medications has been assessed as competent to self-medicate and monitoring occurs as per the policy for self-medication, this is an improvement from the partial provisional audit.

PRN medications administered have the time and date recorded on the PRN administration form. Transcribing is to be avoided. There are no missed medications on the 10 medication administration signing sheets for regular medications that are pharmacy generated. There is an improvement required around aspects of administration and signing documentation.

XXXXX dosage and instructions sighted as received from the GP are all current. This is an improvement from the previous partial provisional audit. There is emergency oxygen available.

Ten medication charts sampled (four hospital, six rest home) all had photo identification. Allergies/adverse reactions are noted on all medication charts sampled. This is an improvement from the previous partial provisional audit. There is an improvement required around indications for PRN medications and GP signature for discontinued medications.

D16.5.e.i.2; Twelve out of 12 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 (HDS(C)S.2008:1.3.12.1)**

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.

**Attainment and Risk:** PA Moderate

**Evidence:**

Controlled drugs are stored within a controlled drug safe. There are weekly controlled drug stocktakes. There is an improvement required around six monthly pharmacy audits of controlled drugs. Controlled drugs are stored within a controlled drug safe. There are weekly controlled drug stocktakes. Standing order supplies are listed on the standing order form. PRN medications administered have the time and date recorded on the PRN administration form. There are no missed medications on the 10 medication administration signing sheets for regular medications that are pharmacy generated. Ten medication charts sampled (four hospital, six rest home) all had photo identification. Allergies/adverse reactions are noted on all medication charts sampled.

**Finding:**

1) There is no evidence of six monthly pharmacy audits of controlled drugs. 2) The standing order form does not comply with MOH standing order guidelines 2012. 3) There is transcribing on three out of 10 PRN medication administration forms. 4) The fentanyl patch is being signed when applied on the regular oral medication signing sheet. There are two signing sheets in place for one resident on XXXXXXX. One form is for three times a day and the pharmacy generated signing sheet is for four times a day. 5) Two out of 10 medication charts did not have a GP signature for discontinued medications. 6) Nine out of 10 medications charts did not have an indication for use of PRN medications.

**Corrective Action:**

1) Ensure the pharmacy complete a pharmacy audit of controlled drugs six monthly. 2) Ensure the standing order form meets current guidelines 3) Transcribing is to cease. 4) Ensure correct administration signing sheets are used. 5) Ensure the GP signs for discontinued medications. 6) All PRN medications prescribed require an indication for use.

**Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

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

**Attainment and Risk:** FA

**Evidence:**

There are food policies/procedures for food services and menu planning appropriate for the service. There is a Monday to Friday cook and weekend cook.

There is a three week rotating menu that has been approved by a dietitian October 2013. This is an improvement from the previous surveillance audit. Variations to the menu are recorded. There is a communication diary (sighted) used between the cooks and staff to record any dietary requirements. The cook is notified if there are any changes. Dietary needs and dislikes are known. Special diets include diabetic desserts, pureed meals and gluten free. Lip plates and specialised utensils are provided for residents as assessed. The main meal is at midday. Hot food temperatures (end cooked) are recorded daily. Freezers and fridges temperatures are checked daily. This is an improvement from the previous partial provisional audit. All foods sighted in fridges and freezers are dated. Dry goods in the pantry are sealed, dated, labelled and off the floor. Food items are rotated weekly with the deliveries.

Staff are observed wearing correct protective wear, caps, aprons and gloves when carrying out duties in the kitchen. There is no barrier between the dining room and kitchen and the chemical cupboard is not locked (link 1.4.2.4).

Residents have the opportunity to provide feedback and suggestions on the menu through resident meetings.

D19.2 ; Staff have attended education on nutrition in February 2014. There is a requirement for cooks to attend food safety and hygiene training (link 1.2.7.5) and this continues as a finding from the previous surveillance audit.

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **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.

#### Standard 1.4.2: Facility Specifications **(**HDS(C)S.2008:1.4.2)

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

**Attainment and Risk:** FA

**Evidence:**

The Brylyn facility holds a current warrant of fitness which expires on 20 September 2014. There is safe internal access between the bedrooms and communal areas. The corridors are sufficiently wide enough to allow residents to mobilise with the aid of walking frames safely and other mobility aids. There is adequate space for the use of a hoist in designated hospital level rooms for safe delivery of care. There is ramp access to the outdoor areas with seating and shaded areas.

Reactive and preventative maintenance occurs. A maintenance person is employed for 10 hours a week and is on-call. Preferred contractors are available 24/7. Medical equipment is calibrated. Hot water temperature in resident areas are monitored monthly and are maintained within the acceptable temperature range. These are improvements from the partial provisional audit.

##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.4.6: Cleaning And Laundry Services **(**HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

**Attainment and Risk:** PA Moderate

**Evidence:**

Chemicals were not all noted to be secure. There are locked chemical cupboards and material safety data sheets for housekeeping and laundry. The dining room is adjacent to the kitchen. These are required improvements recurring from the previous surveillance audit.

##### **Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)**

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)**

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

**Attainment and Risk:** PA Moderate

**Evidence:**

The dining room is adjacent to the kitchen. These are required improvements recurring from the surveillance audit.

**Finding:**

There is no barrier between the kitchen and dining room to maintain resident safety from the staff only area. The chemical cupboard in the kitchen is not lockable.

**Corrective Action:**

Ensure safe storage of chemicals within the kitchen.

**Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.4.7: Essential, Emergency, And Security Systems **(**HDS(C)S.2008:1.4.7)

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The NZ Fire Service approved the evacuation scheme on 14 January 2014. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff. Emergency equipment is available at the facility. First aid training has been provided for staff and the roster designates a person on each duty with a current first aid certificate. Corridors are wide enough to allow residents to pass and to get to egress points quickly in the event of a disaster. There are call bells in the lounge/dining room areas and this is an improvement from the previous surveillance audit.

There are call bells available in all areas which alight at designated areas throughout the facility when activated, there is no sound to the call system (or pager), this is the same for emergency response and is a required improvement.

##### **Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

Alternative energy and utility sources are available in the event of the main supplies failing.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

An appropriate 'call system' is available to summon assistance when required.

**Attainment and Risk:** PA Moderate

**Evidence:**

There are call bells available in all areas including bedrooms, bathroom and communal lounges. Which alight at designated areas throughout the facility when activated, there is no sound to the call system, this is the same for emergency response

**Finding:**

When activated a light appears at designated area/s throughout the facility. Response to resident calls is dependent on staff sighting the alert. There is no sound activated (or pager) call system to get assistance in an emergency (link 1.2.8). Staff interviewed confirm they are reliant on seeing that a call has been activated, and when attending to other residents a delay in response is incurred. Interviews with residents inform call bell response is sometimes delayed (also refer evidence 1.2.8).

**Corrective Action:**

Ensure there is an effective method of summoning staff is in place, particularly in an emergency situation.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

#### Standard 2.1.1: Restraint minimisation **(**HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There are restraint minimisation and safe practice policies and procedures applicable to the size and type of the service. The restraint policy is a no restraint approach with the only exceptions being circumstances where there is imminent danger of residents or others. The restraint co-ordinator is the registered nurse.   
The restraint policy includes a definition of enablers and procedures for assessment and appropriate use of enablers (that is, voluntary restraint). There are currently no enablers or restraints in use.

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.1: Infection control management **(**HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** PA Low

**Evidence:**

The infection control practice is appropriate for the size, complexity, and degree of risk associated with the service. An established and implemented infection control programme is linked into the risk management system (link 1.2.3). The nurse manager interviewed (the infection control coordinator) is informed about practises and reporting and states that staff can contact the registered nurse, GP or nurse manager if required and concerns can be written in progress notes. The infection control co-ordinator has a job description and the finding from the partial provisional audit is considered to have been met. The infection control programme has an issue date of 4/4/13 and review date of 4/4/15, as the programme required annual review, this is a required improvement.

##### **Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)**

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

**Attainment and Risk:** PA Low

**Evidence:**

The infection control programme is appropriate to size and complexity of service. It has an issue date of 4/4/13 and review date of 4/4/15.

**Finding:**

The infection control programme has an issue date of 4/4/13 and review date of 4/4/15. The infection control programme requires annual review.

**Corrective Action:**

Review the infection control programme annually.

**Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)**

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

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

**Attainment and Risk:** FA

**Evidence:**

Infection surveillance is part of the infection control programme. Monthly infection data is collected for all infections that link to standardised definitions. The nurse manager advised that if there is an emergent issue, it is acted upon in a timely manner and discussed at handovers. Infection control is included in the internal audit schedule (link 1.2.3) and education plan – last provided February 2014.

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*