**Bupa Care Services NZ Limited - Rahiri Lifestyle care & Village**

**Current Status:** **28-May-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Provisional audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Rahiri Lifestyle Care and Village provides hospital/medical, dementia and rest home level care for to 49 residents. On the day of audit there were eight residents in the dementia unit, 21 rest home residents and 18 hospital residents.

This audit identified improvements required around aspects of care planning, medication management, documentation, and activities plans.

Bupa is currently in negotiations to purchase Rahiri Lifestyle Care and Village. Bupa's overall vision is "Taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. There is a week by week transition plan established around the purchase, including establishing Bupa systems with the current management and staffing team. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

**Rahiri Lifestyle Care & Village**

Bupa Care Services NZ Ltd

Provisional audit - Audit Report

Audit Date: 28-May-13

**Audit Report**

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Bupa Care Services NZ Ltd |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Rahiri Lifestyle Care & Village | 348 High Street |  | Dannevirke |

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

|  |  |
| --- | --- |
| **Type of Audit** | Provisional audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 28-May-13 **End Date:** 28-May-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

**Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXXX | RN, auditor certificate | 8.00 | 7.00 | 28-May-13 |
| Auditor 1 | XXXXXXXX | RN, auditor certificate | 8.00 | 6.00 | 28-May-13 |
| Auditor 2 | XXXXXXXX | RN, auditor certificate | 8.00 | 6.00 | 28-May-13 |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX |  |  | 2.00 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 24.00 | **Total Audit Hours off site** *(system generated)* | 21.00 | **Total Audit Hours** | 45.00 |
| **Staff Records Reviewed** | 9 of 53 | **Client Records Reviewed** *(numeric)* | 7 of 47 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 7 |
| **Staff Interviewed** | 12 of 53 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 5 |
| **Consumers Interviewed** | 11 of 47 | **Number of Medication Records Reviewed** | 14 of 47 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 0 |

**Declaration**

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

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

Dated this 11 day of June 2013

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

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

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

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

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

**Services and Capacity**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rahiri Lifestyle Care & Village | 49 | 47 |  | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Executive Summary of Audit**

*General Overview*

Oceania Rahiri Lifestyle Care and Village has well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for up to 49 residents including residents that require hospital/medical, dementia and rest home level care. On the day of audit there were eight dementia care residents, 21 rest home residents and 18 hospital residents at the facility.

The facility is managed by an experienced aged care manager who is a registered nurse. The facility manager is supported by a clinical leader, regional operations manager and the management team and support staff at Oceania support office.

The service provides regular training sessions and competencies are completed by staff. There is a comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit identified improvements required around aspects of care planning, medication management, documentation, and activities plans.

Bupa is currently in negotiations to purchase Rahiri Lifestyle Care and Village. Bupa's overall vision is "Taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. There is a week by week transition plan established around the purchase, including establishing Bupa systems with the current management and staffing team. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

*1.1 Consumer Rights*

Residents and their families/whānau are informed of their rights as part of the resident information pack. Residents stated that health care assistants always respected their privacy. Initial and on-going assessment includes gaining details of people’s beliefs and values. Interventions to support these are identified and evaluated. Residents are encouraged to continue with their spiritual activities. Cultural awareness training occurred as part of the annual training programme. There is Maori Health Plan which is implemented.

Residents and relatives spoke positively about care provided at Oceania Rahiri Lifestyle Care and Village. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents’ rights. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

*1.2 Organisational Management*

Oceania Rahiri Lifestyle Care and Village has an established quality and risk management system that supports the provision of clinical care and support An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported to the organisation's management team. There is an active health and safety committee. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice.

There is a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. There is an improvement required around documentation.

*1.3 Continuum of Service Delivery*

The service has a policy for entry to the rest home, hospital continuing care or dementia level of care unit. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. The clinical leader and registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified in the person centred care plans and these are reviewed within the required timeframes with the resident and/or family/whanau input. Care plans are reviewed six monthly, or when there are changes in health status. Person centred care plans - short term are used for acute episodes or short term needs. There is an improvement required regarding the monitoring of the effectiveness of pain relief. Resident files include notes by the GP and allied health professionals.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration. There is an improvement required around medication management.

The activities programme is facilitated by a diversional therapist who runs the programme in the hospital and rest home. She is assisted by a health care assistant who coordinates the programme in the dementia unit. The activities programme provides varied options and activities are enjoyed by the residents. The community including various Churches visit the premises and community outings are arranged on a regular basis. An improvement is required around the development of activity plans for dementia care residents which cover a 24 hour period.

Food is prepared and cooked on site. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented and residents and relatives are happy with the food service.

*1.4 Safe and Appropriate Environment*

There are a range of policies in place to ensure residents have access to a safe and appropriate environment. Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. There are spacious lounge's and dining rooms within each area. External areas are safe and well maintained. There are spacious lounge's and dining rooms within each area. There are adequate toilets and showers for all residents, visitors and staff. Fixtures fittings and floorings are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training and information is provided to staff and there is equipment available should staff need to respond to a civil defence emergency. There is an approved evacuation scheme and emergency supplies are held on site to last for at least three days. The temperature of the facility can be adjusted to the season and individual resident preferences.

*2 Restraint Minimisation and Safe Practice*

Oceania Rahiri Lifestyle Care and Village has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option. There are no residents requiring the use of an enabler and five residents requiring the use of a restraint (bedrail, lapbelt, lowbed). Staff receive training on restraint minimisation and managing residents' behaviours that can be challenging. Review of restraint use is discussed at monthly Registered Nurse and Quality Improvement meetings. Evaluation of restraint use occurs three monthly.

*3. Infection Prevention and Control*

The infection prevention and control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control co-ordinator is a registered nurse who is responsible for coordinating/providing education and training for staff. The co-ordinator has attended external training and is well supported by Oceania management. Infection prevention and control training is provided at orientation and is on-going throughout the year. The infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines. The co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Oceania facilities and has a low rate of infections.

**Summary of Attainment**

* 1. ***Consumer Rights***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

|  |
| --- |
| Consumer Rights Standards (of 12): N/A:0 CI:0 FA: 12 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:23 PA:0 UA:0 NA: 0 |

* 1. ***Organisational Management***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | PA Low | 0 | 3 | 1 | 0 | 0 | 10 |

|  |
| --- |
| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 6 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:21 PA:1 UA:0 NA: 0 |

* 1. ***Continuum of Service Delivery***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | PA Low | 0 | 0 | 1 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Low | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

|  |
| --- |
| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 9 PA Neg: 0 PA Low: 2 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:18 PA:3 UA:0 NA: 0 |

* 1. ***Safe and Appropriate Environment***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | FA | 0 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 5 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

|  |
| --- |
| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 8 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:17 PA:0 UA:0 NA: 0 |

1. ***Restraint Minimisation and Safe Practice***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

|  |
| --- |
| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:0 FA:9 PA:0 UA:0 NA: 0 |

1. ***Infection Prevention and Control***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | FA | 0 | 1 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |  | 0 | 0 | 0 | 0 | 0 | 5 |

|  |
| --- |
| Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

|  |
| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 46 **PA Neg:** 0 **PA Low:** 3 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 97 **PA:** 4 **UA:** 0 **N/A:** 0 |

**Corrective Action Requests (CAR) Report**

Provider Name: Bupa Care Services NZ Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:28-May-13 End Date: 28-May-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.9 | 1.2.9.9 | PA  Low | **Finding:**  Entries are legible, dated and signed by the relevant HCA, registered or enrolled nurse including designation. However progress notes reviewed do not document the actual time the report is written. Person Centred Care Plans reviewed (seven) did not specify/document the date they were completed.  **Action:**  Ensure that progress notes document the time the report is written and that care plans are dated. | 6 months |
| 1.3.7 | 1.3.7.1 | PA  Low | **Finding:**  E4.3,iv Three of the eight residents in the dementia unit, had individual plans which had been developed using the 24 hour wheel diagram method. All three plans were unsigned and undated. Each of these three residents had been admitted between 2010 to 2011. Documentation for recently admitted residents was consistent with Oceania's policy and practice in that each resident had activities plans integrated within their PCCPs and no separate individual plans covering the 24 hour period.  **Action:**  Ensure each resident in the dementia unit has an individualised plan of activities covering the 24 hour period that reflects their former routines and activities that are still familiar to the resident should they need diversional, motivation and or recreational therapy. | 6 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.8 | 1.3.8.2 | PA  Low | **Finding:**  Effectiveness of pain relief administered is not consistently recorded in the residents progress notes or use of a pain assessment monitoring tool.  **Action:**  Ensure pain relief is monitored for effectiveness. | 6 months |
| 1.3.12 | 1.3.12.1 | PA  Moderate | **Finding:**  The CL has completed an assessment for one resident to self-administer medications, however medical notes reviewed did not document that discussion with the GP has occurred and/or if the GP was aware that the resident was self-administer medications. Five medication charts did not evidence review occurring three monthly.  **Action:**  Ensure the GP reviews medication charts at least three monthly. Ensure the GP documents when a resident is competent to self-administering medications immediately. | 1 month |

**Continuous Improvement (CI) Report**

Provider Name: Bupa Care Services NZ Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:28-May-13 End Date: 28-May-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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

**OUTCOME 1.1 CONSUMER RIGHTS**

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

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

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

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

Oceania policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumer Rights. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at orientation and through on-going in-service training and competency questionnaires. Interviews with six health care assistants (HCAs) (two hospital, two rest home and two dementia) showed an understanding of the key principles of the code of rights. Resident rights/advocacy training was provided 06-11-12 (10 attended). Residents interviewed (six rest home and five hospital) and relatives (three hospital, one rest home and one dementia care) confirmed that staff respected privacy, obtained daily consent and choice.

The new owners Bupa advise that clients are to be made aware of their rights e.g. through reading material offered on admission, made available within the facility and discussed with them at intervals during their admission e.g. right to complain / right to support and the independent advocacy services available.

Relevant other acts include Privacy of information. Understanding how the information collected about them may be used / access to this.

The right to open disclosure – informed of incidents/serious events.

Advised that all key staff and care staff will attend annual training on the Code of Rights.

**Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

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

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

There is a welcome information folder that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and as appropriate their legal representative. On-going opportunities occur via regular contact with family. Advocacy pamphlets are clearly displayed at the facility entrance and on noticeboards throughout the facility. Large print posters are also displayed throughout the facility. Code of rights, advocacy information on complaints and compliments is brought to the attention of residents and families at admission, in the information pack and via the two monthly resident/family meetings. Residents interviewed (six rest home and five hospital) and relatives (three hospital, one rest home and one dementia care) confirmed that information has been provided around the code of rights. The facility manager has an open door policy for concerns or complaints.

D6.2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. The facility manager and registered nurses described discussing the information pack with residents/relatives on admission.

D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

**Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect**

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

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

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

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

The facility provides physical, visual, auditory and personal privacy for residents. During the audit, staff demonstrated gaining permission prior to entering resident rooms.

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. Six health care assistants (HCAs) interviewed described ensuring privacy by knocking on doors before entering.

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 actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with six HCAs described providing choice during daily cares. Interview with eleven residents (six rest home and five hospital) all stated staff provided a respectful service and were very approachable and friendly. There is an abuse and neglect policy that is implemented and staff are required to complete education on abuse and neglect. Abuse and neglect training is included as part of the HCA study days. There is a competency question included in the orientation programme around abuse and neglect which staff have completed. Discussions with residents and family members were extremely positive about the care provided.

E4.1a One family member interviewed state that their family member was welcomed into the dementia unit and personal pictures were put up and familiar items of furniture/bedding were placed in the room to make it more homely and more familiar to the resident.

D4.1a Seven resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and is integrated with the residents' Person Centred Care Plans (PCCP). This includes cultural, religious, social and ethnic needs. Interviews with eleven residents confirmed that 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 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.4 Recognition Of Māori Values And Beliefs**

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

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

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

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The policy is cross referenced to Tikanga Recommended Best Practice Policy-Auckland District Health Board. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. Cultural needs are addressed in sexuality/spirituality/intimacy heading of the care plan. There are five residents in the facility that identify as Maori and the care plans reviewed document appropriate culturally safe practices.

D20.1i The service has developed a link with iwi. Cultural training was last provided for staff 20-Dec-12. The Maori health plan identifies the importance of whānau Interviews with six HCAs from across all areas, clinical leader and three enrolled nurses discussed the importance of family involvement. Discussion with five relatives (three hospital, one rest home, one dementia) confirm that they are regularly involved.

Bupa advise that organisational policies including the Māori Health plan will be implemented.

**Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs**

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

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

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

Oceania has policies and procedures to guide staff practice. There is a Maori health plan, Culturally competent services policy and spirituality and counselling policy. Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family involvement and is integrated into residents' person centred care plans. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if any changes are required in delivery of service and care plans. Family are invited to attend. Interviews with five family members (three hospital, one dementia and one rest home) confirmed they are involved in the care planning process and review.

D3.1g The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. There are multi-cultural staff available and interviews with eleven residents (five hospital, six rest home) confirmed that cultural values and beliefs were considered and discussed during preparation and review of the care plan.

Spirit and Culture is one of the seven elements of Oceania's Connect Model of Care. The model assists facilities to celebrate residents' spiritual identity and cultural differences.

D4.1c Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs.

**Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

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

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

The Code of Conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. Enrolled nurses work under the direction and supervision of registered nurses. There are policies to guide staff practice including; Discrimination, Coercion, Harassment and Financial Exploitation; Code of Conduct and Gifts policy. Qualified nurses meeting (monthly) includes any discussions on professional boundaries and concerns. Advised that management provide guidelines and mentoring for specific situations. Interviews with the clinical leader and three enrolled nurses described professional boundaries.

D16.5e: Health care assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with six HCAs could describe how they build a supportive relationship with each resident. Interviews with one family member from the dementia unit confirmed the staff assist to help residents manage their anxieties and distract from behaviours that may be challenging to other residents/visitors.

**Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

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

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

Oceania has robust quality and risk management systems and these are implemented at the facility supported by a number of meetings held on a monthly basis including (but not limited to); quality improvement, health and safety, clinical, domestic and staff meetings. Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of a robust education programme. Extensive annual education programme in place, including internal and external education sessions, core competency assessments and orientation programmes have been implemented. Oceania has its own Aged Care Education Programme in place which is NZQA accredited. Competencies are completed for key nursing skills, registered and enrolled nurses regularly access training and are supported to attain PDRP at the DHB. All RN's have completed their level 1 professional recognition development portfolio (PRDP) and one RN is in the process of completing level 2 PRDP. One RN (a new graduate) – is funded 12 study days plus some extra for her preceptor through Midcentral DHB to complete a year training in clinical practice for aged care. Oceania run a HCA training day, which is repeated to capture all staff. There is a strong commitment to staff development by way of education and in-service training. Education is supported for all staff and a number of HCAs have enrolled or completed a national qualification. At an organisational level, there is a General Manger Clinical and Quality to maintain 'best practice' guidelines/procedures. Implementation of evidenced best practice and legislation requirements are reflected in clinical policies. Care planning is holistic and integrated. Benchmarking via the monthly clinical indicators provided to Oceania Support Office gives meaningful data and report results are provided to each facility and regional operations manager. Quality Improvement alerts are identified to minimise potential risks occurring and the facility is required to complete an action plan. Oceania Rahiri lifestyle care and village is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. Services are provided at Rahiri lifestyle care and village that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for HCAs, registered and enrolled nurses and household staff. There are clear ethical and professional standards and boundaries within job descriptions.

Oceania has implemented its Connect Model of Care throughout its facilities. Connect is made up of seven elements that are specific to the essential parts of care within a facility. The elements can be applied individually or together. The seven elements of the model of care are;

Resident: Creating a range of choice and activities of daily living for residents.

Family: Building on existing relationships with residents families, loved ones and friends.

Spirit and Culture: Facilitating the individual spiritual connection of residents and celebrating their spiritual identity and cultural differences.

Body: Understanding the physical needs and limitations of residents and ensuring exercise programmes are developed to cater to residents capabilities and maintain mobility/movement.

Team: Creating understanding of Oceania's values of respect, excellence, passion and deliver.

Community: The expansion of relationships with the community.

Provider: This is about each facility being linked to all the providers in their region that support an aged care facility.

Rahiri lifestyle care and village has completed three elements of the model of care. Improvements to residents quality of life and how these are achieved by implementing and engaging staff residents, family/whanau and community in each module are documented and videos and accounts of residents, family staff and community involvement with each element are shared with other Oceania facilities.

**Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

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

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

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

Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. The clinical leader and enrolled nurses interviewed (3) demonstrated their responsibility to notify family/whānau of any incident/accident that occurs and contact with family/next of kin is recorded. D16.4b Five relatives (three hospital, one rest home, one dementia) stated that they are always informed when their family members health status changes. Access to interpreter services is identified through the local DHB.

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

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

D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Dementia unit booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new resident’s handbook providing practical information for residents and their families.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

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

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

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

Oceania Rahiri lifestyle care and village has policies in place for advanced care planning, informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights.

There is an End of Life Decisions Policy and Informed Consent policy which help to guide staff practice and promote informed choices made by residents.

Review of seven resident files, three hospital, two rest home and two dementia, all included appropriately signed resuscitation forms, general consent forms and evidence that advance directives are actively discussed with residents and family.

Discussions with the clinical nurse leader and three enrolled nurses identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

D13.1 there were seven admission agreements sighted and all had been signed on the day of admission.

D3.1.d Discussion with five family identified that the service actively involves them in decisions that affect their relative’s lives.

**Criterion 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.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

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

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

Advocacy policy and procedure provides definitions of advocacy and states that information on advocacy is made available. Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the facility manager and clinical leader, described how residents are informed about advocacy and support.

Interviews with 11 residents (five rest home and six hospital) confirmed that they are aware of their right to access advocacy.

D4.1d: discussion with five family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.

D4.1e: seven residents files reviewed included information on residents family/whanau and chosen social networks.

**Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources**

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

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

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

The service has a policy maintaining links with family and community, identifies assistance with the electoral process and visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported by activity staff to access the community as required and the service maintains key linkages with other community organisations.

D3.1h; Discussion with five family (three hospital one rest home, one dementia) that they are encouraged to be involved with the service and care.

D3.1.e; Discussion with staff across the facility and five family members confirmed that residents are supported and encouraged to remain involved in the community and external groups such as church visits, own GP and shopping. This also links with Oceania's Connect model of care.

**Criterion 1.1.12.1 Consumers have access to visitors of their choice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

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

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

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

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights . D13.3h. a complaints procedure is provided to residents within the information pack at entry. The complaints register for 2012 -13 ( two written and two verbal) were tracked, indicating that they had been actioned according to investigation/follow-up letter timeframes and all identified resolution. The monthly staff and quality meetings identified discussion of complaints and outcomes. Discussion with eleven residents (six rest home, five hospital) and five relatives (three hospital, one rest home, one dementia) confirmed they were provided with information on complaints and complaints forms.

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

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

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

**STANDARD 1.2.1 Governance**

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

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

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

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

Oceania's overall vision is "To provide excellent contemporary care that reflects our residents' individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life". There are four key values that are displayed on the wall in the main reception area. There is a site specific business plan that is compiled on consultation with the facility manager and Oceania's regional operations manager (ROM). Business Plan Project Status Report 2012-13 was sighted which was developed 09-Oct-12. The plan is separated into four sections; Physical Product, Services and Choice, Relationships and Market Presence and Financial Performance. The report provides visibility to all aspects of the facility Business Plan, agreed actions and key performance indicators. Additionally, each Oceania facility develops an annual quality plan.(sighted).

Oceania Rahiri lifestyle care and village provides hospital, medical, rest home and dementia level care for up to 49 residents. There were 21 rest home residents and 18 hospital residents and eight dementia level care residents at the time of audit. There were no residents at the facility receiving care under a medical contract.

Rahiri lifestyle care and village has an experienced facility manager (registered nurse) who has been in the role for three years. She is supported by a clinical leader (RN). There are job descriptions for both positions that include responsibilities and accountabilities. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

There is a regional operations manager who is available to support the facility and staff. Advised by the facility manager that the regional operations manager visits two monthly or sooner if there is a request/need.

Clinical indicators completed monthly and forwarded electronically by the facility manager to Oceania support office are part of the benchmarking programme which can highlight/alert areas for improvement.

Policies and procedures are developed at an organisational level with input from staff and external specialist expertise where required.

D17.3di (rest home) & D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

ARC E2.1, The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

Bupa is currently in negotiations to purchase Rahiri Lifestyle Care and Village. Bupa's overall vision is "Taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. There is a week by week transition plan established around the purchase, including establishing Bupa systems (Bupa Quality Programme / annual audit schedule /incident & accident reporting processes and policies / annual education schedule / staff competencies /formal orientation process will be implemented) with the current management and staffing team. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

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

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

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

During a temporary absence, the clinical leader covers the facility manager's role. There is registered nurse cover 24/7 in the hospital wing and an enrolled nurse works in the rest home Monday-Friday. The clinical leader provides registered nurse input into the dementia unit. The service is supported by the regional operations manager and Oceania's support office. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. There is a quality plan 2013 which includes consumer rights, quality and risk management (which includes infection control and health and safety), restraint minimisation, service delivery, education and training, work place culture and dementia specific objectives. The manager provides a monthly report to Oceania support office which includes a wide range of quality indicators in accordance with the quality plan and these are benchmarked against other Oceania services/facilities as part of the benchmarking programme.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

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

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

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

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

Oceania Rahiri lifestyle care and village has a well-established quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, and also to the trust board.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The facility has a master copy on computer of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. Discussion regarding policy development/revision occurs at staff meetings. Release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all facility managers and clinical nurse leaders identifying a brief note of which documents are included at that time. There is a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. Key components of the quality management system link to the monthly quality improvement meetings. There is a standing agenda for monthly quality improvement meetings which are held on the third Monday of each month. These include discussion of residents care issues, clinical updates, benchmarking indicators, audit results and corrective action plans, improvement projects, complaints/compliments, policies and reviews, staff training, supplier performance and any other business. Weekly reports by facility manager to the regional operations manager and quality indicator reports to Oceania support office provide a coordinated process between service level and organisation. Clinical indicator reports that are completed monthly include the following: Abuse, absconder, choking, complaint, sentinel event, falls, infection control, medication ,restraint, weight loss and wounds.

There are monthly accident/incident benchmarking reports completed by the clinical nurse leader that break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents. Weekly and monthly facility manager reports include complaints. Weekly reports from facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. Health and safety committee meets monthly and Health and safety is also an agenda item at the quality improvement meetings. Health and safety and incident/accidents, internal audits are completed. Annual analysis of results is completed and provided across the organisation.

The monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Oceania analyses data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to the facility via graphs and benchmarking reports. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality Improvement forms are utilised and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated.

D19.3:There is a comprehensive H&S and risk management programme in place.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Strategies and equipment available to minimise falls risk are hi low beds, floor sensor mats, walking frames, gutter frames, nurse call bells and mobility aids.

The Bupa organizational goals will be introduced at the care home. Many of these are captured using Bupa’s benchmarking process and regular reporting systems. The goals are; 10% reduction in incidents where staff are harmed by residents; 70% of CGs enrolled or completed a national qualification (Level 2 and 3); 20% of qualified nurses on the Bupa PDRP: No more than 20% of our residents on antipsychotics; All residents on the new Care plan by end of Q1 2014; Roll out of new CG orientation programme. Identification of any KPI that is high – work to reduce. Introduction of BUPA Policies and forms will be phased in over coming weeks. The care home will continue to use any existing policies /procedures and forms until each is superseded by the Bupa documents as they are rolled out during the acquisition plan. As each new Bupa policy is rolled out – the existing policies /procedures and forms must be removed from circulation and destroyed.

Where there are obvious gaps or areas of risk - Bupa will implement relevant policies /documents immediately.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

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. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and H&S meeting reflect a discussion of results.

A sample of incident/accident forms were reviewed for April 2013 from each unit, and all identified that the next of kin were contacted or if family did not wish to be contacted. The incident forms reviewed were 13 falls, (four hospital, four rest home and five for rose view dementia unit.) There is evidence of assessment and first aid provided, registered nurse follow up including clinical observations, post fall assessment forms, development of short term care plans and review of risk assessments, review by GP and referral as appropriate. Contact is documented on either the progress notes or family contact sheet.

There was one medication incident documented where the pharmacist had not signed the Controlled drug register when stock had been returned to pharmacy. Pharmacist was advised of this and it was corrected.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

Register of registered nurses' practising certificates is maintained. Website links to the professional bodies of all health professionals have been established and are available on the computers and in training folder.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Nine files reviewed files (two registered nurses, one enrolled nurse, one cleaner, three HCAs, cook, diversional therapist) and all had up to date performance appraisals. All staff files included a personal file checklist.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. New staff are buddied for a period of time (e.g. HCA six weeks, RN four weeks), staff carry a clinical load after approx. 3 days whilst being buddied. Completed orientation booklets are on staff files. Staff interviewed (clinical leader, three enrolled nurses and six caregivers) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. One HCA interviewed had recently commenced employment at the facility and reported that the orientation process was thorough, with on-going support being provided by the staff including the clinical nurse leader, manger and other more senior HCAs. There is an annual education schedule that is being implemented. External education is available via the DHB and Oceania. There is evidence on RN and EN staff files of attendance at internal and external training days.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the staff meetings.

A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.

D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, restraint, wound management, CPR, and T34 syringe driver.

E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

E4.5f There are eight staff working in Roseview dementia unit, seven staff have completed the required dementia standards. One HCA is in the process of completing dementia unit standards with the Oceania Education Programme.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

There is an Interim RN shortage Policy that aligns with contractual requirements and includes skill mixes. There is good registered nurse cover. Nursing/caring hours per resident day for the various client groups are documented.

There are three units within the facility. There is an experienced facility manager (RN) who works Monday-Friday 08.30-18.00hrs. The clinical leader works 32 hours in this role from 08.00-16.30hrs and as an RN on Sundays 0645-1515hrs. The facility manager and clinical leader provide on call cover. There is an experienced enrolled nurse who works in the rest home Tuesday -Friday 06.45-15.15hrs. There is a senior health care assistant or enrolled nurse on each shift in the rest home and dementia unit. An enrolled nurse works 14.45-23.15 hrs four afternoons per week in the dementia unit.

The service provides 24 hr RN cover. Interviews with relatives and residents all confirmed that staffing numbers were good. Health care assistants and enrolled nurses interviewed stated that staffing ratio to residents is good, that they have input into the roster and management were supportive around change when times are busier.

In planning staffing levels and safe skill mixes, Bupa refer to the Safe staffing Guidelines document which has helped to shape “WAS” as a tool to manage staffing levels. There are no changes to current staffing planned. The organisation has relieving FM/CM’s that are placed throughout the country as needs determine. Operations Manager is covered by another colleague when on leave.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

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

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

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

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure locked filing cabinets at the nurses' station in each unit/department. Archived files are kept in a secure external storage area.

Person Centred Care Plans reviewed (seven) did not specify/document the date they were completed. Policies contain service name. All resident records contain the name of resident and the person completing the entry.

Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.

D7.1 Entries are legible, dated and signed by the relevant HCA, registered or enrolled nurse including designation. However progress notes reviewed do not document the actual time the report is written.

**Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.**

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

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time

**Finding Statement**

Entries are legible, dated and signed by the relevant HCA, registered or enrolled nurse including designation. However progress notes reviewed do not document the actual time the report is written. Person Centred Care Plans reviewed (seven) did not specify/document the date they were completed.

**Corrective Action Required:**

Ensure that progress notes document the time the report is written and that care plans are dated.

**Timeframe:**

6 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.1 Entry To Services**

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

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

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

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

Residents and/or family/whanau are provided with an information pack on entry to the service. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code. There is a criteria for entry to the facility. The facility manager (FM) or clinical leader (CL) require an approval of level of care from Support link assessment team prior to entry.

There is an admission policy, a resident admission and orientation procedure and checklist.

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

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

D14.1 exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement

E3.1 Two resident files were reviewed and all includes a needs assessment as requiring specialist dementia care

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.2 Declining Referral/Entry To Services**

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

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

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

The service has an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member is informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available and if the client did not meet the level of care the facility provided. The client and family/whanau/referrer would be advised if no beds that they could be placed at another facility while awaiting a vacancy. If the client did not meet the level of care the facility provided the referrer would be contacted. The Clinical leader interviewed described a good working relationship with the STAR team at Palmerston North Midcentral Health who were aware of the levels of care provided at Rahiri lifestyle care and village and there had not been any declined entries to date.

**Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

D.16.2, 3, 4: The seven files reviewed (three hospital, two rest home and two dementia care) identified that an assessment was completed within 24 hours which also included a registered nurse resident clinical risk assessment. Information gathered on admission from Support link needs assessment, discharge summaries, GP health records and letters, allied health notes, staff progress notes and discussion, resident/family/whanau participation and feedback provide the basis for the person centred care plan - long term (PCCP). All seven files reviewed identify that the person centred care plan - long term (PCCP) is completed within three weeks. There is documented evidence that the care plans are reviewed by a registered nurse and amended when current health changes. Seven of seven care plans evidenced written evaluations with multidisciplinary (MDT) and resident/family/whanau participation are completed at least six monthly.

Spirituality, cultural values and beliefs are included in the initial assessment and long term PCCP. A cultural assessment is completed on admission. Activity assessments are completed by the activities person. Residents interviewed (six rest home and five hospital) and relatives (three hospital, one rest home and one dementia care) stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files (three hospital, two dementia and two rest home ) included family contact details and communication form which recorded which documented discussions with family/whanau regarding changes to health, incidents, upcoming PCCP reviews and GP visits.

D16.5e: Five of seven files reviewed identified that the GP had seen the resident within two working days. Two residents had been discharged form Midcentral Health and had been seen by a Geriatrician prior to discharge. It was noted in seven resident files reviewed that the GP has assessed the resident as stable and were to be reviewed three monthly. More frequent medical review was evidenced occurring in files of residents with more complex conditions or acute changes to health status. The medical centre Nurse Practitioner was interviewed and explained that part of her role is to visit the residents requiring medical input and liaise directly with the GP regarding possible interventions of care such as medical visit, prescriptions, investigations or follow-up required. There is no after-hours medical service and resident requiring medical attention are transferred to the Emergency department at Midcentral health. The clinical leader and facility manager (a registered nurse) alternate the registered nurse on-call for the facility.

A range of assessment tools where completed in resident files on admission and reviewed at least six monthly if applicable including (but not limited to); a) Tinetti falls risk, mobility, balance and gait assessment b) waterlow pressure area risk assessment, c) continence and bowel assessment (and bowel chart), d) oral assessment e) dietary assessment, f) pain assessment and Abbey pain assessment g) wound assessment and h) challenging behaviour assessment.

All RN's have completed their level one professional recognition development portfolio (PRDP) and one RN is in the process of completing level two PRDP. One RN (new graduate) is funded through Midcentral DHB to complete a year training in clinical practice for aged care.

Clinical staff have undertaken education and training in all areas of clinical care such as safe handling of residents and use of transfer equipment safety, skin and pressure area management, continence management, palliative care and challenging behaviour within the last year. This is followed up with clinical competencies and internal audits. Staff could describe a verbal handover with written handover sheets at the end of each duty that maintains a continuity of service delivery. All resident files (seven) reviewed identified integration of allied health and a team approach.

Seven resident files were reviewed as follows: three hospital residents; two rest home residents and two dementia care residents.

Residents with behaviours that challenge were reviewed from the dementia unit. Behaviours in all two resident files were well identified through the assessment process, management plans implemented; short term care plans were developed for acute episodes of aggressive behaviour with evidence of regular evaluations.

Tracer Methodology: Hospital level 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.*

Tracer Methodology - resident in Dementia care unit

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

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

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

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

Information obtained on admission interview includes (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, family/whānau support, activities preferences, food and nutrition information. Informed consents and resuscitation or end of life information is obtained in a timely manner.

Person centred care plans from each of the three care units reflect the assessments which are used as a basis for care planning. Residents and their family are made aware of the contents of the care plan and this information is available to other health professionals as needed Residents (six rest home and five hospital) advised on interview that assessments were completed in the privacy of their single room. A range of assessment tools where completed in resident files on admission and reviewed at least six monthly or earlier if health needs changed including (but not limited to); a) Tinetti falls risk, mobility, balance and gait assessment b) waterlow pressure area risk assessment, c) continence and bowel assessment (and bowel chart), d) oral assessment e) dietary assessment, f) pain assessment and Abbey pain assessment g) wound assessment and h) challenging behaviour assessment. Baseline observations of blood pressure, pulse, temperature and weight are recorded. Desired outcomes and goals of residents are identified. The RN completes an initial person centred care plan within 24 hours of admission. Continuing needs/risk assessments are carried out by a registered nurse.

Notes by GP and allied health professionals are evident in seven of seven residents integrated files sampled. Families interviewed (three hospital, one rest home and one dementia care ) are complimentary of the clinical and medical care provided and confirm they are kept informed of any significant events, changes in health status and are involved in the care planning.

ARC E4.2; two resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4.2a Challenging behaviours assessments are completed

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

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

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

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

The RN develops the person centred care plan (PCCP) - long term is developed from information gathered over the first three weeks of admission. The PCCP long term care plan is focused on the resident with nursing interventions and support documented to meet the residents desired outcomes to promote wellbeing and independence. The long term care plan includes the residents medical diagnosis and any alerts. Nursing assessments included in the long term care plan are as follows: communication; orientation/mental and emotional needs; mobilisation assessment and interventions (including physiotherapy/occupational therapy; personal hygiene and skin care; oral hygiene; sleep; eating/drinking; elimination; controlling pain including location/type and medications required; respiratory; restraint/enabler if applicable; maintaining safe environment; interests and goals; spirituality; cultural values and beliefs; expressing sexuality; grieving/death/dying. All seven care plans viewed evidenced resident or family/whanau involvement in the care planning process and reviews six monthly.

Residents interviewed (six rest home and five hospital) and relatives (three hospital, one rest home and one dementia care) stated that they and/or their family were involved in planning their care. The resident file also contains the care progress notes; medical notes; referral letters; discharge summaries, risk assessment tools; observation recordings form; weight monitoring, laboratory results. Activities assessments and progress notes are also contained within the integrated file. Allied health professionals record their visits in progress notes in the integrated resident file.

Person centred care plans - short term are used to document any changes in health needs with interventions, management and evaluations. Three examples sighted were for weight loss, skin tear and high risk falls.

The Liverpool care pathway is implemented for residents nearing end of life/palliative care. Staff received palliative care education November 2012 and RN's are competent in the commencement and monitoring of the syringe driver.

RN's attended care planning in-service January 2013. An internal audit was conducted January 2013 and again in April 2013 with noticeable improvement in audit outcomes.

E4.3 two resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, Short term care plans are in use for changes in health status.

D16.3f; seven resident files reviewed identified that family were involved.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

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

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

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

Care delivery is recorded by the RN/health care assistants on each shift. Changes are followed up by registered nurses (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurses initiate a review and if required a GP consultation or referral to the appropriate health professional. The six health care assistants interviewed (two hospital, two rest home, two dementia care) stated that they have all the equipment referred to in PCCP's necessary to provide care, including standing and lifting hoists, pressure relieving mattresses and cushions, shower chairs, shower trolley, transfer belts, slide sheets (slippery sams), wheelchairs, weighing scales, gloves, aprons and masks. The staff in dementia care unit have ready access to a hoist should this be required. All staff report that there are always adequate continence supplies and dressing supplies. Supplies of continence, wound care products and adequate linen supplies were sighted stored in each unit.

Monitoring charts such as blood sugar levels, food and fluid intake charts, weight monitoring and behaviour monitoring charts were evidenced in use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Staff attended urology and incontinence education September 2012. An internal audit was conducted on continence management February 2013.

The clinical leader described the weight loss policy. Residents are weighed monthly and any loss is actively managed with frequent weighs, food charts, and supplementary fluids. The GP is notified in a week if there is no weight gain. A dietitian referral is initiated if required.

Residents requiring oxygen therapy are assessed by the Respiratory nurse.

Pain assessments are completed for all residents receiving regular or prn pain relief. Pain management forms are held in the medication folder for prn pain relief detailing time, type of pain, pain score, medication given. The monitoring of the effectiveness of pain relief in the progress notes is inconsistent (see 1.3.8.2)

Resident falls are recorded in the progress notes, reported to RN/CL and on accident/incident forms, family notified, GP notified, PCCP-short term with interventions (examples sighted - hip protectors, review of medications, sensor mats, mobility aids, ensure call bell within reach) and on-going evaluations by RN Staff attended moving and handling education Nov-12 and falls management education May-13. A physiotherapist referral is initiated if required.

HCA's interviewed (six) were kept informed of residents care and health changes at handover and read the PCCP's. There is a handover period between shifts and regular staff meetings. Daily resident progress notes are maintained.

AD18.3 and 4 Dressing supplies are available and a treatment rooms are well stocked for use. Wound assessment and wound management plans are in place for six residents. Wounds include an elbow pressure ulcer and sacral ulcer (2 residents). Appropriate pressure area management is in place and interventions linked to the short and long term care plans. There is one chronic wound and there is evidence of wound clinic and surgical review involvement. Other wounds currently being treated include three skin tears. The USL wound products representative is available for advice and booked for education later in the year. The district nursing service and wound care clinic nurse is readily available for advice. RN's undergo wound care competencies.

Improvement note: replace wound assessment information (2003) in wound care folder with updated information to reflect current best practice.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

There are is one diversional therapist who is employed Monday to Friday 9 am to 4.pm to provide the activities programme for hospital and rest home residents. The programme in the dementia unit is run by a health care assistant under the supervision of the diversional therapist. The health care assistant is employed specifically for an additional hour a week for the purpose of planning, coordinating and documenting the programme for the residents living in the dementia unit. The plan is then delivered by the health care assistants who are employed to provide care within the dementia unit. The activities programme in the dementia unit runs from 8.30 am to 4pm. There is a 24 hour wheel in operation that alters depending on the resident's moods in the dementia unit and the programme includes doing household activities. Residents in the dementia unit are able to participate in the rest home activities programme from time to time and participation is dependent on their mood and behaviour and the availability of staff to provide supervision. All three programmes include group and individual activities. Group programmes are developed monthly and displayed in large A3 size print in dementia unit (as these residents are prone to rubbing information off white boards). The programme is displayed on white boards for the rest home and hospital residents. The hospital level programme includes but is not limited to: activities such as music, hairdressing, wheelchair walks, stories and group discussions, massage, pet therapy, van rides, newspaper readings, DVDs, external visitors. The rest home activities programme includes but is not limited to: physical activities (eg, exercises, bowls, skittles, walks); music, reminiscing, pet therapy, housie, happy hours, cards, bingo, piano playing, spelling quests, DVDs, CD Music, Manicures, hairdressing, current affairs discussions. The dementia unit programme includes activities related to normal daily living (eg setting the dining room table, clearing dishes, folding some laundry, cooking (icing biscuits)),and other group and individual activities (eg, walks 1:1) housie, exercises, hairdressing, manicures, newspaper reading, visits by external entertainers, sports games (eg quoits, balloon tennis, ball catching). Staff match the programme to the health of the residents and their preferences/preferred choices. Different church denominations take it in turns to come each Sunday afternoon following their morning services. On the day of audit residents in all three areas were observed being actively involved with a variety of activities both group and individual. Some residents choose to do activities in their own rooms.

All residents have an initial social and activities assessment within three weeks of admission in keeping with the Oceania Group recreation activities programme policy. Assessments are completed by the diversional therapist and or the healthcare assistant (if the resident is living in the dementia unit). The assessment includes a complete history of past and present interests, career, and family relationships. Individual plans are developed for the resident and documented and integrated within the resident's person centred care plan (PCCP). Activities attended by the resident are then recorded in a monthly attendance record. A summary of the resident's involvement in activities is recorded within the progress notes. The effectiveness of the plan is evaluated six monthly at the multi-disciplinary PCCP review (sighted).

All 11 residents (six rest home, and five hospital) and five relatives (one rest home, one dementia, and three hospital),stated they were happy with the activities programmes and that people were given choices regarding participation.

D16.5d Each resident has a written and implemented social and recreational programme which is reviewed when the PCCP is reviewed.

E4.3,iv requires a description in the care planning of the individual therapy over a 24 hour period for residents in dementia units. An improvement is required as outlined in 1.3.7.1 below.

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

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

There are three group activities programmes in operation as well as individualised activities.

**Finding Statement**

E4.3,iv Three of the eight residents in the dementia unit, had individual plans which had been developed using the 24 hour wheel diagram method. All three plans were unsigned and undated. Each of these three residents had been admitted between 2010 to 2011. Documentation for recently admitted residents was consistent with Oceania's policy and practice in that each resident had activities plans integrated within their PCCPs and no separate individual plans covering the 24 hour period.

**Corrective Action Required:**

Ensure each resident in the dementia unit has an individualised plan of activities covering the 24 hour period that reflects their former routines and activities that are still familiar to the resident should they need diversional, motivation and or recreational therapy.

**Timeframe:**

6 months

**STANDARD 1.3.8 Evaluation**

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

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

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

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

Initial Person centred care plans (PCCP's) are evaluated within three weeks of admission. PCCP's - long term are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted. Seven of seven PCCP's evidenced evaluations completed at least six monthly. There is a written evaluation completed by the multidisciplinary team (MDT) and includes the CL, RN,DT, pharmacist, resident or relative. Enrolled nurses and HCA's interviewed confirmed they are involved in any changes to changes to residents care and review of PCCP's. The review is discussed with the GP at their routine review of the resident three monthly. Members of the MDT team sign the written evaluation. The RN makes changes to the PCCP - long term.

There are PCCP's - short term care to focus on acute and short-term issues. Changes to the PCCP- long term are made as required and at the six monthly review if required. Examples of PCCP's - short term use included; unexplained weight loss, wounds, challenging behaviours, and falls. Monitoring charts such as fluid balance charts and food intake charts and behaviour monitoring charts were evidenced in use.

Pain assessments are completed for all residents receiving regular or prn pain relief. Pain management forms are held in the medication folder for prn pain relief detailing time, type of pain, pain score, medication given. The monitoring of the effectiveness of pain relief in the progress notes is inconsistent. There are improvements required around the monitoring of effectiveness of pain relief.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated. The Nurse Practitioner interviewed stated that the GP was informed in good time of any concerns the registered nurses have regarding changes in patients' conditions and faxed communication and phone calls were evidenced in seven files reviewed.

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

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

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

Pain assessments are completed for all residents receiving regular or prn pain relief. Pain management forms are held in the medication folder for prn pain relief detailing time, type of pain, pain score, and medication given. The monitoring of the effectiveness of pain relief in the progress notes is inconsistent.

**Finding Statement**

Effectiveness of pain relief administered is not consistently recorded in the resident’s progress notes or use of a pain assessment monitoring tool.

**Corrective Action Required:**

Ensure pain relief is monitored for effectiveness.

**Timeframe:**

6 months

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.9 Referral To Other Health And Disability Services (Internal And External)**

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

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

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

Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation reports and follow up required, investigations and results are maintained on resident files. Examples of referrals sighted were to Support links needs assessment team, Elder Health, Hospice, dietitian, skin specialist, optometrist, ear health clinic, wound clinic, surgical clinic, and respiratory nurse. Allied health professionals record their visits in the allied health progress notes.

D16.4c: The service provided examples of where rest home residents whose condition had changed and the residents were reassessed for a higher level of care and transferred to hospital care wing within the facility or transferred to another facility of the residents/family choosing.

D 20.1; Discussions with registered nurses identified that the service has access to wound care nurse specialists, incontinence specialists, gerontology nurse specialists and dieticians. The clinical leader described the referral process should they require assistance from a wound specialist or continence nurse.

**Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer**

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

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

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

The clinical leader described the document and nursing requirements as per the policy for discharge and transfers. The documentation required includes transfer form and copies of the PCCP, advance directive, drug chart and any other relevant information. The family are informed of any transfers. Previous transfer documentation was sighted in a residents file. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.

**Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

Medication management policies and procedures cover each stage of safe administration of medicines including, delivery, storage, medicine reconciliation and returns. The pharmacy supplies medico blister pack medications and other pharmaceuticals to the facility. Two RN's check medications on delivery and report any discrepancies to the pharmacy. There are two safes in the hospital unit; one being for the controlled drugs (CD's) for the hospital, rest home and dementia units. The second safe is for RN access only and holds the standing order medications for Liverpool care pathway, CD ordering book and register. A weekly stocktake of CD's is carried out by the RN/Enrolled nurse and pharmacist. Each unit has a locked area where the medication trolley is stored. Medications in all the trolleys including GTN sprays, ointments and eye drops had not expired with the exception of eye drop bottles in the Rest Home unit. There are medication fridges in the hospital and rest home units. Both fridges are monitored daily and temperatures are within acceptable ranges. The dementia unit staff have access the rest home fridge. All returns to the pharmacy are held in the hospital medication room and records kept of returns. There are approved biohazard containers available for the safe disposal of sharps. The medication folders include a list of specimen signatures, instructions for the treatment and management of hypoglycaemia and resident pain assessment forms where applicable. All medication competent staff are responsible for medication administration in all areas. All Health Care Assistants (HCA's) and RN's undergo annual medication competencies completed May-13. Medication management education was provided April 2013. Other medicine management education includes nebulizers (Jan and March -13) and Insulin, taking of blood sugar levels (Jan, Feb and March-13). RN's attend annual syringe driver education and competency sessions provided at Arohanui Hospice in Palmerston North last attended May 2013.

Medication charts have photo ID’s. There are special instructions for administration or precautions if applicable with the resident drug chart. There are 'alert' , allergy and duplicate name stickers used where required. Administration signing sheets for regular and prn medications given are signed correctly. Controlled drugs given are signed by two medication competent staff. Telephone verbal orders are signed within two days (sighted). Internal medication management audits were carried out March and May 2013. Corrective actions were implemented.

One resident is self-administering medications as assessed by a registered nurse. There was no evidence of RN monitoring of the dose, frequency and times of medications being self-administered by the resident. There is an improvement required to ensure the GP agrees to the resident self-medicating and this is reviewed at regular intervals.

D16.5.e.i.2; 14 medication charts (four dementia, five hospital and four rest home) were sampled. Five medication charts identified that the GP had not reviewed and signed the medication chart at least three monthly.

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

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

Medication management policies and procedures cover each stage of safe administration of medicines including, delivery, storage, medicine reconciliation and returns.

**Finding Statement**

The CL has completed an assessment for one resident to self-administer medications, however medical notes reviewed did not document that discussion with the GP has occurred and/or if the GP was aware that the resident was self-administer medications. Five medication charts did not evidence review occurring three monthly.

**Corrective Action Required:**

Ensure the GP reviews medication charts at least three monthly. Ensure the GP documents when a resident is competent to self-administering medications immediately.

**Timeframe:**

1 month

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

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

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

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

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

The service employs two cooks, three catering assistants and one kitchen hand. The kitchen is staffed by a cook from 8 am to 4.30 with assistants. Evening staff come in from 4 pm to 6.30 pm to attend to the evening meal. Breakfast is prepared by the night staff. Porridge is prepared in a slow cooker and night staff heat milk and make toast. Staff are guided by the Oceania Group Ltd.’s food safety and kitchen service policies and procedures dated August 2012. There is one kitchen that supplies meals for each area. All of the kitchen team have completed food safety certificates. There is a cleaning schedule in operation. The menu is a four weekly, seasonal menu that has been developed for Oceania by a dietitian (last reviewed March 2013 ). Kitchen fridge, food and freezer temperatures are monitored and documented daily. The kitchen is part of the internal audit programme (last audit occurred 30 April 2013. CARs identified were competed). All residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted in a red book, Staff know the likes and dislikes as do the cooks. Staff are aware of those residents who are identified in the care plans as requiring specialist equipment (eg, special lipped plates, oval plates, dinner plates, special spoons, feeding cups, and straws). Special diets being catered for include soft diets, puree diets and diabetics. Staff make the sustagen up for the residents who need supplementary feeding. Hospital residents are served meals in the hospital lounge/dining area. The residents in the dementia unit have their meals served in the lounge/dining area. Rest home residents are served in the dining room by the kitchen and the cook serves the meal from the Bain Marie. Residents and relatives are satisfied with the food service (confirmed in interview with 11 residents (five hospital and six rest home) and five relatives (one rest home, one dementia unit and three hospital). Meals are well presented (observed) and served on hot plates as appropriate. Alternative meals are offered as required

E3.3f, Staff can access additional nutritious snacks for residents anytime over the full 24 hour period. There is a fridge in the dementia unit which contains sandwiches, milk, protein drinks and puddings.

D19.2 staff have been trained in safe food handling.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.1 Management Of Waste And Hazardous Substances**

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

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

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

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

Oceania has a range of policies and procedures on the management of waste and the prevention of infection. Management of waste and hazardous substances is covered during orientation of new staff and refresher education occurs (eg, education on infection control last occurred 28 February 2013. Education on hazard management occurred on 28 November 2012 and education on health and safety is on-going through the work of the quality team). The majority of chemicals used on the site are supplied by Ecolab and are clearly labelled with manufacturers labels. Material Data Safety sheet information is available. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, gumboots and over boots for showering are available for staff protection. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

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

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

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

Maintenance is currently being carried out by contractors. The facility manager, the administrator or the team leader of household services organises for servicing to occur. Reactive and preventative maintenance occurs (programme documentation sighted). Maintenance requests are recorded in a log system and requests are signed off when actions have been completed.

The building has a current warrant of fitness which expires 21-Jan-14. Electrical equipment is checked annually. Fire equipment is checked by an external contractor. Hoists and medical equipment are checked, serviced and or calibrated. The living areas are carpeted. Vinyl surfaces exist in bathrooms/toilets and kitchen areas. The dementia unit has a mix of cork and linoleum flooring and one bedroom has carpet squares. The flooring in the main living area is vinyl. Resident rooms in the hospital and rest home areas are carpeted with vinyl in ensuites. The Hospital area has 6 bedrooms with ensuites. There are four bedrooms in the rest home with ensuites. There are no ensuite bedrooms in the dementia unit. There are two lounges in the hospital area, 1 lounge plus a bowls room in the rest home area and one lounge in the dementia area. There are separate dining rooms for each area. The facility has multiple numbers of toilets and showers and separate toilets for staff and visitors. The facility is fully equipped with electric beds in all hospital rooms and a number of individual rest home residents have these depending on their individual requirements. The corridors are carpeted with hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens are attractive with plenty of setting and shade..

Residents in the dementia unit have a secure external area to wander in which includes a bird aviary. There is a range of outdoor furniture and a shade sail and umbrellas for providing shade.

There is wheelchair access to all areas.

Interviews with the clinical leader, three of three enrolled nurses and six of six health care assistants (two rest home, two dementia unit and two hospital area) confirmed there was adequate equipment.

ARC D15.3;A range of equipment is available including but not limited to: pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids and weighing scales.

E3.3e: There is one lounge/dining area in the dementia unit. Resident’s rooms provide privacy when required.

E3.4c; There is a safe and secure outside area that is easy to access for residents in the dementia unit.

E3.4d, The lounge area in the dementia unit is designed so that space and seating arrangements provide for individual and group activities.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities**

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

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

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

The facility has five wings (i.e., two in the hospital area (referred to as Birchwood and Lavengro wings), two in the rest home area (referred to as Totara and Kowhai wings) and one wing in the dementia area (referred to as the Roseview wing). There are showers and toilets throughout the facility. All resident rooms share communal facilities except for 10 rooms that have ensuites (i.e., six in the hospital area and four bedrooms in the rest home area).There are adequate visitor and staff toilet facilities with appropriate hand drying facilities available. Communal toilets and bathrooms have appropriate signage and easy access locks. Hot water temperatures are monitored and maintained at/or below 45 degrees Celsius. Privacy is maintained at all times for residents (confirmed by observation and in discussion with 11 of 11 residents (five hospital, and six rest home) and five of five relatives (one rest home, one dementia and three hospital). Fixtures and fittings are appropriate and fit for purpose.

**Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

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

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

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

The rooms and corridors are spacious. Large equipment (eg, wheel chairs and hoists) is able to be easily manoeuvred around the bed and personal spaces and within the corridors. Six health care assistants (two from each area) report that rooms have sufficient space to allow cares to take place. Residents were observed manoeuvring wheelchairs in rooms safely. One resident has a mobility scooter which she charges in her bedroom and rides on within the facility. Her bedroom is sufficiently large enough to cope with this situation.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

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

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

Communal areas are available for relaxation, dinning and for entertainment. The rest home has a large main lounge and a smaller bowls room (complete with raised indoor bowling area) and a dining room. The hospital area has two lounges with one doubling as a dining area. The dementia unit has a combined lounge/dining area. All lounges and dining rooms are easy to access and can accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and all 11 of 11 residents interviewed report they can move around the facility and staff assist them if required

E3.4b:There is adequate space to allow maximum freedom of movement while promoting safety for those that wander in the dementia unit.

**Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

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

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

Oceania has policies to guide staff when doing laundry or cleaning. The laundry manual includes guidance on the following: laundry policy, transport of laundry procedure, soiled line procedure, washing, wool washing, drying, processing storage, speciality linen, cleaning, chemical handling. Material Safety Data Sheets are kept on site. There is a cleaning handbook which includes guidance on how to clean all equipment. The cleaners have a cleaning schedule task list and a cleaning schedule. There are three cleaners and one casual cleaner employed. Cleaning occurs Monday to Friday from 8 am to 1.30 pm (two cleaners). On the weekends there is one cleaner employed who works 5 hours a day. Laundry is done onsite. Laundry staff are employed to work a six week rolling roster. Three laundry workers are employed from 8.45am to 2.15 pm and the other two are employed 8 am to 1.30 pm. The laundry has dirty and clean separation. Laundry services audits are completed on a regular basis (The last audit was completed by the clinical leader in 12-April-13, who identified CARs which have subsequently been resolved. Cleaning is also routinely audited. (The last audit was completed on 03-May-13 and no CARs were identified.) The laundry and cleaning room are designated areas and are clearly labelled and able to be locked when not in use. All chemicals are labelled with manufacturer’s labels.

There is sluice room in the laundry and another sluice room outside of the laundry in the hallway for the disposal of soiled water or waste. Stained clothes and whites are soaked as needed.

All 11 of 11 residents and five of five relatives expressed satisfaction with both cleaning and laundry services.

**Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

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

Oceania has a comprehensive emergency plan dated January 2012. In addition Oceania has produced an Emergency Evacuation Toolkit to guide facility managers so that they can train all registered nurses and health care assistants on the plan. There are flip charts displayed on the wall of the facility to guide staff in an emergency. The facility has an approved fire evacuation scheme which was approved on 02-Apr-07 (letter sighted). Fire evacuations are held six monthly and the time of the drill is varied (ie, the last evacuation was held on 27-May-13. Appropriate training, information, and equipment for responding to emergencies is provided (Staff training in fire safety last occurred on 20-Feb-13 attended by 11 staff). Fire equipment is available (eg, extinguishers and fire blankets). The extinguishers were last checked in November 2012. There is a civil defence kit which is stored in an external shed (sighted). The site stores ten x 25 litre containers of drinkable water for emergencies plus there are three large ceiling tanks of water for use as well. The civil defence kit includes a torch, a radio, batteries, gumboots, waterproof clothing, gloves, handtowels and other items. There is access to gas BBQs, The kitchen is powered by electricity and there is gas piped to the site to heat water and run the dryer. There are emergency medical supplies held in case of an infectious outbreak which includes continence products and additional PPE. There is 24 hours a day, seven days a week registered nurse cover so that residents can be provided with first aid if needed. There is an up-to-date register maintained that lists all residents. Emergency food supplies sufficient for three days are kept in the kitchen and some extra blankets are also available. Hoists have battery backs. Hoists are checked professionally and the electrician is in the process of checking and re-tagging all the electrics. The facility has oxygen cylinders for use in an emergency. There is one resident who uses an oxygen concentrator and this resident would be swapped onto the oxygen cylinder in the event of a power failure. List of names and contact details of staff listed on roster if needed to contact in an emergency. The night security is managed on contract with a local company. The call bell system is electric and indicator panels are placed throughout the facility. Residents have easy access to the call bells and staff answer bells promptly (confirmed in discussion with 11 of 11 residents and five of five relatives.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.8 Natural Light, Ventilation, And Heating**

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

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

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

The facility has plenty of natural light in communal areas and plenty of natural light through external windows in each bedroom. Heating is a mix of electric panel heaters and radiators. Ventilation is managed by opening windows and doors. Facility temperatures are monitored by staff. The facility manager reported that the heating is able to be adjusted as to the season and individual resident need. There is an external area designated for residents who smoke and a separate smoking area for staff off the staff room.

**Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

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

Restraint policy (251) states their philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident’s quality of life however we acknowledge that there may be occasions when a resident’s ability to maintain their own or another’s safety may be compromised and the use of restraint may be clinically indicated.

There is a Regional Restraint group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures.

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has six residents on the register with an enabler in the form of a bedrails. The files reviewed of six residents identified as having an enabler in the form of a bedrail included a comprehensive enabler assessment that covered alternatives and least restrictive options.

The service currently has no residents requiring an enabler and five residents (two requiring a bed rail and one a low bed) in the hospital assessed as restraint. A register for each restraint is also completed that includes a monthly evaluation.

There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, regional restraint meetings and at an organisational level.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

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

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

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

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort.

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. There are no residents are requiring the use of an enabler.

A registered nurse is the restraint coordinator. A job description in place and is signed and dated 26-Jan-12.

**Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

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

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

Assessments are undertaken by a registered nurse in partnership with the resident and their family/whanau. All staff complete a restraint competency assessment.

Restraint assessments are based on information in the person centred care plan, resident discussions and on observations of the staff. There is a restraint assessment authorisation and plan available and this completed for the residents requiring the use of a restraint or enabler. The person centred care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. A restraint assessment form is completed for those residents requiring restraint. Two restraint files were reviewed in the hospital, (two lap belts and low bed). All files included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed monthly (written evaluation sighted).

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

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

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

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

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

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

(f) Maintaining culturally safe practice;

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

(h) Possible alternative intervention/strategies.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

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

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is a registered nurse and is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed at least three monthly and also as part of monthly restraint register reviews and monthly RN meetings. Monthly clinical indicators reported to Oceania support office by the manger benchmark the use of restraint and can highlight is there are any issues corrective actions. Any restraint incidents/adverse events are discussed at the RN and quality meeting and corrective actions initiated. Monitoring and observation process is included in the restraint policy. Advised by the restraint coordinator that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.

The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of three hospital residents with restraint identified observations and monitoring occurring within the prescribed timeframes documented on individual residents’ restraint assessment. Restraint use is reviewed through the three monthly assessment evaluation, monthly RN and staff meetings and six multi-disciplinary meeting and includes family/whanau input. A restraint register is in place. This has been completed for all residents requiring restraint.

**Criterion 2.2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:**

(a) Only as a last resort to maintain the safety of consumers, service providers or others;

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

(d) When the environment is appropriate and safe for successful initiation;

(e) When adequate resources are assembled to ensure safe initiation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

(d) The outcome of the restraint;

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations have occurred three monthly as part of the on-going reassessment for the residents on the restraint register, and as part of care plan review. Families are included as part of this review. A review of two files identified that evaluations are up to date and have reviewed (but not limited to); a) whether the desired outcome was achieved, b) whether the restraint was the least restrictive option and c) the impact. Restraint is reviewed on a formal basis three monthly through restraint register review, monthly clinical indicators reported to Oceania support office and at the national Restraint Authority Group which meets annually. Evaluation timeframes are determined by risk levels.

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

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

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

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

(d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

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

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

Individual approved restraint is reviewed at least three monthly and as part of six monthly multidisciplinary review with family/whanau involvement. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the Regional Restraint Approval Group and information is disseminated throughout the organisation. The organisation and facility are very proactive in minimising restraint usage. There is an Oceania National Restraint Approval Group which meets annually.

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

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

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

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

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

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**STANDARD 3.1 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.

ARC D5.4e ARHSS D5.4e

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

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

The scope of the infection prevention and control programme policy and infection prevention and control programme description are available. There is a job description for the infection prevention and control coordinator and clearly defined guidelines and accountabilities (Job description signed 20 February 2012). The infection prevention and control (IPC) committee includes a cross section of staff all areas of the service The committee and the governing body is responsible for the development of the infection prevention control programme and its review. The programme is developed by the coordinator and is included in the training plan. The programme covers the actions that the IPC committee will undertake for the year (sighted). The plan is also outlined in the infection control policies and procedures manual which was last reviewed February 2012. The coordinator and committee have access to professional advice within the organisation and they have developed close links with the GP's, MedLab, the infection prevention and control and public health departments at MidCentral DHB. There are monthly infection prevention and control meetings. The monthly quality meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and staff meetings. Minutes are available for staff and are on display on the wall by the staff room. The facility has signage if the need to use it for outbreaks and displays this information as needed. Visitors are encouraged to stay away if sick. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy in place to ensure staff do not spread infections. The last outbreak occurred in April 2013, which was an outbreak of suspected scabies, although scabies was never formally confirmed. The outbreak involved two residents and no staff. Scabies was diagnosed by the GP and a skin scraping was done, which came back reporting contact dermatitis. However the GP decided to treat everyone for scabies and all residents and staff were treated. The treatment was coordinated with the public health nurse and all GPs. A meeting was held with all staff. Consent was obtained from all residents and or families. The diagnosis was unable to be confirmed. The situation resolved following treatment of everyone.

**Criterion 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.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

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

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

The infection prevention and control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the which includes the IPC coordinator as chair, an enrolled nurse as deputy chair, plus a registered nurse, three health care assistants, a person from housekeeping, and a staff member from the kitchen. Meetings are held monthly (minutes sighted). The facility also has access to infection prevention and control nurses from MidCentral DHB, public health nurses, G.P's and MedLab plus can consult with Oceania's clinical quality managers for opinions and guidance. The coordinator can access the laboratory for results if needed and has access to ongoing education (last attended infection control training through Bug Control November 2012 (7 hours) held in Palmerston North. She is able to access education as needed and feels well supported by the company.

**Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

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

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

D 19.2a: Oceania's infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines. The infection Control manual includes policy on hand hygiene, standard precautions, transmission based precautions, prevention and management of infections, antimicrobial usage, outbreak management, cleaning of equipment, single use items and renovations and construction and other policies. There is also policy on waste disposal, and notification of diseases. Infection control procedures are included in the kitchen, laundry and the housekeeping manuals. External expertise can be accessed as required. Policy development is primarily driven by Oceania management with input from staff as required

**Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

The infection prevention and control coordinator is responsible for coordinating and providing education and training to staff. The IPC coordinator has attended education and is enrolling in a graduate diploma in IPC which will be held in the latter half of 2013. She and the RN on the committee provide the education for staff. They use outside resources to provide education as well (eg MidCentral IPC nurses). Education was last provided for staff in hand washing on 28 March 2013 and was attended by eight staff. Staff who attended supplied evaluation feedback. Compulsory staff training on the management of an outbreak occurred on 28-Feb-13 and was conducted by MidCentral DHB staff. This external training was attended by 23 staff. MidCentral staff evaluated the training and have the results. The orientation package for all staff includes specific training around hand washing and standard precautions. Resident education is expected to occur as part of providing daily cares. Care plans can also reference infection control as needed. Residents and relatives are provided with education on influenza prior to flu vaccinations occurring. This education is ongoing during the flu season.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

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

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

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection prevention and control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections (both asymptomatic and symptomatic, plus those treated with antibiotics and those not treated with antibiotics). Data are entered into the log form and then logged electronically. The log form is then filed in the resident's file. All infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator, which is supplied to management and head office. Standardised definitions of infections are in place throughout Oceania and are appropriate to the complexity of service provided. Infection prevention and control data are collated monthly and reported at the quality meetings. The surveillance of infection data assists in evaluating compliance with infection prevention and control practices. Remedies are developed when needed and CARS are put in place. Internal audits occur (last audit was completed in May 2013.). There is close liaison with the GP's who advise and provide feedback to the service (confirmed in discussion with the GP's nurse practitioner). Quality Improvement initiatives are developed and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. Infection numbers are counted per month and graphed. The numbers of infections per month per area are very low. Oceania benchmarks infection rates between facilities over time and results are displayed to inform all staff. There is a flu vaccination programme in place. Residents were offered vaccinations in 18-Mar-13 (all but four residents at the time accepted vaccination). Staff are offered free vaccinations as well. The manager forwards infection rates data as per clinical indicators which are reported to Oceania Support Office monthly. Oceania benchmarks the clinical indicators against other similar Oceania sites.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**