

# Oceania Care Company Limited - Heretaunga Home & Village

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Current Status: 3 July 2014

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

## General overview

Heretaunga Home and Village provides rest home and dementia level care for up to 46 residents in single bedrooms and studio rooms. There are 37 residents on the day of this audit. The facility is operated by Oceania Care Company Limited.

This unannounced surveillance audit was undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. This audit included a review of the two aspects of service provision that were identified as requiring improvement in the previous certification audit in November 2012; one of which has been fully addressed and the other still requires improvement. The one that still requires improvement relates to the consistency with monitoring and closing out the corrective action plans.

Three new areas were identified as requiring improvement during this audit relating to timely notification of serious incidents to Oceania support office; the consistency with which staff undertake neurological observations of residents following unwitnessed falls; recording of three monthly reviews of resident's medications on the resident's medication charts.

## Audit Summary as at 3 July 2014

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 3 July 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 3 July 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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### Continuum of Service Delivery as at 3 July 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 3 July 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 3 July 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 3 July 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Oceania Care Company Limited
<b>Certificate name:</b>	Oceania Care Company Limited - Heretaunga Home & Village
<b>Designated Auditing Agency:</b>	Health Audit (NZ) Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Heretaunga Home & Village
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 3 July 2014 <b>End date:</b> 4 July 2014
<b>Proposed changes to current services (if any):</b>	
	Dementia care beds are provided. Reconfiguration of services by converting four existing rest home beds to secure dementia care beds.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	37

## Audit Team

<b>Lead Auditor</b>	XXXXXXXX	<b>Hours on site</b>	12.5	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXXXX	<b>Total hours on site</b>	12.5	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	2.5

## Sample Totals

Total audit hours on site	25	Total audit hours off site	11.5	Total audit hours	36.5
Number of residents interviewed	5	Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	17	Total number of staff (headcount)	40	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	2

## Declaration

I, XXXXXXXXXXX, Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Tuesday, 8 July 2014

## Executive Summary of Audit

### General Overview

Heretaunga Home and Village provides rest home and dementia level care for up to 46 residents in single bedrooms and studio rooms and there are 37 residents on the day of this audit. The facility is operated by Oceania Care Company Limited.

This unannounced surveillance audit was undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. This audit included a review of the two aspects of service provision that were identified as requiring improvement in the previous certification audit in November 2012; one of which has been fully addressed and the other still requires improvement. The one that still requires improvement relates to the consistency with which staff monitor and close out corrective action plans. Three new areas were identified as requiring improvement during this audit relating to timely notification of serious incidents to Oceania support office; the consistency with which staff undertake neurological observations of residents following unwitnessed falls; recording of three monthly reviews of resident's medications on the resident's medication charts.

### Outcome 1.1: Consumer Rights

Residents and family members interviewed report that services are provided in a manner that respects residents' rights and facilitates informed choice. They report that they are happy with the service provided and that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and any significant change in a resident's condition. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code of Rights) information is displayed along with complaint forms.

The facility manager is responsible for complaints and a complaints register is maintained. The residents and their family members can use the complaints issues forms or raise issues at the residents' monthly meetings. The service provides an environment that is conducive to effective communication.

### Outcome 1.2: Organisational Management

Oceania Care Company Limited is the governing body and is responsible for the service provided at Heretaunga Home and Village. Planning documents reviewed include a vision statement, values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Heretaunga Home and Village including regular monthly reporting by the facility manager and the clinical leader to the Oceania support office. The facility is managed by a suitably qualified and experienced facility manager who has worked at Heretaunga Home and Village for the last 19 years. The facility manager is supported by a clinical leader who is a registered nurse and who is responsible for oversight of clinical care provided.

The Oceania Care Company Limited quality and risk management systems are in place at Heretaunga Home and Village. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. There is an internal audit programme in place and improvements are noted with the consistency with which staff develop and implement corrective action plans to address any areas identified as requiring improvement. However, improvements are still required with the monitoring and closing off of these corrective action plans. Risks are identified, and there is

a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms and an electronic database that is able to be reviewed by personnel from Oceania's support office. Improvements are required with the timeliness with which staff from Heretaunga Home and Village notify serious incidents to Oceania support office.

There are policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise is occurring. In-service education is provided for staff at least two weekly and staff are also supported to complete the New Zealand Qualifications Authority Unit Standards for the 'Certificate in Residential Care' via Tai Poutini Polytechnic. A review of staff records provides evidence that human resources processes are being followed that includes but is not limited to reference checking and criminal record vetting, orientations are being completed and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of three health care assistants; two in the dementia unit and one in the rest home. The clinical leader/ registered nurse, or the other registered nurse is on call after hours. Care staff interviewed report there is adequate staff available and that they are able to get through their work.

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

Residents confirm involvement throughout service delivery and staff members are suitably qualified to render services. Support and interventions by the service provider are documented and record the required encouragement, direction, or supervision of residents. Staff members utilise written progress notes to record any resident issues, sighted. The general practitioner's notes as part of the six monthly medical reviews in the resident's files are current. Activity plans reflect everyday living and residents have opportunity to participate in community activities. Individual activity plans are reviewed at the time of the nursing reviews of care plans. Short and long term care plans are specific, comprehensive, and up-to-date and reflect the needs of the residents. Staff members responsible for medicines management complete competencies to ensure safe and appropriated medicines management processes. There are no residents who self-administer medicines.

There are two requirements for improvement relating to recording of neurological observation and three monthly medicines reviews by the general practioners.

Menus are planned and reviewed by the dietitian and fluid and nutritional needs are provided for by the service. Food stores evidence use-by-dates. Satisfaction surveys evidence residents' satisfaction with food services. Food and fridge and freezer temperatures are within specified requirements. The cooks recently completed refresher training in food safety.

### **Outcome 1.4: Safe and Appropriate Environment**

The facility manager advises there have not been any structural alterations to the building since the last audit. The facility manager advises that two doors with digital locks have been relocated to increase the number of beds in the dementia unit by four. The facility manager and fire compliance officer advise that building consent was not required and that the approved fire evacuation scheme remains unchanged. A Building Warrant of Fitness is displayed at the main entrance that expires on 17 August 2014.



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Meeting minutes and completed internal audits reviewed do not consistently provide documented evidence that: corrective actions are being monitored for their effectiveness; are being signed off as completed; and the timeframe and person/s responsible for the corrective action is recorded.	Provide documented evidence that corrective actions are being monitored and signed off as being completed and that the timeframe and person/s responsible for the corrective action/s is being consistently recorded.	180
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	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.	PA Low	A sentinel event was not notified to Oceania support office until 20 days after the initial accident with injury was reported to the clinical leader.	Provide confirmation that staff are aware of their responsibilities in relation to reporting of essential notifications.	90
HDS(C)S.2008	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.	PA Moderate			
HDS(C)S.2008	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.	PA Moderate	Neurological observations are not consistently recorded for un-observed falls.	Staff members to complete neurological observations for all un-observed falls to ensure the safety of residents at all times.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	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.	PA Low	Seven out of the 17 resident medicines files reviewed did not have three monthly reviews recorded for the residents.	All residents to have three monthly reviews of medicines recorded on the medicines charts.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Open disclosure procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed (two rest home and three dementia) provide evidence that communication with family is being documented in communication with family sheets, as well as in the residents' progress notes. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the individual resident's files.

Residents (five rest home) and family (three dementia and two rest home) interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care. The facility manager advises access to interpreter services is available if required via members of staff, the resident's family, and the district health board and interpreter services. The facility manager advises they currently have two residents who have limited English and their family members have provided prompt cards to assist staff when providing care for these residents.

Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed).

Visual inspection provides evidence the Code of Health and Disability Services Consumers' Rights (the Code of Rights) information is readily displayed along with complaint forms.

The district health board contract requirements are met.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Wherever necessary and reasonably practicable, interpreter services are provided.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The facility manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes three complaints for 2014 (two from residents living in the village) and three for 2013 and is reviewed during this audit.

The facility manager reports there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, district health board, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

Complaints policies and procedures are compliant with Right 10 of the Code of Rights. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents (five rest home) and family (three dementia and two rest home) interviewed demonstrate an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues they have during these meetings and this is confirmed during interview of residents.

A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of quality improvement meeting minutes, facility managers and the clinical leader's monthly reports provide evidence of reporting of complaints.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## Outcome 1.2: Organisational Management

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

### Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Oceania Care Company Limited (Oceania) is the governing body and is responsible for the service provided at Heretaunga Home and Village (Heretaunga). The Oceania quality and risk management systems are fully implemented at Heretaunga and documented scope, direction, goals, vision, and mission statement reviewed.</p> <p>Systems are in place for monitoring the service provided at Heretaunga including regular monthly reporting by the facility manager and the clinical leader to Oceania support office via intranet and include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators, and these are sighted during this audit. The monthly business status reports are sighted and these reports are provided to the Oceania executive team and link to the organisations and the facility's business plan.</p> <p>A written quality and risk management plan/policy identifying the organization's quality goals, objectives, and scope of service delivery reviewed and includes statements about quality activities and review processes. A 'Clinical Risk Management Policy' and a 'Clinical Risk Management Plan' are reviewed along with documented values, mission statement and philosophy, which are displayed at the main entrance. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.</p>

The facility manager is an experienced facility manager who has been employed at Heretaunga since 1995. The facility manager was appointed to their current position in 2000. The facility manager is supported in their role by a clinical leader, who is a registered nurse and who was appointed to this position in 2010. The clinical leader and facility manager are supported by another registered nurse. Registered nurse cover is provided seven days a week between 8am and 4.30pm.

The facility manager, clinical leader and the registered nurse are supported by an Oceania quality and clinical manager as well as a regional business operations manager from Oceania. The facility manager has completed the National Diploma in Business (Aged Care Facility Management) via Tai Poutini Polytechnic. The facility manager is not a registered nurse. The clinical leader and the second registered nurse both have current practising certificates. The facility manager's, clinical leader/registered nurse's and the registered nurses curriculum vitae (CV)s and personal files are reviewed and there is documented evidence they attend education to keep themselves up-to-date.

Heretaunga is certified to provide rest home and dementia level care beds and have contracts with the district health board (DHB) to provide rest home, dementia, day care and respite services. On the day of this audit there are 23 residents assessed as requiring dementia level care and 14 assessed as requiring rest home level care.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

<b>Attainment and Risk:</b> PA Low
<p><b>Evidence:</b></p> <p>Criterion 1.2.3.8 was identified as requiring improvement during the last audit as corrective action plans were not being consistently developed and/or monitored to address all of the shortfalls identified. Criterion 1.2.3.8 remains partially attained as corrective action plans are being developed but are not being consistently monitored for their effectiveness and are not consistently being signed off as completed.</p> <p>A 'Quality Improvement Policy', 'Clinical Risk Management Policy', '2014 Quality Audit Schedule' and a 'Heretaunga Quality Improvement Plan 2014' are used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme in place, risks are identified and there is a hazard register. Clinical indicators are documented on an electronic database that is able to be reviewed by personnel from Oceania support office. The Oceania clinical and quality team meet monthly and review the clinical and quality data, review policies and procedures, and clinical documentation.</p> <p>Relevant standards and legislative requirements are identified and are included in the policies and procedures manuals. Policies and procedures reflect current accepted good practice. Policies and procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff report copies of policies are available in the staff room and they are required to read the policy and sign the staff signing sheet. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via 'Time Target', handover, and via meetings.</p> <p>Internal audit schedules and completed audits for 2014 are reviewed during this audit. Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. Review of the quality improvement data provides evidence the data is being collected, collated, evaluated, and analysed to identify trends and that this data is being reported to staff and to the governing body. Quality improvement / staff meetings, care meetings attended by registered nurses, enrolled nurse and senior health care assistants and health and safety meetings are held monthly. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff report during interviews that copies of meeting minutes and print outs of clinical indicators from the Oceania intranet are available for them to review on the noticeboard in the staff room. This is confirmed during visual observations during this audit.</p> <p>Collated results from the resident / family satisfaction survey completed in July 2013 are reviewed and indicate a 32% return rate; 79% of the respondents are 'satisfied', 0.05% are 'unsatisfied' and 20.95% of the questions are not answered. The 0.05% who indicated they are 'unsatisfied' relate to a question concerning their awareness of</p>

'consumer rights legislation' and accident/incident reporting. The resident / family satisfaction survey is currently being completed and seven completed questionnaires are reviewed. The seven respondents indicate they are satisfied with the service provide and all provide positive feedback.

The health and safety manual documents health and safety management systems including a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements, and an emergency plan. A hazard register is reviewed during this audit. Meeting minutes are reviewed and provide evidence of discussion and reporting on quality improvement data. Oceania holds Workplace Safety Management Practices (WSMP) accreditation at tertiary level for ACC workplace safety and this expires on 31 March 2015.

Chemical Safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed: all biomedical equipment has appropriate performance verified stickers in place.

Not all of the district health board contract requirements are met.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> The facility manager is interviewed and reports they are responsible for management of the quality programme. Internal audits undertaken in 2014 are reviewed and improvements are noted with the consistency with which staff document corrective action plans to address any areas identified as requiring improvement. Internal audit

tools and accident / incident forms have sections to record areas requiring improvement and actions to be taken and these are documented. Quality improvement meeting minutes are reviewed and issues requiring improvement are documented.

**Finding:**

Meeting minutes and completed internal audits reviewed do not consistently provide documented evidence that: corrective actions are being monitored for their effectiveness; are being signed off as completed; and the timeframe and person/s responsible for the corrective action is recorded.

**Corrective Action:**

Provide documented evidence that corrective actions are being monitored and signed off as being completed and that the timeframe and person/s responsible for the corrective action/s is being consistently recorded.

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

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

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

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Improvements are required with the timeliness with which staff notify serious incidents to Oceania support office as there is one 'sentinel event' that staff took 20 days to notify to Oceania support office (see criterion 1.2.4.2)

There is an adverse event reporting system in place. All accident/incidents are recorded on an 'Incident/Accident Reporting Form' as well as on an 'Incident Accident Register'. Accident / incident forms are reviewed in residents' files. Copies of these forms are also kept in a folder of adverse events that are filed month-by-month. The clinical leader/registered nurse or the other registered nurse also enters these accidents and incidents on the Oceania intranet as part of the reporting of monthly clinical indicators. Incidents recorded include but are not limited to incidents relating to absconding, choking, falls, infections, medication errors, sentinel events (see 1.2.4.2), wounds, and abuse. An 'Incident/Accident' internal audit was last completed in March 2014.

Communication with families following adverse events, or any change in resident's condition is evidenced in the residents' files reviewed. Staff education on falls management and observations was held on 20 February 2014 and 16 September 2013. Communication education was provided 13 February 2013. With the exception noted under criterion 1.2.4.2, staff interviewed demonstrate an awareness of the adverse event process.

Not all of the district health board contract requirements are met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Oceania 'Incident / Accident and Sentinel Event Policy' is reviewed and provides definitions of incidents/accident, sentinel event and near miss. This policy also describes the management of an incident/accident and a sentinel event. The policy describes the identification of sentinel events, the investigation process and reporting of sentinel events to external agencies. The policy states the general manager, clinical and quality is responsible for reporting of sentinel events to external agencies.

Review of quality improvement data on the Oceania intranet indicates there has been one serious/sentinel event notified to Oceania support office in 2014. An 'Incident / Accident Reporting Form' for a resident who had a fall with injury dated 22 May 2014 is reviewed (see also link criterion 1.3.3.3). This form has follow up action documented by the clinical leader including transfer to hospital. The form indicates the manager, family / power of attorney and resident's doctor have been notified of this accident. The form indicates this event has been escalated to 'serious or sentinel event status' and is signed off by the facility manager on 9 June 2014.

A printout of the Oceania intranet 'Clinical Indicators – Record Your Incidents' dated 10 June 2014 indicates this event was notified as a 'Sentinel Event' to Oceania support office via intranet on 10 June 2014. An email dated 10 June 2014 from the senior clinical and quality manager indicates notification of this sentinel event.

The facility manager is interviewed and advises they have spoken with the senior clinical and quality manager concerning requirements to notify the Ministry of Health as per the requirements of section 31 of the Health and Disability Service (Safety) Act 2001.

Staff are also made aware of their essential notification responsibilities through their job descriptions.

**Finding:**

A sentinel event was not notified to Oceania support office until 20 days after the initial accident with injury was reported to the clinical leader.

**Corrective Action:**

Provide confirmation that staff are aware of their responsibilities in relation to reporting of essential notifications.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The clinical leader is responsible for oversight of the in-service education programme and education for staff is provided at least two weekly. Staff education plans, staff competency register and staff education records are maintained and are reviewed for 2013 and 2014.

Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards for the 'Certificate in Residential Care' via Tai Poutini Polytechnic. There are 13 care giving staff currently working in the dementia unit and six have completed the dementia specific unit standards. Four staff are currently working towards completing the dementia specific unit standards and the remaining three staff members are new employees (less than six months) and are yet to enrol to complete these unit standards.

The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority and are reviewed on staff files (seven of seven) along with employment agreements, criminal vetting, completed orientations and competency assessments. Individual records of education are maintained for each staff member.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, enrolled nurses, dietitian, pharmacist, and general practitioners (GPs) is occurring. An appraisal schedule is in place and current staff appraisals sighted on staff files reviewed.

Four of four health care assistants interviewed working in the rest home and/or the dementia unit (three working morning shifts and one working afternoon shifts) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The district health board contract requirements are met.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is a documented rationale ('Interim Staffing Policy') for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of three health care assistants (HCA); two in the dementia unit and one in the rest home. The clinical leader and the second registered nurse share the after-hours on call and this is clearly indicated on the roster.</p> <p>Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. Residents and family members interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirms adequate staff cover is provided.</p> <p>The district health board contract requirements are met.</p>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** PA Moderate

#### Evidence:

The residents' needs are being met, however the general practitioners' medicines reviews are not consistently completed at three monthly intervals (refer to criterion 1.3.12.6). Residents confirm involvement throughout service delivery and staff members are suitably qualified to render the services.

Five out of five (two rest home and three dementia unit) sampled resident files evidence evaluation and review of the resident care plans. The clinical leader (CL) or the registered nurse (RN) complete an admission assessment on all new residents. The initial care plans are developed on admission whilst data for the long term care plans is collected during the first three weeks, sighted and confirmed at the clinical leader and health care assistant (HCA) interviews. The long term care plan is developed from the information gathered at admission, the initial assessments and risk assessments.

The previous requirement relating to six monthly nursing reviews not being completed in a timely manner and referrals not being communicated are now fully implemented.

The district health board contract requirements are not fully met.

Tracer methodology in the rest home

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

Tracer methodology in the dementia unit

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

**Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> The resident whose care in the dementia unit was assessed after an un-observed fall by the HCA who completed general observations; however the neurological observations were not completed for the resident as the resident fell on top of the walker. Review of the resident's file shows the resident had seven un-observed falls between 15 April 2014 and 17 April 2014. The staff members record general observations however none of these falls have neurological observations recorded. The auditor extended the sample size and looked at incident and accident records for all the un-observed falls recorded during May and June 2014.
<b>Finding:</b> Neurological observations are not consistently recorded for un-observed falls.
<b>Corrective Action:</b> Staff members to complete neurological observations for all un-observed falls to ensure the safety of residents at all times.
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Residents, family and the general practitioners (GPs) confirm they are satisfied with the service. Five out of five residents' files (two rest home and three dementia unit) sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the resident. The required clinical care is recorded in long term care plans as well as in short term care plans such as the management plan for the chest infection.</p> <p>Support and interventions by the service provider are documented and record the required encouragement, direction, or supervision of a resident completing their own personal cares. Staff members utilise written progress notes to record any current resident issues, sighted. The general practitioners' notes are current.</p> <p>Visual inspection of the service evidences adequate continence and dressing supplies in accordance with requirements of their Service Agreement. Five out of five residents in the rest home and five of five family members (two in the rest home and three in the dementia unit) interviewed confirm the care and treatments they are receiving meet their needs.</p> <p>The district health board contract requirements are met.</p>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Activities are appropriate to the service setting, needs and age and culture of the residents. Activity plans reflect everyday living and residents have opportunity to participate in community activities.</p> <p>The activities coordinator in the rest home and the diversional therapist in the dementia unit record attendance at activities and prepare monthly activity programmes. Interviews with the activities coordinator and the diversional therapist confirm participating in satisfaction surveys and resident meetings. Activities in the rest home focus on the abilities and interests of residents at rest home level of care and activities in the dementia unit are specifically chosen with the needs and abilities of the residents in the dementia unit in mind. Interviews with the activities coordinator and the diversional therapist confirm individual activity plans are reviewed at the time of the nursing review of the care plans.</p> <p>The residents and family interviewed confirm activities are meaningful and varied. The district health board contract requirements are met.</p>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Care plans are reviewed every six months, or as required and reviews are comprehensive. One rest home resident reviewed has a short term care plan and the resident reviewed in the dementia unit has amendments to the long term care plan reflecting changes in condition, sighted and confirmed at the clinical leader interview. The service ensures where progress is different from expected, they respond by documenting changes to the care plans, confirmed during the clinical leader interview and sighted. The dementia unit resident files reviewed show a 24 hour clock for the management of challenging behaviour and a specific plan with suggested interventions for managing difficult behaviour. The district health board contract requirements are met.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> <p>Staff members that are responsible for medicines management complete competencies to ensure safe and appropriated medicines management processes. The service has eight health care assistants (HCA's), two enrolled nurses (EN's) and two registered nurses (RN's) of which one is the clinical leader, who are responsible for medicines administration. Medicines management competencies are signed off annually.  The most recent medicines management training was completed on 29 and 30 May 2014.  The facility does not support self-administration of medicines for residents, confirmed at resident, family and the clinical leader interviews. There was no evidence of any residents self-administering medicines during the time of the audit.</p> <p>The afternoon medication round was observed on the first day of audit. The systems and processes for medicines administration are aligned with legislative requirements.</p>

The service has a process for returning medicines to the pharmacy and a random check for expiry dates on medicines show that medicines are within the time-frames for safe use. The RN and the clinical leader are responsible for medication reconciliation.

A controlled drug register is maintained according to legislative requirements. Entries are legible, controlled drugs are checked weekly and the pharmacist completes a six monthly review and stock-take. The medicines fridge temperatures are monitored and controlled drugs are being kept in a locked safe within a locked cupboard.

Medicines management information is recorded to a level of detail which includes resident's medicines charts being legible, the general practitioner signing and dating all new entries and discontinued medicines are signed and dated. Allergies and sensitivities are recorded, each resident has photo identification on their medicines chart however, and not all residents whose charts were reviewed had timely reviews of their medicines charts completed by the general practitioner. Although the clinical leader confirms that medical reviews are conducted at the six monthly multi-disciplinary reviews, seven out of the seventeen resident medicines files reviewed did not have three monthly reviews recorded for the residents.

The district health board contract requirements are not fully met.

### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Medicines management is recorded to a level of detail and communicated to residents in a timely manner. Allergies and sensitivities are recorded, each resident has photo identification on their medicines chart, medicines entries and discontinued medicines are dated and signed by the general practitioner and medicines reconciliation occurs. Not all residents whose charts were reviewed had three monthly reviews of their medicines charts completed by the general practitioner.
<b>Finding:</b> Seven out of the 17 resident medicines files reviewed did not have three monthly reviews recorded for the residents.
<b>Corrective Action:</b> All residents to have three monthly reviews of medicines recorded on the medicines charts.
<b>Timeframe (days):</b> 90 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents' nutritional needs are catered for as each resident has a nutritional assessment completed at admission, confirmed at the clinical leader and the cook interviews. Special needs for residents are being identified on the dietary assessment. Fluid and nutritional needs are provided for by the service. Residents that need additional nutritional requirements or special diets, have their needs met by the service keeping information regarding their needs at hand in the kitchen to ensure specific nutritional needs are catered for. The cook also receives copies of the dietary assessments completed at admission.

Menus are planned and reviewed by the company dietitian, the latest review occurred in March 2014. Visual inspection of the kitchen confirms appropriate food services. Interviews with residents and their family members confirm they receive food services in line with legislative requirements. Food stores evidence use by dates and food is identifiable.

Satisfaction surveys evidence residents are satisfied with food services. Food procurement and storage are according to legislative requirements. Food temperatures, fridge and freezer temperatures are recorded and within specified requirements. The kitchen is cleaned according to a written cleaning roster which is signed off by the person responsible for cleaning duties on the day.

The cooks completed refresher training in food safety training during May 2014, awaiting their certificates.  
The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Three single bedrooms from one end of the rest home and one bedroom from the other end of the rest home have been converted to bedrooms for dementia level care residents. The facility manager advises that two doors with digital locks, one door at each end of the dementia unit, have been relocated to increase the number of beds in the dementia unit by four. The facility manager and fire compliance officer advise that building consent was not required for these alterations and that the approved fire evacuation scheme that was approved in February 1996 remains unchanged. A Building Warrant of Fitness is displayed at the main entrance that expires on 17 August 2014.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The restraint register show that there are no residents using restraint and or enablers in the facility.

Residents in the dementia unit that may present with challenging behaviour are monitored to identify triggers for challenging behaviour. These triggers are identified early in order to prevent challenging behaviour from occurring. The service implemented the 24 hour challenging behaviour clocks with prompts regarding possible challenging behaviour and suggestions of how to deal with possible challenging behaviour.

The service provides on-going training to staff, in de-escalation techniques and the management of challenging behaviour. The clinical leader and health care assistants confirm they are familiar with managing challenging behaviour and de-escalation of challenging behaviour. Training occurred on 28 November 2013, 11 January 2014 and 26 June 2014.

The GPs confirm they are satisfied that challenging behaviour is managed in an appropriated manner.

The district health board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. The infection control coordinator, who is also the clinical leader, completes a monthly infection control monitoring report.

The infection control surveillance report includes the name of the resident, whether the infection occurred in the rest home or the dementia unit, the type of the infection, if the definition of the infection meets the requirements of the of the Centres of Disease Control (CDC), the type of symptoms and when the resident started to present with symptoms, the laboratory results, the type of treatment the resident is commenced on, the outcome of the treatment and when the condition is resolved.

Infection control data is discussed at the monthly quality and staff meetings, sighted meeting minutes. The surveillance data is reported to the support office of Oceania at monthly intervals through an intranet system. The infection control coordinator has a job description to guide the role. The infections are expressed in graphs and the facility participates in internal benchmarking within the Oceania organisation.

Review of data records for the last 12 months indicate that infection rates are low with no adverse trends identified. Audits are completed on a regular basis, sighted. Standard definitions are used to identify infections for surveillance.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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