

Olive Tree Holdings Limited

Current Status: 29 September 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification 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

Olive Tree Rest Home provided residential care for up to 42 residents who required rest home care and dementia rest home level care. The apartments in wing C were reviewed during this audit for rest home residents.

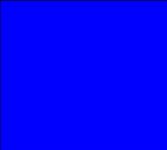
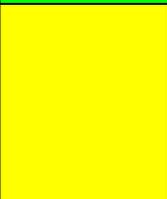
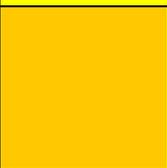
Rest home and dementia services were provided in two wings and occupancy on the day of the audit was 42. The facility was operated by Olive Tree Holdings Limited.

One area was identified as requiring improvement during this audit relating to residents' documentation.

Audit Summary as at 29 September 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 29 September 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 29 September 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 29 September 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.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 29 September 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 29 September 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 29 September 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 29 September 2014

Consumer Rights

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and is brought to the attention of residents' and their families on admission to the facility. Residents and family members interviewed confirmed that their rights were met during service delivery that staff were respectful of their needs, communication was appropriate, and they had a clear understanding of their rights and the facility's processes if these are not met.

During interview residents and family confirmed that consent forms are provided to them prior to admission to ensure they have time for consultation and are informed. Residents and family also advised that time is provided if discussions and explanation are required. Residents and family interviewed provided positive feedback on the care provided.

The general manager is responsible for management of complaints and a complaints register is maintained.

Organisational Management

Olive Tree Holdings Limited is the governing body and is responsible for the service provided at Olive Tree Rest Home. Planning documents reviewed included a business plan with goals as well as a mission statement, values, and philosophy. An organisational chart was also reviewed.

A general manager is responsible for management of the entire facility including the apartments and the villas. The general manager is supported by a clinical manager who is an experienced registered nurse with aged care experience and who is responsible for oversight of clinical care. The clinical manager is supported by a registered nurse. Registered nurse cover is provided seven days a week.

There was evidence that quality improvement data has been collected, collated, and analysed to identify trends and improve service delivery and that this information has been reported to the governing body and to staff. There was an internal audit programme in place and internal audits have been completed. Corrective action plans have been developed, implemented and monitored to address areas identified as requiring improvement. Risks have been identified and the hazard register has identified health and safety risks documented as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events have been documented on accident/incident forms.

Staff meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues. Copies of meeting minutes and graphs of clinical indicators are available for staff to review in the staff room.

There are policies and procedures on human resources management and the validation of current annual practising certificates for health professionals who require them to practice has occurred. In-service education has been provided for staff at least two weekly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care and

dementia and staff have either completed the dementia specific education modules or are working towards completing them. Review of staff records provided evidence human resources processes have been followed and individual education records have been maintained.

There is a documented rationale for determining staffing levels and skill mix and the minimum number of staff is provided during the night shift and consists of two care givers in the dementia unit and two care givers in the rest home. The general manager, clinical manager and the registered nurse share the after-hours on call and are available if required. Care staff interviewed report there is adequate staff available and that they are able to get through their work.

Resident information is entered into a register in an accurate and timely manner although improvements are required as staff are not always recording the time they make the entry in resident's progress notes and medical practitioners names are not always easy to decipher.

Continuum of Service Delivery

The facility had a documented entry criteria, which was communicated to residents, family and referral agencies.

The systems were implemented that evidence each stage of service provision has been developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices.

The documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison was occurring with other services. The residents interviewed confirm that interventions noted in their care plans were consistent with meeting their needs.

A sampling of residents' clinical files validated the service delivery to the residents. The evaluations of care plans were within stated timeframes and reviewed more frequently if a resident's condition changes. The residents and family interviewed confirmed their participation in these evaluations. Where progress was different from expected, the service responded by initiating changes to the care plan or recording the changes on a short term care plan.

Planned activities were appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. The residents' files sampled evidenced individual activities were provided either within group settings or on a one-on-one basis.

There was an appropriate medicine management system in place. Policies and procedures clearly detail service provider's responsibilities. Staff responsible for medicine management had attended in-service education for medication management and had current medication competencies. The residents' who self-administer medicines did so according to policy.

Food, fluid, and nutritional needs of residents were provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Resident's individual needs were identified on admission, documented in nutrition profiles, and reviewed on a regular basis. There was a central kitchen and on site staff that provided the food service. The kitchen staff had completed food safety training.

Safe and Appropriate Environment

Accommodation for residents was provided in single bedrooms and all bedrooms had ensuite facilities. Residents' rooms were observed to be of large and adequate personal space was provided in bedrooms. Nine apartments in Wing C were reviewed as part of this audit as the provider wants to use them for residents who are assessed as requiring rest home level care.

There were lounge and dining areas available throughout the facility and additional areas for residents to sit were observed throughout the facility. External areas were available for sitting and shading is provided in these areas. A safe external area was provided for residents in the dementia unit. An appropriate call bell system was available and security systems were in place.

Visual inspection provided evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing was provided and was used by staff. Review of documentation provided evidence there were appropriate systems in place to ensure the residents' physical environment is safe, and facilities were fit for their purpose.

There were policies and procedures for waste management, cleaning and laundry, and emergency management and these were known by staff. All laundry was washed on site and cleaning and laundry systems included appropriate monitoring systems in place to evaluate the effectiveness of these services. There were safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals.

Restraint Minimisation and Safe Practice

The service had an overarching risk and quality management system that demonstrates compliance with the Standard. The documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents were experiencing services that were least restrictive. The facility was not using restraints or enablers on audit days.

Infection Prevention and Control

The Infection Prevention and Control (IC) Programme included policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice. New employees were provided with training in infection control practices and there was on-going infection control education available for all staff.

Infection control was a standard agenda item at staff and quality meetings. Staff interviews confirmed staff were familiar with infection control measures at the facility.

Surveillance for residents who develop infection were collated at the end of each month and reported as a clinical indicator at staff meetings.

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Olive Tree Holdings Limited
Certificate name:	Olive Tree Holdings Limited
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Certification Audit
Premises audited:	Olive Tree Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 September 2014 End date: 30 September 2014
Proposed changes to current services (if any): Reconfiguration of services by converting nine serviced apartments into rooms for use by residents assessed as requiring rest home level care. These rooms are currently occupied by residents with occupational rights agreement and will be used as rest home rooms as these residents become more dependant and are assessed as requiring rest home level care.	
Total beds occupied across all premises included in the audit on the first day of the audit:	42

Audit Team

Lead Auditor	XXXXXX	Hours on site	12	Hours off site	11
Other Auditors	XXXXXX	Total hours on site	12	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXX			Hours	3

Sample Totals

Total audit hours on site	24	Total audit hours off site	18	Total audit hours	42
Number of residents interviewed	4	Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed	7	Number of staff records reviewed	8	Total number of managers (headcount)	2
Number of medication records reviewed	20	Total number of staff (headcount)	48	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXXX, Managing 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	Not Applicable
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, 7 October 2014

Executive Summary of Audit

General Overview

Olive Tree Rest Home provided residential care for up to 42 residents who required rest home care and dementia rest home level care. The facility also provided accommodation for nine residents in apartments in wing C and 41 residents in wings A and B that are apartment units and residents in these apartments have occupational rights agreements. The nine apartments in wing C were reviewed during this audit as the provider wants to use these rooms for rest home residents.

Rest home and dementia services were provided in two wings and occupancy on the day of the audit was 42. The facility was operated by Olive Tree Holdings Limited.

One area was identified as requiring improvement during this audit relating to residents' documentation.

Outcome 1.1: Consumer Rights

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and is brought to the attention of residents' (if able) and their families on admission to the facility. Residents and family members interviewed confirmed that their rights were met during service delivery that staff were respectful of their needs, communication was appropriate, and they had a clear understanding of their rights and the facility's processes if these are not met.

During interview residents and family confirmed that consent forms are provided to them prior to admission to ensure they have time for consultation and are informed. Residents and family also advised that time is provided if discussions and explanation are required. Residents and family interviewed provided positive feedback on the care provided.

The general manager is responsible for management of complaints and a complaints register is maintained.

Outcome 1.2: Organisational Management

Olive Tree Holdings Limited is the governing body and is responsible for the service provided at Olive Tree Rest Home. Planning documents reviewed included a business plan with goals as well as a mission statement, values, and philosophy. An organisational chart was also reviewed.

A general manager is responsible for management of the entire facility including the apartments and the villas. The general manager is supported by a clinical manager who is an experienced registered nurse with aged care experience and who is responsible for oversight of clinical care. The clinical manager is supported by a registered nurse. Registered nurse cover is provided seven days a week.

There was evidence that quality improvement data has been collected, collated, and analysed to identify trends and improve service delivery and that this information has been reported to the governing body and to staff. There was an internal audit programme in place and internal audits

have been completed. Corrective action plans have been developed, implemented and monitored to address areas identified as requiring improvement. Risks have been identified and the hazard register has identified health and safety risks documented as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events have been documented on accident/incident forms.

Staff meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues. Copies of meeting minutes and graphs of clinical indicators are available for staff to review in the staff room.

There are policies and procedures on human resources management and the validation of current annual practising certificates for health professionals who require them to practice has occurred. In-service education has been provided for staff at least two weekly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care and dementia and staff have either completed the dementia specific education modules or are working towards completing them. Review of staff records provided evidence human resources processes have been followed and individual education records have been maintained.

There is a documented rationale for determining staffing levels and skill mix and the minimum number of staff is provided during the night shift and consists of two care givers in the dementia unit and two care givers in the rest home. The general manager, clinical manager and the registered nurse share the after-hours on call and are available if required. Care staff interviewed report there is adequate staff available and that they are able to get through their work.

Resident information is entered into a register in an accurate and timely manner although improvements are required as staff are not always recording the time they make the entry in resident's progress notes and medical practitioners names are not always easy to decipher.

Outcome 1.3: Continuum of Service Delivery

The facility had a documented entry criteria, which was communicated to residents, family and referral agencies.

The systems were implemented that evidence each stage of service provision has been developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices.

The documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison was occurring with other services. The residents interviewed confirm that interventions noted in their care plans were consistent with meeting their needs.

A sampling of residents' clinical files validated the service delivery to the residents. The evaluations of care plans were within stated timeframes and reviewed more frequently if a resident's condition changes. The residents and family interviewed confirmed their participation in these evaluations. Where progress was different from expected, the service responded by initiating changes to the care plan or recording the changes on a short term care plan.

Planned activities were appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. The residents' files sampled evidenced individual activities were provided either within group settings or on a one-on-one basis.

There was an appropriate medicine management system in place. Policies and procedures clearly detail service provider's responsibilities. Staff responsible for medicine management had attended in-service education for medication management and had current medication competencies. The residents' who self-administer medicines did so according to policy.

Food, fluid, and nutritional needs of residents were provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Resident's individual needs were identified on admission, documented in nutrition profiles, and reviewed on a regular basis. There was a central kitchen and on site staff that provided the food service. The kitchen staff had completed food safety training.

Outcome 1.4: Safe and Appropriate Environment

Accommodation for residents was provided in single bedrooms and all bedrooms had ensuite facilities. Residents' rooms were observed to be of large and adequate personal space was provided in bedrooms. Nine apartments in Wing C were reviewed as part of this audit as the provider wants to use them for residents who are assessed as requiring rest home level care.

There were lounge and dining areas available throughout the facility and additional areas for residents to sit were observed throughout the facility. External areas were available for sitting and shading is provided in these areas. A safe external area was provided for residents in the dementia unit. An appropriate call bell system was available and security systems were in place.

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There were policies and procedures for waste management, cleaning and laundry, and emergency management and these were known by staff. All laundry was washed on site and cleaning and laundry systems included appropriate monitoring systems in place to evaluate the effectiveness of these services. There were safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals.

Outcome 2: Restraint Minimisation and Safe Practice

The service had an overarching risk and quality management system that demonstrates compliance with the Standard. The documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents were experiencing services that were least restrictive. The facility was not using restraints or enablers on audit days.

Outcome 3: Infection Prevention and Control

The Infection Prevention and Control (IC) Programme included policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice. New employees were provided with training in infection control practices and there was on-going infection control education available for all staff.

Infection control was a standard agenda item at staff and quality meetings. Staff interviews confirmed staff were familiar with infection control measures at the facility.

Surveillance for residents who develop infection were collated at the end of each month and reported as a clinical indicator at staff meetings.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	44	0	1	0	0	0
Criteria	0	92	0	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	5
Criteria	0	0	0	0	0	0	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.9	All records are legible and the name and designation of the service provider is identifiable.	PA Low	(i) Staff are not consistently recording the time they are making the entry in resident's progress notes; and (ii) it is not always possible to identify the signature and name of the medical practitioner making entries in resident's notes, including medication charts.	Provide confirmation that (i) staff are consistently recording the time they are making the entry in resident's progress notes; and (ii) the name and designation of the medical practitioner making entries in resident's notes, including medication charts, is identifiable.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Staff receive training in the Code of Health and Disability Services Consumers' Rights' (the Code of Rights) at least annually and staff education records are sighted. Care staff are observed interacting respectfully and communicating appropriately with residents. Staff encourage residents to make choices demonstrating their knowledge of residents' rights.

Residents (four rest home) and family members (three dementia) are able to verify that services are provided with dignity and respect, privacy is maintained, and individual needs and rights are upheld. These findings are also confirmed during review of the responses in the completed resident and family survey questionnaires that were completed in July 2013. The general manager advises the next survey is scheduled for October 2014. The collated results indicate the majority of the respondents are 'satisfied' or 'very satisfied' with service delivery.

Interviews with staff (the general manager, clinical manager, one registered nurse, three care givers working morning and afternoon shifts in the rest home and dementia unit, one activities co-ordinator and a diversional therapist / care giver) demonstrate an understanding of resident rights. Education records reviewed indicate that staff attend training in resident rights as part of their orientation as well as part of the ongoing education programme. This education was last provided in June 2014 by the Health and Disability Advocate.

The District Health Board contract requirements are met.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

The Code of Rights and information on the advocacy service are displayed and are available at the facility. This information is provided as part of the pre-admission and information packs.

Residents (four rest home) and family members (three dementia residents) interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to the resident's admission. The pre-admission and admission information packs are reviewed and contains, but is not limited to, information on the Code, advocacy and complaints processes. Residents and family interviewed confirm explanations regarding their rights occur on admission and at any time that they may have a query. The pack for residents entering the dementia unit also includes dementia specific information including but not limited to challenging behaviour.

The families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and seven admission agreements are reviewed as part of the review of resident's files and all are found to contain this level of information.

Residents interviewed confirm they have access to an advocate and one may be appointed if needed. Residents' meetings are held monthly and review of these meeting minutes indicates residents are aware of their rights. A resident / family satisfaction survey was completed in July 2013 and the completed questionnaires reviewed indicate residents and family are aware of their rights. Family meetings are held for family members who have residents in the safe care unit (dementia) and family members interviewed and review of the satisfaction survey indicates the family appreciate the fact that meetings are being held and find these meetings very helpful.

The District Health Board contract requirements are met.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

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.

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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of residents and family members and during review of the collated results of the completed satisfaction survey questionnaires for residents and family completed in July 2013.

Staff receive training on abuse / neglect as part of the annual in-service education day that was last provided in October 2013. Staff are observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff demonstrate an awareness of residents' rights and the maintenance of professional boundaries.

All bedrooms provide single accommodation and have ensuite facilities.

Activities in the community are encouraged and the general manager and clinical manager advise during interview that some of the residents attend community events independently. Church services are held on site as part of the activities programme.

Values, beliefs and cultural aspects of care are recorded in residents' clinical files reviewed (four rest home and three dementia).

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

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

Attainment and Risk: FA

Evidence:

The organisation has a Māori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. The Māori Health Plan describes that the holistic view of Māori health is to be incorporated into the delivery of services (whanau, Hinengaro, Tinana and Wairau).

There are currently no residents in the facility that identify as Māori. A cultural assessment is completed as part of the care plan for residents and is reviewed on the resident's files.

Access to Māori support and advocacy services is available if required via a Kaumatua from a local marae as well as from the local District Health Board. Family are able to be involved in the care of their family members.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education was last provided as part of the in-service education day that was last provided in February 2014.

The District Health Board contract requirements are met.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

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

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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

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

Attainment and Risk: FA

Evidence:

Documentation reviewed during this audit provides evidence that appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Documentation reviewed lists the details on how to access appropriate expertise including cultural specialists, and interpreters.

Residents' files reviewed demonstrate that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whānau contact details. Residents have a cultural assessment completed as part of the care planning process.

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. These findings are supported during review of the completed questionnaires for the resident/relative satisfaction survey completed in July 2013. The general manager (GM) advises the next survey is scheduled for October 2014. Church services are held on site as part of the activities programme and some residents go out to attend church services with the support of family and friends.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.

The District Health Board contract requirements are met.

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and a staff files reviewed (eight) include copies of employee handbooks / house rules that all staff are required to adhere to. These documents also address any conflict of interest issues including the accepting of gifts and personal transactions with residents and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which are reviewed on eight staff files.

During interview the receptionist / administrator describes the process for managing residents' 'comfort account' funds.

A review of the accident/incident reporting system, complaints register and interview of the general manager indicates there have been no allegations made alleging unacceptable behaviour.

Residents (four rest home) and family (three dementia residents) interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

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

Attainment and Risk: FA

Evidence:

Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. Documentation reviewed provides evidence that policies and procedures are based on evidence-based rationales.

Education is provided by specialist educators and District Health Board (DHB) education programmes as part of the in-service education programme which is overseen by an experienced registered nurse who has worked as an educator at the polytechnic for many years and works eight to 10 hours each week. This is confirmed during review of education records and interviews of the general manager, the educator / registered nurse, the clinical manager and the registered nurse who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators.

The general manager and educator / registered nurse advise that the registered nurses (RNs) attend education at the DHB and have completed the professional development recognition programme (PDRP) via the DHB.

Staff interviewed confirm understanding of professional boundaries and practice.

The District Health Board contract requirements are met.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

Residents and family interviewed confirm that staff communicate very well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care.

The general manager advises access to interpreter services is available if required via Massey University, the District Health Board and the local community if required. They also advise there are currently no residents who require interpreter services.

The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Seven admission agreements are reviewed and this is clearly communicated in each agreement.

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.

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The general manager, the clinical manager, as well as the registered nurse (RN) report informed consent is discussed and is recorded at the time the resident is admitted to the facility.

Residents/family are provided with various consent forms on admission for completion as appropriate and these are reviewed on seven resident's files (four rest home and three dementia). Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these are reviewed on resident's files.

Staff interviewed (three care givers, one RN, one diversional therapist / care giver, one activities co-ordinator and the clinical manager) demonstrate a good understanding of informed consent processes.

Residents (four rest home) and family (three dementia) interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.

Residents' files reviewed demonstrate written and verbal discussions on informed consent have occurred and residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education on the Code of Rights, which included advocacy and consent, was provided in June 2014 by the advocate from the Nationwide Advocacy Services.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

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

Attainment and Risk: FA

Evidence:

There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these are reviewed.

Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they have attended education on the Code of Right, advocacy, and complaint management.

Residents and family interviewed confirm that advocacy support is available to them if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission. Visual inspection provides evidence the nationwide advocate details are displayed along with advocacy information brochures. Admission / pre-admission information is reviewed and provides evidence advocacy, complaints and Code of Rights information is included.

The District Health Board contract requirements are met.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

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

Attainment and Risk: FA

Evidence:

There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service (for example, visitors are required to sign in and out via registers). The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs.

Residents and family members interviewed confirm they can have access to visitors of their choice, and confirm they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a van is available to take residents on community visits. Some residents go out independently on a regular basis. The rest home residents also participate in activities within the Olive Tree Village complex.

Residents' files reviewed demonstrate that progress notes and the content of care plans include regular outings and appointments (records sighted).

The District Health Board contract requirements are met.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.13: 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 general manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes 10 complaints for rest home residents for 2014 and 10 for 2013. The complaints register is reviewed during this audit.

The general manager advises there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, Police, District Health Board (DHB), 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. 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 (four rest home) and family (three dementia) interviewed demonstrate an understanding and awareness of these processes. Family meetings for residents in the dementia unit are held monthly as are rest home resident meetings and residents and family members are able to raise any issues they have during these meetings. This is confirmed during interview of residents and family and review of resident meeting minutes.

A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of clinical and quality meeting minutes and the general manager's monthly reports to the director provides evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirm this information is reported to them via their staff meetings.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

A business plan and a risk management plan are reviewed and include goals. Also reviewed is a mission statement, values, vision and objectives. An organisational chart is also reviewed during interview of the general manager. The general manager (GM) is a registered nurse (RN) and was appointed in July 2013. The GM has worked in aged care management positions for the last 10 years and for the 10 years prior to that they have worked in health management roles. The GM has completed various management papers at university. The GM is supported by a clinical manager (CM) who is an experienced RN with a current practising certificate. The CM, who was appointed in April 2013, has an applied master's degree in nursing and their thesis is in dementia care. The CM has worked in the aged care sector for the last 10 years in various roles and they have overall responsibility for the management of care provided. The CM is supported by another RN who works fulltime. There is an RN on site seven days a week between 8am and 4.30pm as well as after-hours via an on-call roster shared between the three RNs; that is, the GM, the CM and the RN. The personal files and annual practising certificates for the three RNs are reviewed on their personal files and are current.

The GM provides monthly reports to the director and a selection of these are reviewed during this audit.

The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.

Olive Tree Rest Home is currently certified to provide 25 rest home level beds and 17 dementia level care beds. Occupancy is at 100% in both areas during this audit. There is one resident aged less than 65 years assessed as requiring dementia level care.

The service provider is proposing to have the nine apartments in C wing that are currently owned by residents by way of an occupational rights agreement, certified to be used by residents assessed as requiring rest home level. The GM advises that these nine apartments are currently owned by their inhabitants and Olive Tree staff are providing supported living for the residents occupying them. The GM advises these nine apartments are registered under the Retirement Villages Act. The GM also advises there is no time frame for when they are wanting to use these rooms for rest home residents but are proposing to allow the current apartment inhabitants to 'age in place' as they become more dependant.

Olive Tree Holdings Limited and Olive Tree Dementia Care Limited have contracts with the District Health Board (DHB) to provide aged related residential care (rest home and dementia), respite care, day programme and residential non-aged 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:

Finding:

Corrective Action:

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

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

Attainment and Risk: FA

Evidence:

There are appropriate systems in place to ensure the day-to-day operation of the service continues should the general manager or the clinical manager be absent. The clinical manager fills in for the general manager and the full time registered nurse fills in for the clinical manager with support from the general manager who is also a registered nurse. The director is also available for support and advice if required.

Interview of the clinical manager and the registered nurse (RN) confirms their responsibility and authority for this role. Also reviewed are an organisational chart and job descriptions for the general manager, clinical manager and the RN.

Services provided meet the specific needs of the resident group within the facility. There are 17 residents assessed as requiring dementia level care and 25 assessed as requiring rest home level care during this audit. There is one resident who is aged less than 65 years of age who is assessed as requiring dementia level care and who is in the dementia unit.

The District Health Board contract requirements are met.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A quality improvement and risk management plan as well as a business plan are reviewed and are used to guide the quality programme and include quality goals and objectives. There is an internal audit programme in place and completed internal audits for 2014 are reviewed, along with processes for identification of risks. 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. A Health and Safety manual is available that includes relevant policies and procedures.

The general manager is responsible for ensuring the organisations quality and risk management systems are maintained. Weekly clinical and quality meetings are held and are attended by the general manager, the clinical manager and the registered nurse (RN). The general manager advises that during these meetings policies, forms and other documents needing review/development are discussed. Meeting minutes are reviewed and confirm this.

Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. There is documented evidence quality improvement data is being collected, collated, analysed, and evaluated, including reporting on numbers of various clinical indicators and quality and risk issues to staff and the director. These minutes and reports also provide evidence of discussion of any trends identified, as well as reporting on infection control and health and safety. Staff interviewed report they are kept well informed of quality and risk management issues including clinical indicators. Quality improvement data reviewed, including internal audits, adverse event forms and meeting minutes provide evidence that corrective action plans are being developed, implemented and signed off as being completed to address the issue/s that require/s improvement.

Monthly staff meetings and three monthly health and safety meetings are held and there is documented evidence of reporting on numbers of various clinical indicators, quality and risk issues and of any trends identified in these meetings. Copies of meeting minutes and graphs of clinical indicators are available in the staff room and graphs of clinical indicators are reviewed on a noticeboard in the staff room.

Adverse events are documented on accident/incident forms and copies of these are retained in the resident's files.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service reflects current accepted good practice, and reference legislative requirements. Policies / 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 confirmed during interviews that they are advised of updated policies and they confirm the policies and procedures provide appropriate guidance for the service delivery.

A Health and Safety Manual is available that includes relevant policies and procedures and there is a hazard reporting system available and a hazard register. Chemical Safety data sheets are available that identify the 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. Electrical safety stickers are observed in place.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.9 (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: FA

Evidence:

Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Registered nurses (RN) are advised of all adverse events and are responsible for investigating the event as well as for documenting any corrective actions required. The on call RN visits the facility and assesses any resident if there is an injury or if the staff are concerned. There is an RN on site seven days a week between 8am and 4.30pm and they assess all incidents that occur during these hours. The provider has recently reviewed their processes following unwitnessed falls and has implemented a system where neurological observations are taken for at least the first 24 hours. Education has been provided for staff on taking and recording neurological observations on 24 September 2014.

Resident files reviewed (four rest home and three dementia) provides documented evidence of communication with family and GP on the accident/incident form, in resident progress notes, and in whanau/family communication sheets. All residents also have an untoward event log in their file. There is also evidence reviewed during this audit of notification to family of any change in the resident's condition. This finding is confirmed during interviews of residents and family member. There is an open disclosure policy.

Corrective action plans to address areas requiring improvement are documented on accident/incident form and there is evidence of monitoring of this.

Staff confirm during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions; policies and procedures; and staff education, which is confirmed via review of documentation. Staff also confirm they are completing accident / incident forms for adverse events. Education on accident and incident reporting, neurological observations, risk management and hazards was provided in September 2014.

Policy and Procedures comply with essential notification reporting (e.g. health and safety, human resources, infection control).

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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: 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:

Written policies and procedures in relation to human resource management are available and are reviewed during this audit. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (eight of eight) along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments (as appropriate). Copies of annual practising certificates are reviewed for all staff that require them to practice and are current.

A part time educator who is a registered nurse (RN) is employed for eight to ten hours a week to develop and implement an education programme and there is evidence available indicating in-service education is provided for staff at least twice a month. The educator / RN also provides two hourly compulsory sessions every two months that all staff are required to attend and attendance records for these compulsory sessions are reviewed during this audit. The education planner for 2014 is reviewed and provides evidence that as well as the two monthly compulsory sessions additional ongoing education is provided. A competency register is maintained and competencies are reviewed during this audit and indicate staff have current competencies in place as appropriate.

The educator / RN is an Aged Care Education (ACE) assessor and staff are supported to complete the ACE modules. All staff are required to complete the ACE dementia specific modules and are enrolled when they have completed their orientation. The majority of staff have completed the dementia specific modules and those that have not completed these modules (two) are working towards completing this programme. All staff working in the dementia unit have completed the dementia specific unit standards. Individual records of education are maintained for each staff member and copies are reviewed in staff files. An appraisal schedule is in place and current staff appraisals are sighted on all staff files reviewed.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The educator / RN advises that staff are orientated for at least two to four shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided (i.e., the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values & philosophy).

Care staff interviewed (two caregivers working in the dementia unit and rest home), one diversional therapist / care giver, one activities co-ordinator, the clinical manager and a registered nurse confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and the 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: 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 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

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

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

Attainment and Risk: FA

Evidence:

There is a documented rationale (Rostering Policy) in place for determining service provider levels and skill mixes in order to provide safe service delivery at Olive Tree Rest Home. A 'Staffing Plan for Dual Certification and Registration of Apartment Beds as Rest Home' is reviewed and indicates that when between one and five apartments are used for residents assessed as requiring rest home care, an additional minimum of 50 hours a week will be provided increasing to an additional 80 hours a week when all nine apartments are used by rest home level residents.

Registered nurse (RN) cover is provided seven days a week between 8am and 4.30pm as well as being available on call after hours. The minimum amount of staff on duty is between 11.15pm and 7am and consists of two caregivers in the dementia unit and two care givers in the rest home as well as one of the registered nurses (RN) being on call. The on call RN carries the on call phone. The general manager advises that staff hours are adjusted according to resident occupancy and dependency levels.

Care staff interviewed report there is adequate staff available and that they are able to get through their work. There is at least one staff member with a current first aid certificate on each shift although all staff are required to complete their first aid certificate.

Residents and family interviewed report staff provide them with adequate care.

The District Health Board requirements are met.

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

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

Attainment and Risk: 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 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

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

Attainment and Risk: PA Low

Evidence:

Resident information is entered in an accurate and timely manner into a register (electronic) that is appropriate to the service and is in line with legislative requirements. Interview with the receptionist confirms the resident details are entered onto an electronic record on the day of admission. The receptionist also advises that they print out a hard copy of this register whenever there are any changes.

Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. Resident files reviewed provide evidence that an entry into the residents' clinical record is made on each shift and entries are dated and signed. However, improvements are required as not all entries in residents' notes have the time of entry documented and it is not always easy to identify the signature and name of the medical practitioner making entries in residents' notes, including medication charts (criterion 1.2.9.9.)

A visual inspection of the facility provides evidence that residents' information is stored in staff areas and is held securely and is not on public display. Clinical notes are current and are accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifier.

Staff interviewed including caregivers, the clinical manager, an RN, a diversional therapist, an activities co-ordinator and the general manager confirm they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible.

The District Health Board contract requirements are not all met.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

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

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 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

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

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 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

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

Attainment and Risk: PA Low

Evidence:

Seven resident files (four rest home and three dementia) and 20 medication charts (10 rest home and 10 dementia) are reviewed. Staff are making entries in resident's progress notes each shift and with the exception of the medical practitioners, include their name and designation at the end of each entry. Some of the entries in the progress notes have the time the entry is made recorded.

Finding:

(i) Staff are not consistently recording the time they are making the entry in resident's progress notes; and (ii) it is not always possible to identify the signature and name of the medical practitioner making entries in resident's notes, including medication charts.

Corrective Action:

Provide confirmation that (i) staff are consistently recording the time they are making the entry in resident's progress notes; and (ii) the name and designation of the medical practitioner making entries in resident's notes, including medication charts, is identifiable.

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: 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 (HDS(C)S.2008:1.3.1)

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

Attainment and Risk: FA

Evidence:

The policy and procedures for entry criteria, assessment and entry screening are recorded and implemented. The service's philosophy is recorded, displayed at the facility and communicated to residents, family, relevant agencies and staff. The pre- admission enquiry form is available and lists all relevant information of the prospective resident. The service provides information to potential referral sources. This facility operates 24/7.

Seven of seven residents' files sampled, including seven of seven residents' admission agreements. All residents' admission agreements sampled evidence residents' and facility representative sign off. The admission agreement defines the scope of service and includes all the contractual requirements.

The clinical manager (RN) interview confirms access and entry processes are followed. There are two facility information packs available for residents and their family, one for the rest home residents and one for the dementia residents. Resident information packs are sighted and contain all relevant information.

The residents' files sampled demonstrate all needs assessments are completed for either rest home or dementia levels of care.

Interviews with four of four rest home residents and three of three dementia family members confirm the admission process is conducted by staff in timely manner, all relevant admission information is provided and discussion held with staff in respect of resident care have been conducted.

The District Health Board contract requirements are met.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

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

Attainment and Risk: FA

Evidence:

The scope of the service provided by the facility is identified and communicated to all concerned. A process to inform residents in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the clinical manager (RN). The clinical manager states residents will be declined entry if not within the scope of the service or if a bed is not available at the time, the resident will be referred back to the NASC service or their name entered onto a waiting list if this is requested by the resident or a family member.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The initial care plan is developed on admission to guide clinical staff in the resident's care for the first three weeks of admission to the facility. The long term care plan is developed and implemented within the required timeframe of three weeks. Risk assessment tools are utilised and re-evaluations of these occur on a regular basis to ensure interventions are appropriate and that the goals set by the individual residents can be effectively met. The clinical staff have input into the review of each resident's individual care plan and this occurs six monthly or more often if required. The clinical staff interviewed confirm that team work is encouraged and that continuity of care occurs and this is reflected in the seven of seven residents' care plans and daily progress records reviewed. The general practitioners (GP) record an entry on medical progress notes at every contact with the resident to ensure the records are current. In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input, according to specified timeframes and the service is coordinated to promote continuity of service delivery. The residents' assessments and care plans are developed and reviewed by the clinical manager (RN) or the registered nurse. The daily interventions and support with activities of daily living are implemented with the help of trained carers.

Appropriate education is provided for staff at all levels. The staff competency assessments are current and staff competency registers record competencies for clinical staff in restraint, medication, hoist, insulin administration, nebuliser and oxygen competencies. The clinical staff interviewed state they are updated and skilled to care for residents and also confirm residents and/or family members are involved in all stages of service provision.

The four of four rest home residents and three of three dementia family member interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews. The residents' files sampled evidence multidisciplinary involvement and daily handovers ensure day to day continuity of care. The auditor evidenced verbal briefing /hand over from am to pm shift.

The seven of seven residents' files (four rest home and three dementia) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations. The family communication sheets are maintained, sighted in all seven residents' files reviewed.

The GP interview confirms that the staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff.

The District Health Board contract requirements are met.

Tracer methodology-rest home.

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

Tracer methodology- dementia.

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.

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

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

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

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents' needs, outcomes and goals are identified via the assessment process and are recorded. The facility has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.

The residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider (NASC) assessments are available. The facility has appropriate resources and equipment. The RN interview confirms that assessments are conducted in a safe and appropriate setting including visits from the doctor.

The four of four rest home residents and three of three dementia family interviews confirm their involvement in assessments, care planning, review, treatment and evaluations of care. The resident files evidence risk assessments are conducted on admission and reviewed along with the resident long term care plan at six monthly intervals or when resident's condition alters.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The residents' files sampled evidence the residents' lifestyle care plans are individualised and up-to-date. The interventions sighted reflect assessed needs and goals of the resident and they are consistent with best practice in working with older adults. The residents' files sampled evidence the clinical care/treatment/support or interventions that are to be provided by the staff are current, the risk assessment findings are recorded on the care plans and there is evidence of discussions and sign off by residents and family members. The resident lifestyle care plan includes resident's needs relating to communication; personal care; skin integrity; eating and drinking; elimination; mobility; activities ; breathing; pain; sleep; safe environment; restraint if required; sexuality needs; cultural needs; spirituality; and behavioural management if this is required.

The long-term and short-term goals are identified by the residents, family and service providers and reviewed at regular intervals, at least 6 monthly or as needs change. The residents have input into their care planning and review, confirmed at all four rest home resident interviews and also confirmed at the three dementia family interviews. The clinical staff interviewed confirm that care plans are accurate and up to date. The facility ensures access to regular GP care, confirmed at GP interview and current GP progress reports.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: 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 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.

The residents' files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. The GP documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement.

The four of four rest home residents and three of three dementia family interviews confirm their and their relatives' current care and treatments they are receiving meet their needs. The family communication sheets record family communications, sighted in all residents' files sampled.

The resident care audit was conducted in May 2014 with 96% compliance and corrective actions addressed. The care plans and residents notes audit was last conducted in May 2014 with 100% compliance

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An interview with the diversional therapist (DT) and the recreational therapist (RT) confirm the activities programme meets the needs of the service group and the service has appropriate equipment. There are two activities programmes at the facility, one for the rest home residents and one for the dementia residents. The DT is employed for 15 hours a week, Monday to Friday from 1.30pm to 4.30 pm in the dementia unit. The dementia unit activities programme is planned from Monday to Sunday and includes the sun downing period. The DT states the care staff implement the activities programme when the DT is not in the dementia unit, confirmed at care staff interviews and observed on audit days. The three of three dementia family interviews confirm the activities programme in the dementia unit is conducted by the DT and the care staff, the residents are provided with appropriate activities and there is active participation in the programme. Residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. Regular exercises and outings are provided for those able to partake.

The activities staff are responsible for conducting residents' activities assessments, activities care planning, planning and implementation of the activities programmes, and evaluation of the activities care plans. The recreational therapist is employed in the rest home and provides activities between the hours of 9.30 am to 4.30 pm Monday to Friday. The residents' activities attendance records are maintained, both in the rest home and the dementia unit, sighted.

The activities staff and the clinical manager (RN) state there is a dementia support group for family members and they meet every two months. The family members of the dementia residents are informed of the support group meetings and invited to attend. Interviews with the dementia family members confirm this and state this support is valued and appreciated. A monthly newsletter and monthly activities programme is sent by email to the dementia family members, confirmed at family interviews. The newsletter and the monthly rest home activities programme is provided for each rest home resident, confirmed at rest home residents' interviews.

The rest home residents' meetings are held monthly, minutes of the meetings are sighted for June, July and August 2014. The resident meeting minutes are displayed on notice boards.

The residents' files sampled demonstrate the individual activities care plans are current and record support is provided within the areas of leisure and recreation, health and well-being. The diversional / activities therapy resident care plan includes resident's needs relating to physical ability; cognitive; emotional; social; spiritual and cultural needs. Monthly activities progress notes are recorded and six monthly activities care plan evaluation are implemented, sighted in all residents' files sampled.

Resident diversional therapy programme audit was last conducted in July 2014 with 100% compliance.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. The family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews. The care plan evaluations are conducted by the RN with input from the resident, family, care givers, diversional therapist and GPs. The residents and family interviews confirm their participation in care plan evaluations and this is evidenced in the files reviewed. The multidisciplinary annual reviews are conducted with input from the RN, resident, GP, family, DT and any other staff involved in the care of the resident. The multidisciplinary reviews sighted are current.

Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. The residents' files evidence referral letters to specialists and other health professional when this is required.

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.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

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

Attainment and Risk: FA

Evidence:

The service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services.

The residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. In all of the residents' files sampled there is evidence of family communication sheets that document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented.

The District Health Board contract requirements are met.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

The residents' files evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files, where this is required.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The medication areas in the facility, evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. There is one controlled drugs storage in the facility and this is secure. The controlled drug register is maintained and evidences weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded.

All staff authorised to administer medicines have current competencies, sighted in staff files sampled and on the staff competency register. Additional staff competencies are conducted and these include; insulin administration; oxygen administration; nebuliser use, sighted on competency registers. The medication rounds in the rest home and dementia unit are observed and evidence staff are knowledgeable about the medicine administered and sign off, as the dose is administered. Staff education in medicine management was conducted in April 2014 by a pharmacist and in September 2014 by the staff educator (RN).

Twenty medicine charts are sampled (10 rest home and 10 dementia). The medicine charts evidence residents' photo identification, medicine charts are legible, PRN medication is identified for individual residents and correctly prescribed, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. The residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given). The residents at the facility who self-administer medicines do so according to policy.

Sighted medication audit results conducted in September 2014 with 100% compliance. Pharmacy six monthly controlled drug register audit was conducted in August 2014.

The District Health Board contract requirements are 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:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The food service policies and procedures are appropriate to the service setting with a new seasonal six weekly menu being introduced six monthly. The menu is with the dietitian to be reviewed, sighted communication in respect of this.

An interview with the head cook confirms they are aware of the residents who have been identified with weight loss and the residents' individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the head cook. Food safety training for kitchen staff has been conducted, sighted.

Additional snacks are available for residents when the kitchen is closed and these are sighted in the dementia unit kitchenette. Residents are offered fluids throughout the day.

The residents' files sampled demonstrate monthly monitoring of individual resident's weight. The residents interviewed are satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided.

The food temperatures are recorded, sighted. The fridge, chiller and freezer temperatures are recorded, sighted. All decanted food is dated.

The kitchen services audit was conducted in June 2014 with 100% compliance. The nutritional compliance audit was last conducted in August 2014 with 95% compliance with corrective actions addressed. The resident meal satisfaction survey/ questionnaire was conducted in May 2014 and the results record overall satisfaction with the meal service.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

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

Attainment and Risk: FA

Evidence:

There are documented processes in place for the management of waste and hazardous substances. Policies and procedures specify labelling requirements. Material safety data sheets provided by the chemical representative are available and are accessible for staff. Education was last provided on chemical safety for all staff in May 2014. Staff interviewed report they receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. A sluice facility is provided for the disposal of waste, and protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substances being handled are provided and are being used by staff. For example, gloves, aprons, and masks are sighted in the sluice room. All bedrooms have ensuite facilities.

The District Health Board contract requirement is met.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.2: 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:

A maintenance person is employed for 40 hours a week and is interviewed during this audit. The maintenance person advises gardeners are employed to manage the lawns and gardens. The maintenance person advises that external contractors are used for plumbing, electrical and other specialist areas. During interview the maintenance person and the general manager confirm there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. This finding is confirmed during visual inspection and review of maintenance documentation.

This audit included a review of the nine apartments in Wing C that the service provider wants to certify for use by rest home residents and these rooms are suitable for use by rest home residents.

Planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration/performance verified stickers in place on medical equipment and electrical safety tags are viewed on electrical items. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 31 July 2015.

A visual inspection of the facility provides evidence of safe storage of medical equipment. Corridors wide and residents are observed safely passing each other; safety rails are secure and are appropriately located.

The external areas are safely maintained and are appropriate to the resident groups and setting. A secure external area is provided for residents in the dementia unit. Residents are protected from risks associated with being outside (e.g., provision of adequate and appropriate seating; provision of shade; and ensuring a safe area is available for recreation or evacuation purposes).

Care staff interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

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

Attainment and Risk: FA

Evidence:

All bedrooms have full ensuite facilities and there are an adequate number of communal toilets and wash hand basins for residents. Toilets and showers are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are 45 degrees Celsius or below.

Toilets have appropriate access for residents based on their needs and abilities. Communal toilets and showers have a system that indicates if it is vacant or occupied. There is also a safe locking system that provides for privacy but allows service providers access in the case of emergency. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.

The District Health Board contract requirement is met.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

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.

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

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

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

Attainment and Risk: FA
Evidence: All bedrooms provide single accommodation. Visual inspection provides evidence that bedrooms are of various sizes and adequate personal space is provided in bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff, residents and family. The bedrooms are large enough to allow access for mobility aids. The nine apartments in Wing C that the provider is wanting certified for rest home level care provide adequate personal space. These apartments also have a separate lounge / sitting area and kitchen for tea and coffee making. There are no cooking facilities in these apartments. The District Health Board contract requirements are met.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

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.

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

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

Attainment and Risk: FA

Evidence:

Visual inspection evidences adequate access is provided to the lounges, sitting areas and dining room area. There are other alcoves/ communal areas throughout the facility where residents are able to sit. Residents observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. The dementia unit has a separate lounge and dining room areas as well as another lounge at one end of the unit. The serviced apartments, that the provider is wanting certified for rest home use, have their own lounge and dining areas.

The District Health Board contract requirement is met.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Cleaning policy and procedures, and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons.

All linen is washed on site and there is adequate dirty / clean flow. All care staff are responsible for the laundry and the general manager is interviewed in the laundry and describes the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.

Visual inspection of the facility provides evidence of implementation of appropriate cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning are reviewed. The chemical representative also provides reports during their visits.

Visual inspection of the facility provides evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste (i.e., sluice room, convenient hand washing facilities are available, and hygiene standards are maintained in storage areas).

Residents and family interviewed state they are satisfied with the cleaning and laundry service and this finding is confirmed during review of the collated satisfaction survey results.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification are available. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

New Zealand Fire Service letter dated 24 May 2010 is reviewed that advises the evacuation scheme is approved, is sighted during this audit. The last trial evacuation was held on 05 May 2014 and the next one is scheduled for late October 2014.

All staff are required to have a current first aid certificate and there is at least one staff member on duty with a current first aid certificate. A schedule with expiry dates of the first aid certificates is reviewed. Emergency and security management education is provided as part of the annual in-service education day and staff interviewed confirm this.

Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.

A visual inspection of the facility evidences: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.

A visual inspection of the facility evidences emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.

There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas. Residents interviewed confirm they have a call bell system in place which is accessible and staff

respond to it in a timely manner. Response times to call bells are able to be monitored via a computerised system. The nine apartments in Wing C have call bells that are connected to the existing system.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

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

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

Finding:

Corrective Action:

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

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

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

Attainment and Risk: FA

Evidence:

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Air temperatures are monitored monthly and these are reviewed during this audit. Residents and family interviewed confirm the facility is maintained at an appropriate temperature.

Visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

The District Health Board contract requirement is met.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The service has an overarching risk and quality management system and documented systems are in place for a restraint free environment. The restraint minimisation and safe practice (RMSP) policy definitions of enablers and restraint align with the NZS 8134.2 Standard. There are no residents using restraint or enablers on audit days.

The staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. The staff competency register records restraint competencies for all clinical staff are current. The staff education programme on RMSP /Enabler training was conducted in October 2013. The challenging behaviour management training/education was conducted in February 2014.

Managing challenging behaviour audit was conducted in June 2014 with 100% compliance. The restraint and enabler policy compliance audit was last conducted in September 2014 with 100% compliance.

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control (IC) policy meets the needs of the service and provides information and resources to inform the service providers on infection prevention and control, confirmed at staff interviews.

The delegation of infection control matters throughout the organization is clearly documented along with an IC co-ordinator job description. The infection control co-ordinator is the clinical manager (RN). There is evidence of regular reports on infection related issues by regular reporting systems and these are communicated to staff and management. The IC policy/ programme is reviewed annually.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

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

Attainment and Risk: FA

Evidence:

The infection control programme meets the needs of the service and provides information and resources to inform and guide staff. The IC co-ordinator has access to relevant and current information which is appropriate to the size and complexity of the service, including but not limited to; IC manuals, internet, access to experts (DHB and Lab), and on-going in-service education. The IC is an agenda item at the facility's meetings, evidenced during review of meeting minutes and interviews with staff.

The District Health Board contract requirement is met.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

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

Attainment and Risk: FA

Evidence:

Policies and procedures on the prevention and control of infection include written material that is relevant to the service and reflects current accepted good practice and relevant legislative requirements. The policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interview.

The IC policies and procedures are developed and reviewed regularly in consultation and input from relevant staff. IC policies and procedures identify links to other documentation in the organisation e.g. health & safety, quality and risk.

The District Health Board contract requirements are met.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The service provider's documentation evidences that infection control education is provided to all staff, as part of their initial orientation and is provided as part of the on-going in-service education programme.

Staff interviewed advice that clinical staff identify situations where IC education is required for a resident such as; hand hygiene, cough etiquette, multi-resistant micro-organisms and education is conducted.

The IC staff education was provided in February 2014 by the staff educator (RN). All education sessions have evidence of staff attendance and content of the presentations. There is evidence in the kitchen staff meeting minutes of kitchen staff education on IC in September 2013 and December 2013.

The District Health Board contract requirement is met.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

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

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 3.4.5 (HDS(IPC)S.2008:3.4.5)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The IC programme / policy details surveillance processes. The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes.

Infection control monthly data is completed for each resident and includes type of infection, lab results, sensitivities, antibiotics prescribed, dose, duration, intervention, review and outcome. An infection log is maintained.

The numbers of infections are collated at the end of each month and reported as a clinical indicator to management and to staff at meetings. The care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, daily handovers, short term care plans and progress notes. This is evidenced during attendance at the staff handover and review of residents' files.

The hand washing audit was conducted in February 2014 and July 2014, both with 100% compliance. An external contractor conducts audits around housekeeping and kitchen services, sighted for July 2014.

A norovirus outbreak occurred in April 2014 and documentation evidences notification of the outbreak to the Public Health Service at DHB and appropriate management of the outbreak.

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.

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

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