

# Oceania Care Company Limited - Greenvalley Lodge Rest Home

---

Current Status: 2 October 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

Greenvalley Lodge provided care for up to 50 residents (30 rest home and 20 dementia unit beds with occupancy of 48 residents on the days of audit). The business and care manager was responsible for the overall management of the facility and had been in the role for three months with support from the clinical and quality manager. The clinical manager provides clinical oversight.

Service delivery was monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

The staffing policy was the foundation for workforce planning. Staffing levels were reviewed for anticipated workloads and acuity with rosters indicating that staffing reflected resident acuity and bed occupancy.

Improvements are required to review of the activities programme by a diversional therapist or equivalent and to infection control.

## Audit Summary as at 2 October 2014

Standards have been assessed and summarised below:

### Key

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

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

### Consumer Rights as at 2 October 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.
--	--	--

### Organisational Management as at 2 October 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.		Standards applicable to this service fully attained.
---	--	--

### Continuum of Service Delivery as at 2 October 2014

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

### Safe and Appropriate Environment as at 2 October 2014

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

### Restraint Minimisation and Safe Practice as at 2 October 2014

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

## Infection Prevention and Control as at 2 October 2014

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

## Audit Results as at 2 October 2014

### Consumer Rights

Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Residents were treated with respect and received services in a manner that considered their dignity, privacy and independence. Information regarding consumers' rights, access to advocacy services and how to lodge a complaint was available to residents and their family with a system for managing complaints in place. The residents' cultural, spiritual and individual values and beliefs were assessed on admission. Informed consent policy and processes were implemented by the service, meeting contractual requirements. Staff ensure residents were informed and had choices related to the care they received.

### Organisational Management

Oceania had a documented quality and risk management system that supported the provision of clinical care and support. Policies were reviewed at head office with input from managers across the services. Quality and risk performance was reported across the facility meetings and monitored by the organisation's management team through the business status reports. Benchmarking reports were produced that include incidents/accidents, infections, complaints and clinical indicators.

There were comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service had an orientation/induction and training programme in place with staff employed to meet resident numbers and acuity. There was a business and care manager and clinical manager in place with support from the clinical and quality manager.

### Continuum of Service Delivery

The resident's entry in to the services was facilitated in a competent, equitable, timely, and respectful manner. All residents had appropriate needs assessments. Each stage of assessment, planning, provision of care and review/evaluation was undertaken by suitably qualified staff with current practising certificates. The clinical manager (CM) conducted the initial assessment using standardised risk assessment tools. An information pack was provided to the resident/families on admission. Admission agreements were signed on admission by the residents or their families. Declined residents were referred back to the referrer in a timely manner.

The service had an integrated system of documentation. The general practitioner (GP) admitted new residents within 24-48 hours and conducted three monthly reviews or more often as required. Person centred care plans were reviewed three monthly. Multi-disciplinary reviews were conducted six monthly.

Activities provided by the service were appropriate to the needs of the residents. There is an area for improvement regarding diversional therapist overview with the activities.

The contents of the verbal hand-over between shifts were comprehensive. Progress notes were maintained and the levels of documentation by the staff reflected the care provided during the shifts.

Referrals were made to specialist medical services as well as other allied health professionals. There were policies and procedures for transition, exit, discharge or transfer of residents. Yellow envelopes were utilised by the service to transfer residents to the hospital.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo a competency assessment annually. The CM and RN were responsible for all areas of medication management and worked alongside a contracted pharmacy. There were no expired or unwanted medications. There were two residents in the rest home unit that self-administer their medicines. The self-administration policy and procedures were in place.

Food service was prepared on site and overseen by two cooks over seven days. The summer and winter menu plans were annually. Each resident was assessed by the CM on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. Modified diets were provided by the service. Meals were provided at appropriate times of the day. Residents interviewed report satisfaction with the food service provided. Food temperatures and chiller/fridge/freezer temperatures were daily monitored. The cleaning schedule was completed daily.

### **Safe and Appropriate Environment**

All building and plant complied with legislation. There was a maintenance programme implemented that included equipment and electrical checks. The facility was appropriately designed to meet the needs of residents assessed as requiring rest home or dementia level care with a secure unit in place for residents with dementia. Fixtures, fittings and floor and wall surfaces were made of accepted materials for this environment.

Laundry was outsourced and the managers and staff monitor cleaning to ensure that the facility was well maintained. Essential emergency and security systems were in place with regular emergency drills completed. Call bells were evident across the facility.

An improvement is required to ensuring that the call bell system is operational at all times.

### **Restraint Minimisation and Safe Practice**

The service had clear and comprehensive policy and procedures which meet the requirements of the restraint minimisation and safe practice standard. Restraint and enablers were only used to prevent harm and promote independent mobilisation. There were established systems and practices for the assessment, approval, monitoring, evaluation and review of any type of restraint.

Staff training and competency assessment in safe the use of restraint occurred at least annually. Monitoring and review of individual restraint interventions occurred at an appropriate frequency to determine whether there is an ongoing need for the restraint methods in place. The committee also conducted regular quality reviews of restraint activity that ensured compliance with their policies and to consider all aspects of restraint usage, including the effectiveness and frequency of staff training. There were no residents using restraints or enablers.

### **Infection Prevention and Control**

There was a documented and implemented infection control programme which was appropriate to the service. The plan and outcomes were reviewed annually. Infection prevention and control policies and procedures were clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflected current accepted good practice and were readily available for staff. Infection control education was provided by the clinical manager who was responsible for infection prevention and control activities. The education was relevant to the service setting. The type of infection surveillance undertaken was appropriate to the size and type of the service. Results of the surveillance were acted upon, evaluated and reported to relevant personnel in a timely manner. Staff and residents were offered annual influenza vaccinations.

# 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

<b>Legal entity name:</b>	Oceania Care Company Limited
<b>Certificate name:</b>	Oceania Care Company Limited - Greenvally Lodge Rest Home
<b>Designated Auditing Agency:</b>	Health Audit (NZ) Limited
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Greenvally Lodge Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 2 October 2014 <b>End date:</b> 3 October 2014

**Proposed changes to current services (if any):**  
Includes Dementia Care

<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	48
---	----

## Audit Team

<b>Lead Auditor</b>	XXXXXXXX	<b>Hours on site</b>	14	<b>Hours off site</b>	8
---------------------	----------	----------------------	----	-----------------------	---

<b>Other Auditors</b>	XXXXXXXX	<b>Total hours on site</b>	14	<b>Total hours off site</b>	6
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	3

## Sample Totals

Total audit hours on site	28	Total audit hours off site	17	Total audit hours	45
Number of residents interviewed	8	Number of staff interviewed	8	Number of managers interviewed	3
Number of residents' records reviewed	8	Number of staff records reviewed	7	Total number of managers (headcount)	3
Number of medication records reviewed	16	Total number of staff (headcount)	46	Number of relatives interviewed	8
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

I, XXXXXXXX, 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 Monday, 20 October 2014

## Executive Summary of Audit

### General Overview

Greenvalley Lodge provided care for up to 50 residents (30 rest home and 20 dementia unit beds with occupancy of 48 residents on the days of audit). The business and care manager are responsible for the overall management of the facility and had been in the role for three months with support from the clinical and quality manager. The clinical manager provided clinical oversight.

Service delivery was monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

The staffing policy was the foundation for workforce planning. Staffing levels were reviewed for anticipated workloads and acuity with rosters indicating that staffing reflected resident acuity and bed occupancy.

Improvements are required to review of the activities programme by a diversional therapist or equivalent and to infection control.

### Outcome 1.1: Consumer Rights

Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Residents were treated with respect and received services in a manner that considered their dignity, privacy and independence. Information regarding consumers' rights, access to advocacy services and how to lodge a complaint was available to residents and their family with a system for managing complaints in place. The residents' cultural, spiritual and individual values and beliefs were assessed on admission. Informed consent policy and processes were implemented by the service, meeting contractual requirements. Staff ensure residents were informed and had choices related to the care they received.

### Outcome 1.2: Organisational Management

Oceania had a documented quality and risk management system that supported the provision of clinical care and support. Policies were reviewed at head office with input from managers across the services. Quality and risk performance was reported across the facility meetings and monitored by the organisation's management team through the business status reports. Benchmarking reports were produced that include incidents/accidents, infections, complaints and clinical indicators.

There were comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The service had an orientation/induction and training programme in place with staff employed to meet resident numbers and acuity. There was a business and care manager and clinical manager in place with support from the clinical and quality manager.

### Outcome 1.3: Continuum of Service Delivery

The resident's entry in to the services was facilitated in a competent, equitable, timely, and respectful manner. All residents had appropriate needs assessments. Each stage of assessment, planning, provision of care and review/evaluation was undertaken by suitably qualified staff with current practising certificates. The clinical manager (CM) conducted the initial assessment using standardised risk assessment tools. An

information pack was provided to the resident/families on admission. Admission agreements were signed on admission by the residents or their families. Declined residents were referred back to the referrer in a timely manner.

The service had an integrated system of documentation. The general practitioner (GP) admitted new residents within 24-48 hours and conducted three monthly reviews or more often as required. Person centred care plans were reviewed three monthly. Multi-disciplinary reviews were conducted six monthly.

Activities provided by the service were appropriate to the needs of the residents. There is an area for improvement regarding diversional therapist overview with the activities.

The contents of the verbal hand-over between shifts were comprehensive. Progress notes were maintained and the levels of documentation by the staff reflected the care provided during the shifts.

Referrals were made to specialist medical services as well as other allied health professionals. There were policies and procedures for transition, exit, discharge or transfer of residents. Yellow envelopes were utilised by the service to transfer residents to the hospital.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo a competency assessment annually. The Clinical manager (CM) and registered nurse (RN) were responsible for all areas of medication management and worked alongside a contracted pharmacy. There were no expired or unwanted medications. There were two residents in the rest home unit that self-administer their medicines. The self-administration policy and procedures were in place.

Food service was prepared on site and overseen by two cooks over seven days. The summer and winter menu plans were annually. Each resident was assessed by the CM on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. Modified diets were provided by the service. Meals were provided at appropriate times of the day. Residents interviewed report satisfaction with the food service provided. Food temperatures and chiller/fridge/freezer temperatures were daily monitored. The cleaning schedule was completed daily.

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

All building and plant complied with legislation. There was a maintenance programme implemented that included equipment and electrical checks. The facility was appropriately designed to meet the needs of residents assessed as requiring rest home or dementia level care with a secure unit in place for residents with dementia. Fixtures, fittings and floor and wall surfaces were made of accepted materials for this environment.

Laundry was outsourced and the managers and staff monitor cleaning to ensure that the facility was well maintained. Essential emergency and security systems were in place with regular emergency drills completed. Call bells were evident across the facility.

An improvement is required to ensuring that the call bell system is operational at all times.

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

The service had clear and comprehensive policy and procedures which meet the requirements of the restraint minimisation and safe practice standard. Restraint and enablers were only used to prevent harm and promote independent mobilisation. There were established systems and

practices for the assessment, approval, monitoring, evaluation and review of any type of restraint. Staff training and competency assessment in safe the use of restraint occurred at least annually. Monitoring and review of individual restraint interventions occurred at an appropriate frequency to determine whether there is an ongoing need for the restraint methods in place. The committee also conducted regular quality reviews of restraint activity that ensured compliance with their policies and to consider all aspects of restraint usage, including the effectiveness and frequency of staff training. There were no residents using restraints or enablers.

### Outcome 3: Infection Prevention and Control

There was a documented and implemented infection control programme which was appropriate to the service. The plan and outcomes were reviewed annually. Infection prevention and control policies and procedures were clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflected current accepted good practice and were readily available for staff. Infection control education was provided by the clinical manager who was responsible for infection prevention and control activities. The education was relevant to the service setting. The type of infection surveillance undertaken was appropriate to the size and type of the service. Results of the surveillance were acted upon, evaluated and reported to relevant personnel in a timely manner. Staff and residents were offered annual influenza vaccinations. .

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	42	0	3	0	0	0
Criteria	0	90	0	3	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 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of	PA Low			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
		the service.				
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	There is no evidence of diversional therapist input in the activity plans for the residents in the dementia unit. li) The 24 hour activity plans in the dementia unit are insufficiently detailed to assist the staff in managing the residents in the dementia unit.	Ensure that a diversional therapist will have input in the development of the activity plans in the dementia unit. li) Develop an individual resident focused 24 hour activity plans for the dementia residents.	180
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.5	An appropriate 'call system' is available to summon assistance when required.	PA Low	Some call bells checked were not operational on the first day of the audit (six call randomly selected were not operational).	Ensure that call bells are operational at all times.	60

HDS(IPC)S.2008	Standard 3.3: Policies and procedures	Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	PA Low			
HDS(IPC)S.2008	Criterion 3.3.1	There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.	PA Low	The staff transports laundry bags from the main floor to the basement using rolled plastic. The rolled plastic does not cover the whole surface of the stairs and the sides of the stairs. The laundry bags containing dirty and soiled resident's clothes, linens and beddings touch the sides of the stairs when the staff drops the laundry bags on the rolled plastics. The lift is only used to transport food to and from the kitchen.	The service must ensure that the rolled plastics used to transport laundry bags will cover the whole surface of the stairs as well as the sides of the stairs.	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 education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Interviews with the clinical manager, three of three caregivers and the registered nurse confirm their understanding of the Code.

Examples are provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.

The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information. The information pack includes a philosophy for the dementia unit that is to 'provide a safe and therapeutic care of residents in a home-like, comfortable environment that enhances quality of life and minimises risks'. The rights documented in the dementia information book are from the perspective of staff respecting the resident and treating the resident with dignity. The rights are threaded through the information book as each point is discussed e.g. challenging behaviours and the rights of residents and obligations and rights of staff.

Training around the code of rights and complaints was last provided in March and August 2014. The auditors noted respectful attitudes towards residents on the day of the audit.

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:**

A registered nurse discusses the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code are also held at during the monthly residents' meetings (meeting minutes sighted). Residents and family interviews confirm their rights are being upheld by the service. Information regarding the Health and Disability Advocacy Service is clearly displayed in multiple locations throughout the facility and in a brochure that is held at reception.

Code of rights leaflets are available at the front entrance of the service and in the dementia unit. Code of rights posters are on the walls in the service in both the rest home and dementia unit.

The resident right to access advocacy services is identified for residents and advocacy service leaflets are available at the entrance to the service. If necessary, staff will read and explain information to residents as stated by the caregivers and registered nurse interviewed.

Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.

Eight rest home residents and eight family members interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process.

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:**

The service has a philosophy that promotes dignity and respect and quality of life.

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code.

Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values with the registered nurse and clinical manager interviewed stating that the care plans are completed with the resident and family member (confirmed by residents and family interviewed). Interventions to support these are identified and evaluated. Residents are addressed by their preferred name and this is documented in eight of eight files reviewed.

A policy is available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality (sexuality and intimacy) in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour.

The service ensures that each resident has the right to privacy and dignity, which is recognised and respected. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room. The bedrooms in the dementia unit particularly demonstrate the emphasis the service places on bringing belongings into the service to orientate the resident. One family member especially asked states that this is a highlight of the service and states that while there are two residents in particular who take things from rooms, the property is easy to find and return with staff helping with this.

Three health care assistants interviewed report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirm the residents' privacy is respected.

Health care assistants interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist is available to be called as required. Health care assistants assist residents with their activity programme and the three interviewed state that there are always plenty of resources able to be accessed on a 24-hour basis.

The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to provide guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation's mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code. Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation – last provided in August 2014. Staff interviewed are aware of the signs of abuse and neglect. Staff are also provided with training around challenging behaviour (last provided in June 2014) and staff in the dementia unit were observed to use strategies documented in plans to manage challenging behaviour. Four family members in the dementia unit confirm that any challenging behaviours are dealt with effectively and quickly.

Resident files reviewed (eight of eight) identifies that cultural and /or spiritual values, individual preferences are identified and these are discussed as part of the monthly meetings as issues are identified as described by the clinical manager. There are weekly Catholic service, monthly Anglican services and a small prayer group that comes in weekly. The services are generally held in the dementia unit so that all can join in.

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 service implements the Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan.

Staff have access to the cultural safety, the Treaty of Waitangi and Maori Health in nursing education and practice guidelines.

Links to local kaumatua Maori services are documented and include the Awataha Marae Incorporated Society, Te Puna Hauora o te Raki Pae Whenua, Lady Allum iwi.

There are no Maori residents living at the facility during this full certification audit. There are no staff members who identify as Maori.

All residents have a cultural assessment completed and the clinical manager confirms that this would be completed for Maori residents as for all residents. Eight files include a cultural assessment. Staff interviewed report specific cultural needs are identified in the residents' care plans. This was further evidenced in eight of eight resident files selected for review (five rest home and three dementia).

Staff are aware of the importance of whanau in the delivery of care for their Maori residents.

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:**

The service identifies each resident's personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline.

Residents and family are involved in the assessment and the care planning processes, confirmed in interviews with residents and families. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan and includes input from the resident and their family (confirmed by residents and family members).

Staff have access to guidelines around cultural considerations and cultural protocols.

There are no residents with any special cultural needs and all residents speak English.

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:**

The facility implements Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care. There is a policy around professional boundaries.

Job descriptions include responsibilities of the position, ethics, advocacy and legal issues with a job description sighted on seven of seven staff files reviewed.

The orientation and employee agreement provided to staff on induction includes standards of conduct.

Interviews with staff including the activities coordinators, three caregivers across the dementia unit and rest home, registered nurse and the clinical manager confirm their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.

Family and visitors are encouraged to visit particularly for residents in the dementia unit with the service providing a welcoming and supportive environment.

The District Health Board contract requirements are met.

### 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:**

Greenvalley Lodge implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed annually. There is a quality framework that supports an internal audit programme. Benchmarking occurs across all the Oceania facilities.

There is a training programme and managers are encouraged to complete management training.

There is a monthly regional management meeting.

Specialised training and related competencies are in place for the registered nursing staff.

Residents (eight rest home) and families (eight) interviewed expressed a high level of satisfaction with the care delivered.

The general practitioner reports a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills.

Consultation is available through the organisation's management team that includes a registered nurse and dietitian.

The business and care manager, clinical manager and the clinical and quality manager are committed to improving service delivery at Greenvalley Lodge.

Improvements have continued to be undertaken since the last provisional and certification audit including meal choices for residents, menus displayed on tables, close to full occupancy in the newly developed dementia unit, van outings now offered regularly, a system introduced for regular podiatry, clear parameters introduced for contacting the general practitioner (noted by the general practitioner as an improvement), more senior staff on duty with increases in registered nurse rostering, introduction of a facilitator to work with a resident in the dementia unit to create 3D models with an increase in activities for all residents in the dementia unit, upgrading of call bell system, improvements in the handover system. The service has colour coded the incident forms with guidelines included so that staff can complete other documentation as required. The service is also getting more involved in the community with a focus on cultural activities and events.

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:**

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in 15 of 15 completed accident/incident forms.

Family contact is recorded in residents' files – sighted in eight of eight files reviewed.

Interviews with eight family members (four dementia unit and four rest home) confirm they are kept informed. Family also confirm that they are invited at least annually to the care planning meetings for their family member.

Family interviewed confirm that they are invited to attend the monthly resident meetings and two residents interviewed state that they find the resident meetings very valuable to be able to discuss any issues. Both state that improvements are made when suggestion/concerns are raised.

Interpreter services are available when required from the District Health Board. Interpreting services have not had to be used to date however there are staff also able interpret on a day to day basis if required e.g. Phillipino, Indian.

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

Staff have had training around communication in August 2014.

Staff have had training around open disclosure last in March and August 2014.

Family members throughout the facility including the dementia unit are encouraged to communicate with staff, to ask questions and to engage in care planning and multi-disciplinary meetings with residents and family members confirming this.

The service has a homely hotel concept that includes a focus on hospitality and customer service. There are examples given around giving time to family to talk and discuss their feelings/issues and this is confirmed by the residents and family interviewed.

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:**

Residents and their families are provided with all relevant information on admission.

Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services.

Informed consent obtained includes the following: consent for sharing of information, consent for care and treatment, outings and photos. There is a consent for non-routine treatment or procedure completed e.g. for the flu injection.

There are advance directives used with residents who are competent to have a resuscitation order signing the form. Five of five resident files for residents in the rest home have advance directives signed by the resident.

Six of eight admission agreements sighted have all been signed on the day of admission. Two agreements were for residents who entered the service prior to January 2013.

The sample size is increased by three for residents who have entered the service in 2014. All have an agreement signed on the day of admission.

Discussion with residents and family identify that the service actively involves them in decisions that affect their lives and encourages residents to be as independent as possible.

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:**

Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service.

The activities coordinator responsible for facilitating the monthly residents' meetings, reports information is regularly provided to the residents regarding their right to access advocacy services through HDC. Staff training on the role of advocacy services is included in training on The Code of Health and Disability Consumers' Rights – last provided for staff in March and August 2014.

Discussion with family and residents identifies that the service provides opportunities for the family/EPOA (enduring power of attorney) to be involved in decisions and they state that they have been informed about advocacy services. Copies of the EPOA are retained in resident files.

The resident file includes information on resident family/whanau including next of kin and chosen social networks.

Staff including the three caregivers interviewed are aware of the right for advocacy and how to access and provide advocacy information to residents if needed.

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:**

The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings (earlier in winter to coincide with dusk) but visitors can arrange to visit after doors are locked.

Families interviewed confirm they can visit at any reasonable time and are always made to feel welcome. The administrator is praised by all family members interviewed as being a key person who is always there for them, meeting and greeting and dealing with any requests/concerns with immediate access to the 'right' person.

Family are seen coming and going freely on the days of the audit. Four family members for residents in the dementia unit state that they enjoy visiting the unit and 'feel part of a family'. All know other resident names and engage with other residents as well as their own family member.

Residents are encouraged to be involved in community activities and maintain family and friends networks. Links are also encouraged through church with some residents still engaged in community activities including attending their own church services to movies, visiting the RSA, lunches at local cafés and restaurants with a special craft café identified that engages residents in activities as well as enjoying social company.

Residents have performing groups who entertain residents. Residents are included in shopping visits and outings with families. Family members of residents in the dementia unit state that staff take extra time to ensure that their needs are met and support them to be with their family member.

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 organisation's complaints policy and procedures is in line with the Code and includes time-frames for responding to a complaint. Complaint's forms are available at the entrance.

A complaints register is in place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint's folder. There has been a complaint made in June 2014 that is currently being investigated by the District Health Board with corrective actions lodged with the District Health Board.

Two complaints lodged in 2014 were selected for review. There is documented evidence of time-frames being met for responding to these complaints.

Eight rest home residents and eight family members (four dementia unit and four rest home) all state that they would feel comfortable complaining. One family member states that a complaint had been made and this has been addressed with 'excellent outcomes' described by the family member.

The clinical and quality manager and business and care manager state that there has been one complaint with the Health and Disability Commission since the last audit. HDC has confirmed that the complaint has been withdrawn and there are no follow up actions required. The complaint has been forwarded to the District Health Board which is investigating concerns raised.

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:**

Greenvalley Lodge is part of the Oceania group with the executive management team including the CEO, general manager, operations manager, regional operational managers and clinical and quality managers providing support to the service. Communication between the service and managers takes place on a monthly basis.

Oceania has a clear mission, values and goals. The vision is to be the provider of choice for senior New Zealanders of care and lifestyle options in a way that meets and exceeds the expectations of our residents, staff and stakeholders. The mission is 'we provide excellent contemporary care that reflects our residents' individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life'.

The facility can provide care for up to 50 residents (30 rest home specific beds and 20 beds in the dementia unit) with occupancy of 48 on the day of the audit (29 rest home residents and 19 requiring dementia level care).

The business and care manager is responsible for the overall management of the facility and has been in the role for three months. The business and care manager is a registered nurse (with current annual practicing certificate - sighted), over eight years' experience in aged care with previous experience in intensive care, theatre recovery and trauma counselling. Professional development relating to the management of an aged care facility exceeds eight hours with completion of a business management diploma.

The clinical and quality manager is a registered nurse with over 15 years in 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:**

In the absence of the business and care manager, a clinical manager is in charge with support from the clinical and quality manager.

The current clinical manager has been employed at the service for four months and has five years' experience in aged care. The clinical manager also has District Health Board experience as a quality auditor and has worked in emergency departments overseas.

The clinical and quality manager provides support to a number of Oceania facilities and is a registered nurse, has a certificate in business management, diploma in management and over 15 years' experience in aged care including home care and hospital/rest home/dementia facilities. The clinical and quality manager has been in management roles for ten years.

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:**

Greenvalley Lodge uses the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reported on through the business status reports sighted for 2014.

The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to stay that they have read and understood – sighted and confirmed by the three caregivers interviewed.

Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed.

There is documented evidence of communication with staff in the monthly meetings including health and safety, infection control, quality and staff meetings as well as in the registered nurse and health care assistant meetings and two monthly restraint meetings. All staff interviewed (five caregivers, two registered nurses, the clinical manager, the diversional therapist, one cook) report they are kept informed of quality improvements and corrective action plans.

Results are benchmarked across all Oceania aged care facilities with a business status report completed by the business and care manager monthly (sighted). This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.

There is an annual family and resident satisfaction survey which took place last in July 2014. A high level of satisfaction is documented in the survey report and this correlates with resident and family feedback received on the day of the audit (four family members from the rest home and four from the dementia unit and eight rest home residents).

The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan are in place for the service. There is a hazard management programme documented 2014 with a hazard register for each part of the service e.g. kitchen, office. There is evidence of hazards identification forms completed when a hazard is identified and the hazard form updated. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.

The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation – expiry date 31 March 2015. Health and safety is audited monthly.

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:**

The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified.

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the clinical manager, business and care manager and clinical and quality manager.

Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.

Fifteen incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event.

Information gathered is regularly shared at the monthly executive management and regional meetings with the business and care manager documenting incidents which are then graphed, trends analysed and benchmarking of data occurring.

The colour coding of incident forms e.g. for falls, medication errors has included guidelines that prompt staff to follow procedures. The three caregivers interviewed describe this as having helped their practice.

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:**

The registered nurse, the clinical manager and the business and care manager hold current annual practising certificates. Visiting practitioner practising certificates include the general practitioner, podiatrist and dietitian.

Seven staff files randomly selected for audit include appointment documentation e.g. signed contracts, job descriptions, reference checks and interviews. There is an annual appraisal process in place with all staff having a current performance appraisal. First aid certificates are held in the registered nurses staff files and in files of other staff with the business and care manager confirming that there are always two staff members on duty with a first aid certificate.

Police checks are completed in staff files.

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract. Health care assistants are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and senior caregivers who administer medicines to residents. Other competencies are completed including hoist, oxygen use, hand washing, wound management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower with completed competencies in staff files.

The organisation has a mandatory education and training programme with sessions held weekly. Staff attendances are documented and there is evidence of between 10 and 20 staff attending. Staff who do not attend are expected to read the training material and sign to state that they have completed and understood the training. The frequency of the training allows staff to attend all topics within the year. The three health care assistants state that they value the training.

Education and training hours exceed eight hours a year.

There are 16 health care assistants who work in the dementia unit. Twelve staff have completed the dementia unit training and 20 are enrolled. Three new staff have not yet enrolled however the expectation is that they will enrol as soon as they have completed three months in the role.

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:**

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.

The rosters for an occupancy of 48 residents meets occupancy and acuity levels with two health care assistants in the dementia unit morning and afternoon with one overnight. There are three health care assistants in the morning in the rest home, two in the afternoon and one at night. A health care assistant floats overnight between the dementia unit and the rest home.

There is a registered nurse who does 24 hours a week mostly in the dementia unit and this includes being on site over the weekend. The business and care manager is currently advertising for another registered nurse to work 15 hours a week with the same focus. This supports the clinical manager.

The business and care manager (RN) works full-time Monday – Friday and the clinical manager works full-time. On call is covered by the registered nurses, the business and care manager and the clinical manager.

Residents and families interviewed confirm staffing is adequate to meet the residents' needs.

There are currently 46 staff including the business and care manager, clinical manager, registered nurse, two activities coordinators, nine household staff including kitchen and cleaning staff and a maintenance staff member. An administrator also completes reception duties and there are 30 healthcare assistants including 16 who work in the dementia unit.

The District Health Board contract 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:** FA

**Evidence:**

The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service.

There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.

Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member including designation.

Resident files are protected from unauthorised access by being locked away in an office. Informed consent is obtained from residents/family/whanau on admission to display photographs. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This includes medical care interventions. Medication charts are in a separate folder with medication and this is appropriate to the service.

The District Health Board contract requirements are 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:** 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 1.2.9.10 (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 entry to the service policy is sighted and includes the procedure to be followed when a resident is admitted to the service. The clinical manager (CM) reports that an admission agreement is provided and this is sighted in all of the eight reviewed resident files. The residents and family report the admission agreement is discussed with them prior to admission and all aspects are understood.

All residents have needs assessments completed by the Waitemata District Health Board (DHB) needs assessment service prior to admission to the service. A welcome pack is also sighted which contains information about the service. The CM admits residents to the service using standard risk assessment tools.

Both telephone and walk-in enquiries are recorded in the enquiry register.

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:**

When a resident's entry into the service is declined, the resident is referred back to the referrer to ensure that the resident will be admitted to the appropriate level of care they are assessed for. There is evidence in the declining entry to the service policy and as confirmed by the clinical manager. There is documented policy on decline of entry to the service.

#### 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 residents receive timely, competent, and appropriate services that meet their assessed needs and desired outcome/goals. The registered nurses, physiotherapist, diversional therapist, general practitioner (GP) and pharmacists have current practising certificates sighted. Service delivery documentation is overseen by the clinical manager (CM). The eight reviewed resident's files contain evidence of initial assessments and care plans being completed and risk assessment tools being reviewed in the required timeframes. The CM has completed the InterRAI training and will be implementing the process after the audit. The person centred care plan template is personalised, reviewed and amended within required timeframes. The clinical risk assessments and follow up times for documentation reviews are all completed. Short term care plans are consistently developed when acute conditions are identified. The RNs document the date of resolution in the sighted short term care plans. Post fall assessments are completed for all falls. The person centred care plans (PCCPs) in the eight reviewed residents' files are reviewed every six months. The PCCPs are resident-focused and customised to the need of the residents.

The CM reports there is a process for annual multidisciplinary resident review. Families are also invited to attend these reviews. There is evidence in the eight reviewed resident's files that the family/whanau are involved in all care changes and six monthly reviews. There are two witnessed hand overs- one is between the RN and the morning caregivers and the other one is between the morning and afternoon RNs. The contents of the hand over is comprehensive to ensure continuity of care. The CM reports that the hand over sheet is reformatted to provide more information about the residents to all staff.

There is an integrated system to facilitate continuity and traceability of information in the resident's files. There are specified areas for the GP, RNs, caregivers and other members of the allied health team to document their notes.

The service has one contracted GP who visits twice a week or at other times if required. There is evidence that the GP admits residents within 24-48 hours of admission to the facility. The GP on interview verbalises satisfaction with the care provided to the residents. The GP is contacted regarding any concerns with residents and has a good working relationship with the clinical manager. The eight residents interviewed are very positive about the staff, GP and all aspects of care.

The District Health Board contract requirements are met.

Tracer Methodology 1: Rest home level of care

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

Tracer Methodology 2: Dementia level of care

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The initial nursing assessment includes good use of risk assessment tools and these include RN assessment, tinetti, waterlow, dietary, mobility, cognition, oral, continence, pain, depression, and cultural assessments. There are also assessment tools for post falls and challenging behaviours. Evidence is sighted in all eight reviewed resident's files that assessments are conducted within the specified timeframes and the assessment information are utilised as part of person centred care plan development. The CM conducts all PCCP reviews and residents/families are involved in the six monthly reviews.

The District Health Board contract requirement is 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 person centred care plans (PCCPs) in the eight reviewed resident's files are resident-focused and evidence inputs from other members of the health team. The interventions are related to the desired goals/outcomes. The CM utilises a standard template for the care plan. The PCCPs are written in a language that is user friendly and easy to comprehend. The PCCPs are updated when the interventions are not effective as identified during regular assessments and six monthly reviews. The short term care plans are developed when a resident develops acute infections. The residents report that they are included in the care planning and are aware of any changes and these are discussed with them. This is evidence in all eight reviewed resident's files. Care staff report they are informed of any changes to care plans during the hand overs.

The service has an integrated system in documentation. The RNs and caregivers write in the same section while the GP and other members of the allied health team write in specific sections in the resident's file.

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 documented interventions in the eight reviewed residents' files are sufficiently detailed and well-documented to address the assessed needs and desired outcomes. The interventions in managing acute infections are documented in the progress notes, wound care plans and short term care plans. There is documented evidence in all eight reviewed resident's files that the interventions relating to the residents' assessed needs and desired outcomes are evaluated as required and timeframes to ensure residents' desired outcomes are being met. The eight interviewed clinical staff report they are informed of any care plan changes during hand overs and have relevant in-service education as required including wounds and falls prevention.

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:** PA Low

**Evidence:**

Activities provided by the service are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The activities coordinator develops the yearly activity plans with the activities assistant. The weekly activities are posted in the rest home and dementia unit. The activities coordinator updates these activities board on a daily basis. The rest home and dementia unit residents have the same activity programme with the more one on one sessions provided for the dementia unit residents. The five out of five reviewed resident files in the rest home have well-documented activity plans that reflect the resident's preferred activities. The resident activities participation log is sighted.

The 24-hour dementia unit activity plans are insufficiently detailed to assist the staff in managing the residents. There is no evidence of diversional therapist input in the three of three reviewed activity plans in the dementia unit.

The District Health Board contract requirements are not fully 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:** PA Low

**Evidence:**

Activities provided by the service are appropriate to the needs, age and culture of the residents. The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. The activities are physically and mentally stimulating. External visits for the residents include picnics, beach trips and van trips. The six residents report on interview that the activities are positive and include exercise and music. The residents in the rest home and dementia unit have the same activity programme with the more one on one session provided for the residents in the dementia unit. The five reviewed resident files in the rest home have well-documented activity plans that reflect the resident's preferred activities. The resident activities participation log is sighted.

The activity plans are completed and reviewed six monthly in all eight reviewed resident's files.

**Finding:** i) There is no evidence of diversional therapist input in the activity plans for the residents in the dementia unit. ii) The 24 hour activity plans in the dementia unit are insufficiently detailed to assist the staff in managing the residents in the dementia unit.

**Corrective Action:** i) Ensure that a diversional therapist will have input in the development of the activity plans in the dementia unit. ii) Develop an individual resident focused 24 hour activity plans for the dementia residents.

**Timeframe (days):** 180 (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:**

Individual short term care plans are seen for wound care, infections, falls and challenging behaviours. These are kept in the resident's file and staff write in the progress notes every shift as evidence in the file. The resolution of the identified problem is documented in the short term care plans. PCCPs are reviewed every six months or earlier as required and this is evidence in all reviewed resident's files. Evidence is seen of the family/whanau involvement in the six monthly reviews. There is evidence in the documentation when an event occurs that is different from expected and requires changes to service. The interviewed residents and family members report that they are given the opportunity to be involved in all aspects of care and reviews. The eight interviewed clinical staff have adequate knowledge of the care plan and the required documentation.

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 policy related to exit, transfer or transition states that residents will have access to appropriate external treatment and support services and will be referred in a timely fashion. All referrals are clearly documented in the progress notes and in the diary. The clinical manager (CM) informs the resident's family of upcoming appointment and are invited to attend and assist. There is a referral form in place. All eight reviewed resident's files evidence referrals to other health services which includes dietitian, mental health services, needs assessment, speech language therapist, wound and physiotherapist referrals. Residents are given a choice of GP when they are admitted. Most residents use the GP contracted by the service. If the need for other services are indicated or requested, the GP sends a referral to seek specialist service provider assistance from the Waitemata DHB. The resident and the family are kept informed of the referrals made by the service.

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 service uses a transfer document when residents are transferred to the public hospital or to another service. The form highlights any known risks, such as falls, includes current medications, current information related to the national health index number (NHI), date of birth (DOB), next of kin, instruction regarding specific treatments and may include a medical referral as appropriate. When the resident is transferring to another facility another form is used outlining activities of daily living, reason for transfer, current medical problems, past history, medications, current signing sheets, current treatments and observations. As well as the current care plan. A verbal handover is given by the CM. There is open communication between the service and family/whānau in relation to all aspects of care, including exit, discharge or transfer. The CM provides verbal hand overs when transferring the residents to another service and receives hand overs from the hospital when a resident is discharged to the service.

The District Health Board contract requirement is met.

### 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 service has a medicine management system to ensure that the residents receive medicines in a safe and timely manner. The 16 out of 16 reviewed medication charts reflect three monthly GP reviews, discontinued medications are signed and dated by the GP, allergies are documented, all have photos for identification and written legibly. The CM conducts medication reconciliation on admission of a new resident or when a resident is discharged from the hospital back to the service.

The two witnessed staff during medication rounds (one in the rest home and one in the dementia unit) demonstrate compliance with the medication administration policies and procedures of the service. The staff use the hand sanitizer in the medication trolley before and after administering medications. All staff who administer medications have current medication competencies as evidenced in the files. The annual medication competency training in-service is last conducted on September 2014 which is attended by six out of 11 medication competent staff.

There is no expired or unwanted medications sighted. Expired medications are returned to the pharmacy in a timely manner. The controlled drugs register is current and correct. The two residents on controlled drugs have pain assessments and monitoring in place. The service conducts a weekly and a six-monthly stocktake of controlled drugs as sighted in the controlled drugs register.

There are two residents who self-administer medications. The self-administration policies and procedures are in place. The two residents confirm that the CM provides adequate information regarding their medications. The medications are kept in a locked cupboard as sighted.

The medicine fridge is monitored daily and the temperatures sighted are within normal ranges. There are sharp bins sighted in the medication room.

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 policy manual details the principals of food safety, ordering, storage, cooking, reheating and food handling. Staff infection prevention and control requirements are also detailed. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. The kitchen also provides healthy finger foods in the dementia unit lounge and are replaced every morning by the kitchen hand.

The service provides the residents with meals that meet their food, fluids and nutritional needs. The CM completes the dietary requirement form on admission and provides a copy to the kitchen. The cooks and CM update the kitchen board regularly. The service also provides additional or modified foods depending on the need of the residents including their likes and dislikes. This include puree, soft, mince/moist, high energy/high protein and diabetic meals. A menu planner is in place to provide residents with meal options and this is included in the activities by the activities coordinator.

Fridge and chiller temperatures are monitored daily. Food temperatures are monitored and recorded after cooking and before serving to the residents. The kitchen staff use a clean technique in preparing meals for the residents. All prepared foods in the chillers like sandwiches are covered and dated. A kitchen cleaning schedule is sighted and completed daily. Cooked meals are transported to the dining areas and in the rooms via a bain marie. The main serving area opens to both dementia and rest home units dining areas thus simultaneous serving of meals occurs. The meals are well presented as sighted during the observed lunch. All eight interviewed residents verbalise that they enjoy the food provided by the service.

The service conducts monthly weighing of residents or more frequent as required as evidence in the weight monitoring folder. Weights are stable as sighted.

The weekday cook places orders directly to their suppliers. The cook reports that they use the first in-first out system for all their food supplies.

There are two cooks who manage the kitchen. The weekday cooks have worked in the service for three years. Both cooks have current food handling certificates as sighted in the staff files. The weekday cook reports on interview that they have good support by management with food supplies and understands the individual requirements of the residents.

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:**

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

The provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. During a tour of the facility protective clothing and equipment is observed in all high risk areas.

Visual inspection of the facilities 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. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

The District Health Board contract requirements are 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 current Building Warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 21 September 2015). There have been no building modifications since the last audit.

There is a planned maintenance schedule implemented.

The lounge areas are designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit.

The following equipment is available: one pressure relieving mattresses, shower chairs, a full hoists and sensor alarm mats. There is a test and tag programme two yearly and this is up to date.

Interviews with three health care assistant, the registered nurses and the clinical manager confirm that there is adequate equipment.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required.

There are safe outside areas that is easy to access for residents and family members with handrails and ramps in place.

There is a steep turning bay outside the main door and any visitors or residents returning are encouraged to drop any person with limited mobility off at the door.

In the dementia unit, the lounge area is designed so that space and seating arrangements provide for individual and group activities and there are quiet and low stimulus areas that provide privacy when required. There is a safe and secure outside area that is easy to access with a courtyard that is interactive and includes a path with many doors opening back into the building.

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:**

There are adequate numbers of accessible toilets/bathing facilities. This includes full ensuites, visitors, toilets and communal toilets conveniently located close to communal areas.

Communal toilet facilities have a system that indicates if it is engaged or vacant noting that these were put in for some communal toilets and showers on the day of the audit.

Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Eight residents and eight family members interviewed report that there are sufficient toilets and showers with a number of rooms having their own ensuite including a toilet in each bedroom in the dementia unit.

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

#### **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:**

There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.

Equipment was sighted in rooms requiring this.

Rooms can be personalized with furnishings, photos and other personal adornments and the bedrooms in the dementia unit indicate that all are encouraged to have personal items with thought given to placement of these.

There is sufficient room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.

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:**

The service has lounge/dining areas in the rest home and in the dementia area with smaller withdrawal areas available. Areas used for activities are large with appropriate floor coverings in each part e.g. carpet only in the lounge area of the room and lino in the dining areas. All areas are easily accessed by residents, visitors and staff.

Residents are able to access areas for privacy if required.

Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.

There is a specific area for the hairdresser is located in the rest home area.

There is adequate space in the dementia unit to allow maximum freedom of movement while promoting safety for those that wander. The dementia unit is secure at all times.

The District Health Board contract requirements are 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:**

Laundry is subcontracted to a service and is independent to Greenvalley Lodge. Eight residents and eight family members state that the laundry is returned with minimal loss of property. There is seven day a week cover by laundry staff to ensure that laundry is taken off site and returned on a daily basis.

There are cleaners on site during the day seven days a week. The cleaners were observed to have the trolley in the room with them when cleaning and all had appropriately labelled containers.

Ecolab products are used with training around use of products last provided in July 2014 with another training planned for October 2014

Cleaning is monitored through the internal audit process with no issues identified in audits last completed in 2014.

Chemicals and cleaning cupboards are locked.

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:** PA Low

**Evidence:**

An evacuation plan was approved by the New Zealand Fire Service on 25 May 1988 with a fire design report submitted by an external company in February 2013.

An evacuation policy on emergency and security situations is in place.

A fire drill takes place six-monthly with evidence of emergency drills completed as per schedule in 2014. The orientation programme includes fire and security training. Staff confirm their awareness of emergency procedures.

There is always one staff member at least with a first aid certificate on duty – confirmed through review of the roster and confirmed by the business and care manager.

All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. There is back up emergency lighting in place.

An electronic call bell system is in place and this has been checked by an external company in July 2014. There are call bells in all residents' rooms, residents' toilets, and communal areas including the hallways, dining room and communal areas. Some call bells checked were not operational on the first day of the audit. These were fixed by the maintenance staff. An improvement is required to ensuring that the call bell system is operational at all times.

There is no call bell in one small lounge in the rest home area however bedrooms open into the lounge and all have call bells.

The doors are locked in the evenings doors can only be opened from the inside. Systems are in place to ensure the facility is secure and safe for the residents and staff. External lighting is adequate for safety and security with sensor lights on the outside of the building.

The District Health Board contract requirements are partially 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

An electronic call bell system is in place and this has been checked by an external company in July 2014. There are call bells in all residents' rooms, residents' toilets, and communal areas including the hallways, dining room and communal areas.

**Finding:**

Some call bells checked were not operational on the first day of the audit (six call randomly selected were not operational).

**Corrective Action:**

Ensure that call bells are operational at all times.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **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. Documentation and 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. There is a designated external smoking area.

Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.

The District Health Board contract requirements are 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 promotes a restraint-free environment. The clinical manager (CM) is the delegated restraint coordinator with relevant authorities and responsibilities. The signed restraint coordinator job description is sighted. An approval group is established headed by the restraint coordinator. Restraint is included in the monthly quality improvement (QI) meeting as sighted in the minutes of the September 2014 QI meeting. Restraint usage is kept to an absolute minimum and restraint decisions are always in collaboration with the GP. The restraint coordinator is knowledgeable about the restraint process – from obtaining consent to regular monitoring. The use of de-escalation techniques are mentioned by the restraint coordinator before commencing any resident on restraint. All staff are trained/educated regarding the restraint policy and procedures, de-escalation techniques and managing challenging behaviours. This restraint in-service training is provided annually and is last conducted on September 2014. The hand outs provided reflect the restraint/enablers approved in this facility. The policy on restraint minimisation and safe practice includes the definitions of restraint and enablers which aligns with the requirements of the standards.

The restraint register is current and shows that there is no resident using restraint or enabler.

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 responsibility for infection control co-ordinator (ICC) is clearly defined and there are clear lines of accountability for infection control matters in the facility. The clinical manager is the delegated infection control co-ordinator (ICC) and the signed job description is sighted in the file. The ICC is supported by the business and care manager (BCM) and by the clinical and quality manager (CQM). The ICC is responsible to for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation including advice from the Waitemata DHB infection control and prevention expert.

The service has a clearly defined infection control programme that is last reviewed in February 2014. The infection control committee is composed of the ICC, BCM, RN, administration, cook, laundry/cleaner, maintenance and caregiver. The infection control committee meets every first week of each month as sighted. Infection control is also included in the monthly quality improvement meeting as sighted.

The use of antibiotics is monitored and recorded infection log which includes the date the infection is identified, type, prescribed antibiotics, length prescribed and the date the infection is resolved. Infections are classified as respiratory, urinary, gastro-intestinal, wound/skin and systemic. The infections rates are collated for benchmarking and the results are discussed in the quality improvement meetings. This is evidence in the September 2014 minutes of the meeting.

Infectious diseases prevention policy is in place to prevent visitors suffering from, or exposed to and susceptible to, from exposing others while still infectious. Resident's families and relatives are encouraged not to visit when they are unwell. Hand sanitizers are in the main reception area as well as in the corridors.

The RN and four caregivers interviewed confirm timely ongoing communication is occurring when residents are suspected or confirmed as having an infection. This includes shift handovers and discussion at monthly QI meetings. The infection control policies and procedures are available to the staff in the rest home unit nurse's station.

The ICC advises there are no residents with a multi-drug resistant organism.

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 ICC confirms being responsible for facilitating infection prevention and control activities. The ICC has attended relevant education on infection prevention and control. This includes a study day provided by an external infection prevention and control consultant on 17 September 2013 and certificate of attendance sighted. The CM who is the delegated ICC liaises with the GP if there are any concerns about a resident with a known or suspected infection. The GP confirms that the CM contacts the surgery when a resident manifests signs and symptoms of infections. The ICC is responsible for gaining infection control, infectious disease and microbiological advice and support, where this is not available within the organisation. The Waitemata DHB infection control and prevention expert provides advice for the ICC. The ICC is also knowledgeable on who to advise in the event of an outbreak.

The infection control committee is composed of the ICC, BCM, caregiver, laundry/cleaner, maintenance, administration and cook. The infection control committee is very first week of each month as verified.

The ICC conducted an infection control audit last June 2014 with an outcome of 34%. Corrective actions are implemented and all corrective actions are signed off by the BCM during the day of the audit.

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:** PA Low

**Evidence:**

Documented policies and procedures for the prevention and control of infection aligns with current accepted good practice and relevant legislative requirements and are readily available in the service. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. The service does not have consistent implementation of the policies and procedures and best practice. Staff transports laundry bags to the basement by means of using rolled plastics from the main floor going down to the basement. The rolled plastics does not cover the whole surface of the stairs as well as the sides of the stairs. This is an area for improvement in 3.3.1. Staff are noted to be wearing gloves and aprons during care and there are no staff walking in the corridors wearing gloves or aprons. All interviewed staff demonstrate excellent knowledge on infection control prevention including the importance of proper hand washing.

The District Health Board contract requirements are not fully 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:** PA Low

**Evidence:**

The infection control prevention and control policies and procedures of the service comply with the relevant legislation and current accepted good practice. This is available for the staff in the rest home nurse's station.

**Finding:**

The staff transports laundry bags from the main floor to the basement using rolled plastic. The rolled plastic does not cover the whole surface of the stairs and the sides of the stairs. The laundry bags containing dirty and soiled resident's clothes, linens and beddings touch the sides of the stairs when the staff drops the laundry bags on the rolled plastics.

The lift is only used to transport food to and from the kitchen.

**Corrective Action:**

The service must ensure that the rolled plastics used to transport laundry bags will cover the whole surface of the stairs as well as the sides of the stairs.

**Timeframe (days):** 90 (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:**

Education is provided for staff on infection prevention and control as a component of the orientation and ongoing education programme. The infection control in-service education sessions in infection control and standard precautions are last conducted on August 2014 which is attended by eight staff. Residents and families are provided with advice on infection prevention and control activities via resident meetings as evidence in the minutes of the meeting. The resident meeting minutes includes discussion on the importance of hand hygiene and the overall number of resident infections to promote resident awareness. Infection control prevention and prevention is included in the annual education session planner.

The RN and four caregivers interviewed demonstrate good knowledge in infection control and prevention. Staff are able to discuss the importance of hand washing and the appropriate use of gloves. Kitchen staff are wearing gloves when preparing meals. Staff serving lunchtime meals are wearing gloves as sighted.

Hand hygiene is also part of the activities developed by the activities coordinator and by the ICC.

The ICC is booked for infection control training as confirmed by the organisation's training coordinator.

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 surveillance for infection rate is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. The infection control surveillance is appropriate to the size of the service. Infection rates are monitored monthly and collated by the ICC which includes urinary tract infections,

skin/ wound, respiratory tract infections, gastro-intestinal tract infections and systemic infections. These infections are entered in the intranet system for benchmarking within the organisation. Infection rates are discussed during the monthly quality improvement meetings as well as infection control committee meetings as sighted. The interventions to reduce, manage and prevent the infections are discussed during monthly quality improvement meetings as evidence in the records.

The results of the monthly infection surveillance are sighted in the intranet and in the infection control folder.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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