# Oceania Care Company Limited - St Johns Wood Rest Home & Village

## Current Status: 7 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

St Johns Wood Care Centre (St Johns Wood) provides residential care for up to 60 residents who require hospital and rest home level care and occupancy on the day of the audit was 41. The facility is operated by Oceania Care Company Limited.

A new non-clinical business and care manager was appointed in June 2014 and is supported by a clinical manager who was appointed in July 2014. There have been no changes to the building since the last audit. Five areas were identified as requiring improvement during this audit relating to quality and risk management, adverse event reporting and resident care planning.

## Audit Summary as at 7 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 |
|  | 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 7 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 7 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Continuum of Service Delivery as at 7 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 medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 7 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. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 7 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 7 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. |  | Standards applicable to this service fully attained. |

## Audit Results as at 7 October 2014

### Consumer Rights

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

During interview residents and family confirmed that consent forms were provided to them prior to admission to ensure they had time for consultation and that they were fully informed. Time was provided if discussions and explanation were required.

The business and care manager were responsible for the management of complaints and a complaints register was maintained. The residents can use the complaints forms, raise complaints directly with the business and care manager, the clinical manager, or with any member of staff.

### Organisational Management

Oceania Care Company Limited is the governing body and is responsible for the service provided at St Johns Wood. Planning documents reviewed included a vision statement, values, quality objectives, quality indicators and quality projects. Systems were in place for monitoring the service provided at St Johns Wood including regular monthly reporting by the business and care manager and the clinical manager to the Oceania support office. The facility is managed by a suitably qualified and experienced business and care manager who is an enrolled nurse with aged care experience. The business and care manager is supported by a clinical manager, who was appointed to this position in July 2014, is a registered nurse and is responsible for oversight of clinical care provided.

The Oceania Care Company Limited quality and risk management systems were implemented at St Johns Wood although improvements are required as quality improvement data was not being analysed to identify any trends and corrective action plans were not consistently developed and implemented to address shortfalls identified. Improvements are also required because resident and family meetings were not held on a regular basis. Improvements are required with adverse event reporting.

A hazard register was maintained that identified health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk.

There were policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise was occurring. A review of staff records provided evidence that human resource processes were being followed (e.g., reference checking, criminal record vetting, and interview questionnaires were completed), orientations were being completed and individual education records were maintained.

In-service education was provided for staff as part of the annual compulsory education day that all staff are required to attend. Staff were also supported to complete the New Zealand Qualifications Authority Unit Standards via the ‘Oceania Certificate in Residential Care’. A review of staff records provided evidence that individual education records were maintained.

There was a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that was based on best practice. The minimum number of staff was provided during the night shift and consisted of one registered nurse and two health care assistants. The clinical manager was on call after hours. Care staff interviewed report there was adequate staff available and that they were able to get through their work.

Resident information was entered into a register in an accurate and timely manner. Residents' files were integrated and documentation was legible with the name and designation of the person making the entry identifiable.

### Continuum of Service Delivery

The facility had a documented entry criteria, which was communicated to residents, family and referral agencies. The service provision within the organisation was undertaken by suitably qualified and experienced staff members.

The systems were implemented that evidence each stage of service provision has been developed with resident and/or family input and was coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into assessment, care planning, evaluation of care and access to a typical range of life experiences and choices. The documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison was occurring with other services.

A sampling of residents' clinical files validated the residents received adequate and appropriate services meeting their assessed needs and desired outcomes. The residents’ care plan was individualised and up to date. The evaluations of care plans were within stated timeframes and reviewed more frequently if a resident’s condition changes. Where progress was different from expected, the service responded by initiating changes to the care plan or recording the changes on a short term care plan. The residents interviewed confirmed that interventions noted in their care plans were consistent with meeting their needs.

There are areas identified as requiring improvement around service delivery timeframes.

The planned activities were appropriate to the group setting and displayed. Activities reflect the skills, strengths and the interests of the residents. The residents and family interviewed confirmed satisfaction with the activities programme. The residents' files evidenced individual activities were provided either within group settings or on a one-on-one basis.

The medication management systems provided safe and appropriate prescribing, dispensing, review, storage, disposal and reconciliation of medicines. The policies and procedures clearly detailed service provider’s responsibilities. The staff responsible for medicine management had attended in-service education for medication management and had current medication competencies. The residents' who self-administered medicines did so according to policy.

The food service policies and procedures were appropriate to the service setting with a new seasonal four weekly menu being introduced six monthly and this has been reviewed by a dietitian. The food, fluid, and nutritional needs of residents were provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The resident's individual dietary needs were identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Wharerangi Care Centre has a central kitchen and on site staff that provided the food service for the St Johns Wood. The kitchen staff had completed food safety training.

### Safe and Appropriate Environment

The facility has rest home rooms, hospital rooms and assisted care suites. Seven apartments were also certified to provide rest home level care although these rooms were not being used by rest home or hospital level residents during this audit. All of the bedrooms provide single accommodation and had full ensuite facilities. There were also adequate toilet and shower facilities throughout the facility.

Residents' rooms were large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. There were lounges and dining areas available throughout the facility and external areas were available for sitting and shade. An appropriate call bell system was available and security systems were in place.

There were policies and procedures for waste management, cleaning and laundry, and emergency management and these were known by staff. Staff received training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provided evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing was provided and was used by staff.

Review of documentation provided evidence there were appropriate systems in place that ensured the residents’ physical environment was safe, and facilities were fit for their purpose. Laundry for St Johns Wood and Wharerangi, which is another Oceania facility in Taupo, was washed on site at St Johns Wood. Cleaning and laundry systems included appropriate monitoring systems in place that evaluated the effectiveness of these services. Staff had completed appropriate training in chemical safety. There was safe and hygienic storage areas for soiled linen.

### Restraint Minimisation and Safe Practice

The service had an overarching risk and quality management system that demonstrated compliance with the Standard. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents were experiencing services that were least restrictive. There were four residents using restraint and four residents using enablers on audit days.

The residents' files sampled evidenced resident and family input into the restraint approval process, restraint assessment and risk processes were being followed, monitoring of restraint was occurring and each episode of restraint was being evaluated. Interviews with residents and family members confirmed restraint and enablers were being used safely. The restraint committee meeting minutes evidenced an approval review process.

### Infection Prevention and Control

The infection prevention and control programme included policies and procedures for the prevention and minimisation of infection and cross infection, and contained all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice. New employees were provided with training in infection control practices and there was on-going education available for all staff.

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

Surveillance for residents who developed infection were collated at the end of each month and reported as a clinical indicator to Oceania support office and to staff through meetings.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Oceania Care Company Limited |
| **Certificate name:** | Oceania Care Company Limited - St Johns Wood Rest Home & Village |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | St Johns Wood Rest Home & Village | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 7 October 2014 | **End date:** | 8 October 2014 |

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

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 41 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 15 | Total audit hours | 39 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 12 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 20 | Total number of staff (headcount) | 42 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXX, 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 | Yes |
| g) | Health Audit (NZ) Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health Audit (NZ) Limited has finished editing the document. | Yes |

Dated Friday, 24 October 2014

## **Executive Summary of Audit**

**General Overview**

St Johns Wood Care Centre (St Johns Wood) provided residential care for up to 60 residents who required hospital and rest home level care and occupancy on the day of the audit was 41. The facility is operated by Oceania Care Company Limited.

A new non-clinical business and care manager was appointed in June 2014 and was supported by a clinical manager was appointed in July 2014. There have been no changes to the building since the last audit.

Five areas were identified as requiring improvement during this audit relating to quality and risk management, adverse event reporting and resident care planning.

**Outcome 1.1: Consumer Rights**

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

During interview residents and family confirmed that consent forms were provided to them prior to admission to ensure they had time for consultation and that they were fully informed. Time was provided if discussions and explanation were required.

The business and care manager were responsible for the management of complaints and a complaints register was maintained. The residents can use the complaints forms, raise complaints directly with the business and care manager, the clinical manager, or with any member of staff.

**Outcome 1.2: Organisational Management**

Oceania Care Company Limited is the governing body and was responsible for the service provided at St Johns Wood. Planning documents reviewed included a vision statement, values, quality objectives, quality indicators and quality projects. Systems were in place for monitoring the service provided at St Johns Wood including regular monthly reporting by the business and care manager and the clinical manager to the Oceania support office. The facility was managed by a suitably qualified and experienced business and care manager who is an enrolled nurse with aged care experience. The business and care manager was supported by a clinical manager, who was appointed to this position in July 2014, is a registered nurse and is responsible for oversight of clinical care provided.

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Resident information was entered into a register in an accurate and timely manner. Residents' files were integrated and documentation was legible with the name and designation of the person making the entry identifiable.

**Outcome 1.3: Continuum of Service Delivery**

The facility had a documented entry criteria, which was communicated to residents, family and referral agencies. The service provision within the organisation was undertaken by suitably qualified and experienced staff members.

The systems were implemented that evidence each stage of service provision has been developed with resident and/or family input and was coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into assessment, care planning, evaluation of care and access to a typical range of life experiences and choices. The documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison was occurring with other services.

A sampling of residents' clinical files validated the residents received adequate and appropriate services meeting their assessed needs and desired outcomes. The residents’ care plan was individualised and up to date. The evaluations of care plans were within stated timeframes and reviewed more frequently if a resident’s condition changes. Where progress was different from expected, the service responded by initiating changes to the care plan or recording the changes on a short term care plan. The residents interviewed confirmed that interventions noted in their care plans were consistent with meeting their needs.

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The food service policies and procedures were appropriate to the service setting with a new seasonal four weekly menu being introduced six monthly and this has been reviewed by a dietitian. The food, fluid, and nutritional needs of residents were provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The resident's individual dietary needs were identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Wharerangi Care Centre has a central kitchen and on site staff that provided the food service for the St Johns Wood. The kitchen staff had completed food safety training.

**Outcome 1.4: Safe and Appropriate Environment**

The facility has rest home rooms, hospital rooms and assisted care suites. Seven apartments were also certified to provide rest home level care although these rooms were not being used by rest home or hospital level residents during this audit. All of the bedrooms provide single accommodation and had full ensuite facilities. There were also adequate toilet and shower facilities throughout the facility.

Residents' rooms were large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. There were lounges and dining areas available throughout the facility and external areas were available for sitting and shade. An appropriate call bell system was available and security systems were in place.

There were policies and procedures for waste management, cleaning and laundry, and emergency management and these were known by staff. Staff received training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provided evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing was provided and was used by staff.

Review of documentation provided evidence there were appropriate systems in place that ensured the residents’ physical environment was safe, and facilities were fit for their purpose. Laundry for St Johns Wood and Wharerangi, which is another Oceania facility in Taupo, was washed on site at St Johns Wood. Cleaning and laundry systems included appropriate monitoring systems in place that evaluated the effectiveness of these services. Staff had completed appropriate training in chemical safety. There were safe and hygienic storage areas for soiled linen.

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

The service had an overarching risk and quality management system that demonstrated compliance with the Standard. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents were experiencing services that were least restrictive. There were four residents using restraint and four residents using enablers on audit days.

The residents' files sampled evidenced resident and family input into the restraint approval process, restraint assessment and risk processes were being followed, monitoring of restraint was occurring and each episode of restraint was being evaluated. Interviews with residents and family members confirmed restraint and enablers were being used safely. The restraint committee meeting minutes evidenced an approval review process.

**Outcome 3: Infection Prevention and Control**

The infection prevention and control programme included policies and procedures for the prevention and minimisation of infection and cross infection, and contained all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice. New employees were provided with training in infection control practices and there was on-going education available for all staff.

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

Surveillance for residents who developed infection were collated at the end of each month and reported as a clinical indicator to Oceania support office and to staff through meetings.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 47 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 2 | 3 | 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 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.1 | The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | Resident meetings have not been held on a regular basis. | Provide confirmation that resident meetings are being held on a regular basis. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality improvement data is not being evaluated and analysed to identify any trends. | Provide evidence that quality improvement data is being evaluated and analysed to identify trends. | 90 |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Internal audits, meeting minutes and completed satisfaction surveys are reviewed with areas identified as requiring improvement but no corrective action plan has been developed, implemented and monitored to address these shortfalls. The person/s responsible for developing and/or implementing the corrective action plan/s, and timeframes, are not consistently documented. | Provide documented evidence that where shortfalls are identified following internal audits, in meetings and satisfaction surveys, that a corrective action plan is developed, implemented and monitored, and that the person/s responsible and the timeframes are clearly documented. | 90 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | (i)Resident files reviewed indicate that three residents had unwitnessed falls in August 2014 (one) and September 2014 (two) and neurological observations were not recorded for these residents; (ii) an accident/incident form for one of the residents has not been signed off as completed and there is no evidence of communication with family following this event; and (iii) a resident had an unwitnessed fall and told their family who told a staff member. There is no accident/incident form for this event and there is no record in the resident’s notes that they had experienced a fall. | Provide evidence that (i) neurological observations are recorded for all residents who experience unwitnessed falls and/or have an injury that could result in a head injury; (ii) all accident/incident forms are fully completed and that evidence of communication with family members is recorded; and (iii) accident and incident forms are completed for all adverse events | 90 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.3 | Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Timeframes for completion of risk assessments and long term care plans are not consistently adhered to. | Provide evidence service provision timeframes adhere to the standards, DHB contract requirements and Oceania policies. | 90 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Staff receive training in the Code of Health and Disability Services Consumers’ Rights’ (the Code) at least annually as part of the compulsory education day that all staff are required to attend. Staff education records are sighted and confirm attendance at these education days by clinical and non-clinical staff. Care staff are observed interacting respectfully and communicating appropriately with residents. Staff encourage residents to make choices demonstrating their knowledge of residents’ rights.

Residents (two hospital and four rest home) and family members (two hospital and two rest home) are able to verify that services are provided with dignity and respect, privacy is maintained, and individual needs and rights are upheld. These findings are also confirmed during review of the resident and family survey that was completed in April 2014 and August 2014. A corrective action plan has not been developed and implemented to address the shortfalls identified in these satisfaction surveys (see link criterion 1.2.3.8).

Interviews with staff (the business and care manager, clinical manager, three registered nurses, one enrolled nurse, two health care assistants, one activities co-ordinator and a physiotherapist) demonstrate an understanding of resident rights.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

The Code of Rights and information on the advocacy service are displayed and are available at the facility and in the information pack provided on admission to the facility.

Residents and family members interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to the resident’s admission. The enquiry/admission pack is reviewed and contains, but is not limited to, an A-Z information booklet, information on the Code, advocacy and complaints processes. Residents and family interviewed confirm explanations regarding their rights occur on admission and at any time that they may have a query.

The families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and nine admission agreements (four rest home and five hospital) are reviewed as part of the review of resident’s files and are found to contain this level of information.

Residents interviewed confirm they have access to an advocate and one may be appointed if needed. An independent advocate visits this facility as well as another Oceania facility in Taupo, at least four times a week but was unavailable for interview during this audit.

Resident / family satisfaction surveys completed in 2014 indicates residents and family are aware of their rights.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of residents (two hospital and four rest home) and family members (two hospital and two rest home).

Staff receive training on abuse / neglect as part of the compulsory education days and records reviewed indicate attendance by clinical and non-clinical staff. Staff are observed knocking before entering residents' rooms and keeping doors closed while attending to residents.

Activities in the community are encouraged and several residents attend community events independently. Where a resident wishes to continue with their hobbies or self-cares this is encouraged. Church services are held on site as part of the activities programme.

Values, beliefs and cultural aspects of care are recorded in residents’ clinical files reviewed (five hospital and four rest home).

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

Access to Māori support and advocacy services is available if required via members of staff who guide the business and care manager as to the most appropriate person/agency to contact. Family are able to be involved in the care of their family members and staff interviewed report they encourage this.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education is provided as part of the compulsory education days for all staff.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. These findings are supported during review of the resident/relative satisfaction surveys completed in April and August 2014. Church services are held on site weekly as part of the activities programme and some residents go out to attend church services with the support of family and friends. A chaplain is on site at least four times a week but is not available for interview during this audit.

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and a code of conduct that includes house rules. These documents also address any conflict of interest issues (e.g. the accepting of gifts and personal transactions with residents) and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which are reviewed on seven staff files. Education on Oceania vision and values, teamwork and boundaries is provided for all staff as part of the compulsory inservice day and evidence of attendance is reviewed on staff files (seven).

Processes for the management of resident’s comfort funds are described by the business and care manager as well as the auditing and reconciliation of the funds by Oceania support office.

A review of the accident/incident reporting system, complaints register and interview of the business and care manager indicates there have not been any allegations of inappropriate behaviour by staff.

Residents and family interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

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

Education is provided by specialist educators as part of the in-service education programme and this is confirmed during review of education records and interview of the business and care manager, the clinical manager, registered nurses (three) and one enrolled nurse who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. The business and care manager, the clinical manager and the registered nurses advise the District Health Board (DHB) specialist nurses provide education and support for the clinical staff as needed.

Staff interviewed confirm understanding of professional boundaries and practice.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families and these are reviewed. Residents' files reviewed (four rest home and five hospital) provide evidence that communication with family members is being documented in residents' records. With one exception, there is evidence of communication with the GP and family following adverse events (see link criterion 1.2.4.3), which is recorded on the accident/incident forms, on family communication sheets, and in the individual resident's files.

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

The business and care manager advises access to interpreter services is available if required via the local community, family members and interpreter services if required. They also advise there are currently no residents who require interpreter services in the facility.

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

Staff interviewed (two health care assistants, three RNs, one enrolled nurse, the business and care manager and the clinical manager) demonstrate a good understanding of informed consent processes.

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

Residents' files reviewed demonstrate written and verbal discussions on informed consent have occurred and residents’ files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the Code of Rights as part of the compulsory inservice education days.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they attended education on the Code of Rights, advocacy, and complaint management as part of the in-service education programme. This was confirmed during review of staff education records.

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

The independent advocate who visits this facility and the other Oceania facility in Taupo at least four times a week is not available for interview during this audit.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

Residents and family members interviewed confirm they can have access to visitors of their choice, and confirm they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a mobility van is available to take residents on community visits. Some residents go out independently on a regular basis.

Residents' files reviewed demonstrate that activity plans identify support/interest groups. Progress notes and care plan content includes regular outings and appointments (records sighted).

The District Health Board contract requirements are met.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The business and care manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes 11 complaints for 2014 and the complaints register is reviewed.

The business and care manager advises there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents (two hospital and four rest home) and family (two hospital and two rest home) interviewed demonstrate an understanding and awareness of these processes.

A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of quality and staff meeting minutes and the business and care manager’s monthly reports provides evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirm this information is reported to them via their staff meetings and that graphs of this data is available for them in the staff room.

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:**

Oceania Care Company Limited (Oceania) is the governing body and is responsible for the service provided at St Johns Wood Care Centre (St Johns). The Oceania quality and risk management systems are implemented at St Johns Wood and the documented scope, direction, goals and vision are reviewed.

Systems are in place for monitoring the service provided at St Johns Wood including regular monthly reporting by the business and care manager (BCM) and the clinical manager (CM) to Oceania support office via the Oceania intranet. Reporting includes reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators and is sighted during this audit. The monthly business status reports are sighted and these reports are provided to the Oceania executive team and link to the organisations and facility’s business plan.

A written quality and risk management plan/policy identifying the organization’s quality goals, objectives, and scope of service delivery is reviewed and includes statements about quality activities and review processes. A 'Clinical Risk Management Policy' and a 'Clinical Risk Management Plan' are reviewed along with documented values, mission statement and philosophy, which are displayed at the main entrance. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

The BCM is an enrolled nurse who was appointed to this position July 2014. The BCM is an experienced manager who has worked in the aged care sector in management roles for the last 15 years. The BCM is supported in their role by a clinical manager (CM) who was appointed to this position in an acting capacity in July 2014 and subsequently appointed as the CSM in September 2014. The CM has worked at St Johns Wood as a registered nurse (RN) since April 2010. The CM is responsible for oversight of the clinical care provided to residents at St Johns Wood.

These two managers are supported by an Oceania clinical and quality manager as well as a regional business operations manager from Oceania. Both managers have current practising certificates. The CMs and BCMs curriculum vitae (CV) and personal files are reviewed and there is documented evidence they attend education to keep themselves up-to-date.

St Johns Wood is certified to provide hospital (medical and geriatric) and rest home level care and have funding contracts to provide aged related residential care (rest home and hospital), community support services, long term support - chronic health conditions services, and residential non-aged services. On day one of this audit there are 26 residents assessed as requiring rest home level care and 15 residents assessed as requiring hospital level care. There is one resident aged less than 65 years who is assessed as requiring rest home level care.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are appropriate systems in place to ensure the day-to-day operation of the service continues should the business and care manager (BCM) and/or the clinical manager (CM) be absent. The CM relieves the BCM if they are absent and one of the registered nurses relieves the CM if they are absent. There is also support provided by the BCM from another Oceania facility in Taupo as well as from one of the clinical and quality managers from Oceania. Support and assistance is also provided by other personnel from Oceania support office as required. Twenty four hour registered nurse (RN) cover is provided and the CM is on call after hours if required.

Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the BCM and CM confirm their responsibility and authority for their roles.

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:** PA Low

**Evidence:**

A 'Quality Improvement Policy', 'Clinical Risk Management Policy' and a '2014 Quality Audit Schedule' are used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme in place, risks are identified and there is a hazard register. Clinical indicators are documented on an electronic database that is able to be reviewed by personnel from Oceania Support Office. The Oceania clinical and quality team meet monthly and review the clinical and quality data, review policies and procedures, and clinical documentation.

Relevant standards and legislative requirements are identified and are included in the policies and procedures manuals. Policies and procedures reflect current accepted good practice. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff report copies of policies are available in the care stations. Staff also report they are advised of updated policies via the staff meetings and quality meetings and that copies of updated policies are available for them to review in the staff room. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery.

Internal audit schedules and completed audits for 2014 are reviewed during this audit. Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. Review of the quality improvement data provides evidence the data is being collected, collated and reported to staff and the governing body but is not being analysed to identify trends and improvements are required (see criterion 1.2.3.6). Improvements are also required as resident meetings are not being held on a regular basis (see criterion 1.2.3.1). Corrective action plans are not being consistently documented and implemented to address shortfalls identified during internal audits and in meetings and improvements are required (see criterion 1.2.3.8).

Quality, infection control and health and safety meetings are held monthly and meeting minutes are reviewed. Registered nurse / enrolled nurse meetings are held monthly. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff report during interviews that copies of meeting minutes and graphs of clinical indicators are available for them to review in the staff room. This is confirmed during visual observations during this audit.

The health and safety manual documents health and safety management systems including a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements, and an emergency plan. Risks are identified, and there is a hazard register which is reviewed that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Meeting minutes are reviewed and provide evidence of discussion and reporting on accident/ incidents; hazards; staff wellness programme, health and safety objectives and maintenance. Oceania holds Workplace Safety Management Practices accreditation at tertiary level for ACC workplace safety and this expires on 31st March 2015.

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

Not all of the District Health Board contract requirements are met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A family/whanau meeting was held on 17 July 2014 and meeting minutes are reviewed during this audit. Minutes indicate that residents attended this meeting and provided feedback. The Chaplain, who also acts as an independent advocate for residents is in attendance at this meeting as is the activities co-ordinator. A corrective action plan to address the various issues raised by residents during this meeting is reviewed. The business and care manager (BCM) advises they are proposing to have the next resident/family meeting on 16 October 2014 and propose to hold these meetings two monthly.

Resident meeting minutes dated 18 December 2013 are also reviewed.

**Finding:**

Resident meetings have not been held on a regular basis.

**Corrective Action:**

Provide confirmation that resident meetings are being held on a regular basis.

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

##### **Criterion 1.2.3.3 (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:** PA Low

**Evidence:**

Collated results for a resident/family satisfaction survey completed in April 2014 and Relatives survey completed in August 2014 are reviewed. Print outs of clinical indicators from the Oceania intranet are reviewed and indicate that the data is collated as a total number and is reported to staff and the Oceania support office. Copies of print outs of clinical indicators and monthly reports from the Oceania intranet are reviewed attached to meeting minutes and care staff report during interview that they are kept informed of any trends that are identified. Meeting minutes reviewed indicate that Time Target electronic timesheet used by staff is used to send messages and reminders to staff.

**Finding:**

Quality improvement data is not being evaluated and analysed to identify any trends.

**Corrective Action:**

Provide evidence that quality improvement data is being evaluated and analysed to identify trends.

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

##### **Criterion 1.2.3.7 (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:** PA Moderate

**Evidence:**

Internal audits templates have a section at the end for staff to record the problems identified, the actions required, as well as the timeframe and person responsible. Meeting minute templates have sections for recording the action, person responsible and the date signed off and are completed to varying degrees.

Collated results for a resident/family satisfaction survey completed in April 2014 and a relative’s survey completed in August 2014 are reviewed and areas requiring improvement are identified.

**Finding:**

Internal audits, meeting minutes and completed satisfaction surveys are reviewed with areas identified as requiring improvement but no corrective action plan has been developed, implemented and monitored to address these shortfalls. The person/s responsible for developing and/or implementing the corrective action plan/s, and timeframes, are not consistently documented.

**Corrective Action:**

Provide documented evidence that where shortfalls are identified following internal audits, in meetings and satisfaction surveys, that a corrective action plan is developed, implemented and monitored, and that the person/s responsible and the timeframes are clearly documented.

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There is an adverse event reporting system in place that includes the recording of accident/incidents on an ‘Incident/Accident Reporting Form’. However, improvements are required as not all adverse events are being documented and signed off as completed (see criterion 1.2.4.3).

The clinical manager (CM) enters the accidents and incidents on the Oceania intranet as part of the reporting of monthly clinical indicators. Incidents recorded include but are not limited to incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse. An ‘Incident/Accident’ internal audit was last conduced in September 2014 and three areas were identified as requiring improvement, however the documented corrective action plan does not address all of the shortfalls identified (see link criterion 1.2.3.8).

Resident files reviewed provide evidence that incident accident forms are completed as well as general observations being recorded for residents following falls. Oceania policy requires ‘Neurological Observation Chart’ and ‘Fall – Post Assessment Form’ to be completed for residents who have falls, but these have not been consistently completed for all unwitnessed falls and improvements are required (see criterion 1.2.4.3). Registered nurses (RN) assess all residents following falls and adverse events resulting in injury. RNs are responsible for reviewing all adverse event forms and ensuring they are fully completed and that corrective action plans are developed. Resident files have adverse event logs to record all adverse events.

With one exception, communication with families following adverse events, or any change in resident’s condition is evidenced in the residents’ files reviewed (see criterion 1.2.4.3). Family advise during interview that they are contacted following adverse events and if there is any change in their relatives condition.

Staff education on communication and documentation is provided as part of the compulsory education day that all staff attend. During interviews staff demonstrate an awareness of the adverse event process.

Staff are made aware of their essential notification responsibilities through their job descriptions, Oceania policies and procedures and professional codes of conduct.

Not all 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:** PA Moderate

**Evidence:**

‘Incident/Accident Reporting Form’ is in place to record adverse events. The business and care manager advises that all completed forms are reviewed by the registered nurse who is responsible for completing a corrective action plan and for contacting the family and GP. The clinical manager is responsible for reviewing these forms and entering the data on to the Oceania intranet.

Resident files have ‘event logs’ to record any accident/incident involving the resident.

Family interviewed report that staff contact them to advise of any adverse events involving their relative.

**Finding:**

(i)Resident files reviewed indicate that three residents had unwitnessed falls in August 2014 (one) and September 2014 (two) and neurological observations were not recorded for these residents; (ii) an accident/incident form for one of the residents has not been signed off as completed and there is no evidence of communication with family following this event; and (iii) a resident had an unwitnessed fall and told their family who told a staff member. There is no accident/incident form for this event and there is no record in the resident’s notes that they had experienced a fall.

**Corrective Action:**

Provide evidence that (i) neurological observations are recorded for all residents who experience unwitnessed falls and/or have an injury that could result in a head injury; (ii) all accident/incident forms are fully completed and that evidence of communication with family members is recorded; and (iii) accident and incident forms are completed for all adverse events

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The clinical manager and business and care manager (BCM) are responsible for oversight of the in-service education programme at St Johns Wood. During interview the BCM advises an annual education plan is developed that is based on the Oceania education plan and that in-service education sessions are provided at least monthly. They also advise that staff are required to attend one compulsory education day a year that lasts eight hours. These compulsory sessions include key education topics and education records for each staff member is reviewed on seven staff files.

Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the ‘Oceania Certificate in Residential Care’ programme. Staff are required to attend the compulsory Oceania education sessions each year to progress through the Oceania career pathway programme. In-service education plans are reviewed for 2013 and 2014.

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

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

Two of two health care assistants interviewed working morning shifts, three RNs covering all shifts and one enrolled nurse (EN) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a documented rationale (‘Interim Staffing Policy’) which is supplemented by an ‘Interim RN Shortage Policy', for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of one registered nurse (RNs) and two health care assistants (HCAs). The CM is on call after hours. A review of the staff roster / hours and interview of the BCM indicates that between 7am and 9pm the village, including the seven apartments certified for rest home use but not currently used for this purpose, is staffed independently of the rest home and hospital. The BCM advises that it is rare for staff from the rest home and hospital to have to provide support for village residents.

Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. Residents, including one from the apartments, and family members interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirm adequate staff cover is provided.

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:**

Resident information is entered in an accurate and timely manner into a register (electronic) that is appropriate to the service and is in line with legislative requirements. Interview with the receptionist and BSA confirms the resident details are entered into an electronic record on the day of admission.

Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. Resident files reviewed provide evidence that an entry into the resident’s clinical record is made on each shift and entries are clear, dated and signed.

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

Administration staff and clinical staff interviewed confirm they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible. Robust systems are used to manage resident information systems including archiving of resident documentation.

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 policy and procedures for entry criteria, assessment and entry screening are recorded and implemented. The clinical manager /RN interview confirms access and entry processes are followed. This facility operates 24 hours a day, seven days a week. Oceania vision, mission and values statements are recorded, displayed at the facility and communicated to residents, family, relevant agencies and staff. The pre- admission enquiry form is available and lists all relevant information of the prospective resident.

The admission agreement defines the scope of the service and includes all contractual requirements. Nine of nine residents' files are sampled, including nine of nine residents' admission agreements. All residents' admission agreements sampled evidence residents' and /or family and facility representative sign off.

There is a facility information pack available for resident and their family. A resident information pack is sighted and contains all relevant information.

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

Interviews with six of six residents ( four rest home and two hospital) and four of four family members ( two hospital and two rest home) confirm the admission process is conducted by staff in a timely manner, all relevant admission information is provided and discussions held with staff in respect of resident care is conducted.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The systems to decline resident entry to the service are documented. The scope of the service provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the clinical manager /RN. The clinical manager states resident will be declined entry if a bed is not available at the time and the resident will be referred back to the NASC 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:** PA Moderate

**Evidence:**

In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and the service is coordinated to promote continuity of service delivery. Six of six resident (four rest home and two hospital) and four of four family (two hospital and two rest home) interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews.

Six of six clinical staff (three registered nurses (RN), one enrolled nurse and two health care assistants) and one clinical manager/RN interviews confirm residents and/or family members are involved in all stages of service provision.

Nine of nine residents' files (four rest home and five hospital) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate a team approach into reviews and evaluations. Family communication sheets are maintained, sighted in all nine residents' files reviewed. The auditor evidenced verbal briefing from am to pm shift.

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

Staff competency assessments are current and staff competency registers record competencies for clinical staff in restraint, medication, hoist, insulin administration, nebuliser and oxygen competencies. RNs complete wound competency.

There are areas identified as requiring improvement around service delivery timeframes.

The District Health Board contract requirements are not fully met.

Tracer methodology-rest home.

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

Tracer methodology- hospital.

*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:** PA Moderate

**Evidence:**

Nine of nine residents’ files sampled (four rest home and five hospital). Four of the nine residents’ files are of residents’ admitted in 2014 (one rest home and three hospital). There is evidence of a risk assessment not completed on admission in one of four files reviewed. Four of four files evidence risk assessments are not completed within required timeframes. Two of four residents’ files evidence the long term care plans have not been completed within the required three week timeframe of admission to the facility.

**Finding:**

Timeframes for completion of risk assessments and long term care plans are not consistently adhered to.

**Corrective Action:**

Provide evidence service provision timeframes adhere to the standards, DHB contract requirements and Oceania policies.

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

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

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

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

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

Six of six residents (four rest home and two hospital) and four of four family (two hospital and two rest home) interviewed confirm their involvement in their and their family members assessments, care planning, review, treatment and evaluations of care.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The residents' files sampled evidence residents' care plans are individualised and up-to-date. The long-term and short-term goals are identified by the residents and service providers and reviewed at regular intervals, at least six monthly or as needs change. The residents and where required family members have input into care planning and review, confirmed at all six residents and four family interviews. The clinical staff interviewed confirm that care plans are accurate and up to date.

The residents' files sampled evidence the clinical care/treatment/support or interventions that is to be provided by staff is current, the risk assessment findings are recorded on the care plans and there is evidence of discussions and sign off by residents and /or family members.

The facility ensures access to regular GP care, confirmed at GP interview.

Person centred care planning audit was conducted in September 2014, however there is no recorded evidence of a corrective action plan (refer to 1.2.3.8).

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

Six of six residents (four rest home and two hospital) and four of four family (two hospital and two rest home) interviews confirm their and their relative’s current care and treatments they are receiving meet their needs. The family communication sheets record family communications, sighted in all nine residents' files sampled.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An interview with the activities co-ordinator (AC) confirms there is one activities programme provided at the facility and the activities programme is reviewed monthly and signed off by a diversional therapist, sign off sighted. The AC confirms the activities programme meet the needs of the service group and the service has appropriate equipment. The residents’ activities attendance records are maintained and are sighted. The residents' files sampled demonstrate the individual activities care plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being. Residents’ activities monthly progress reports record attendance and participation in activities during that month and the AC states they ask the residents for any feedback and suggestion for future activities on a monthly basis.

An interview with the physiotherapist is conducted and confirms they have input into assessment, planning and evaluation of residents’ mobility. The physiotherapist clinical progress notes are located on residents’ files and care plans record mobility interventions and the required input from the physiotherapist and staff.

The residents, family and staff interviews confirm the activities programmes include input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. Six of six residents and four of four family interviewed confirm residents' and their family members' past activities are considered and there is a choice to participate in activities. Active participation by the residents is observed in the activities provided on audit days. Sighted residents’ meeting minutes held in December 2013 and July 2014 (refer to 1.2.3.1).

The last activities audit shows results of 100% compliance.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. The care plan evaluation are conducted by the RN with input from the resident, family, health care assistants, activities co-ordinator, physiotherapist and GPs.

The family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews. The residents and family interviews confirm their participation in care plan evaluations and this is evidenced in the files reviewed.

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

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

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:**

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

The medication round observed evidences staff are knowledgeable about the medicines administered and sign off, as the dose is administered. All staff authorised to administer medicines have current competencies, sighted in staff files sampled and on the staff competency register. Additional staff competencies are completed and these include; insulin administration; oxygen administration; nebuliser use, sighted on competency registers. The staff education in medicine management was provided in May 2014.

Twenty medicine charts are sampled (10 rest home and 10 hospital). All medicine charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted, discontinued medicines are dated and signed by the GPs and the residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given).

There is recorded evidence of resident competency assessments to self-administer medicines, completion of signing sheets and safe storage of medicines

Sighted medication audit results for July 2014, with corrective actions to be addressed (refer to 1.2.3.8).

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 is provided from another Oceania facility and delivered to St Johns Wood, confirmed at business and care manager, the head cook and kitchen staff interviews. The head cook interview confirms the processes around food preparation and serving of food at Wharerangi Care Centre and transportation and serving of food at St Johns Wood. The food service policies and procedures are appropriate to the service setting with a new seasonal four weekly menu being introduced six monthly. The menu was last reviewed by a dietitian in September 2014, sighted. There are documented protocols for management of residents with unexplained weight loss or gain, including referral to a dietitian and speech language therapist, as required. Additional snacks are available for residents when the kitchen is closed. The residents are offered fluids throughout the day.

The kitchen staff are aware of the residents’ individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review. There are current copies of residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the head cook and the kitchen assistant. The food safety training for kitchen staff have been provided. The in-service /training records and staff records evidence the food safety training was provided in March 2014 and nutrition and hydration education occurred in April 2014.

The residents' files sampled demonstrate monthly monitoring of individual resident's weight. The resident's nutritional needs and interventions are identified and documented on the care plans. The residents interviewed are satisfied with the food service provided, however temperature of food is reported to be cold by four of six residents. The business and care manager interview confirms they are aware of issues around the food temperatures. There is a documented corrective action plan around complaints regarding the temperature of meals and progress towards the kitchen at St Johns Wood to be operational and provide the food service for this facility rather than the food service being prepared at Wharerangi Care Centre and delivered to the facility.

The food temperatures are recorded, sighted. The fridge, chiller and freezer temperatures are recorded, sighted. All decanted food is dated with expiratory dates recorded on containers.

The kitchen services audit was completed in October 2014 with 100% compliance.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements 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 are accessible for staff. A hazard register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in September 2014. This finding is confirmed during interviews of domestic staff and review of staff education records.

Monthly visits are made by the chemical supplier representative who reviews kitchen, cleaning and laundry processes and their reports are reviewed.

Sluice facilities are available throughout the facility for the disposal of waste and hazardous substances. A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example, goggles/visors, gloves, aprons, footwear, and masks are viewed in the sluice room, laundry and cleaners’ room.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There have not been any alterations undertaken to the building since the last audit although an ongoing refurbishment programme is in place. Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose.

A full time maintenance person is employed and is responsible for maintenance at St Johns Wood and Wharerangi. This person is interviewed and confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration / performance reports for medical equipment and electrical safety tags for electrical items. A current Building Warrant of Fitness is displayed that expires on 15 October 2014 and the BCM advises inspections have been completed and a new one is due to be issued.

A visual Inspection of the facility provides evidence of safe storage of medical equipment; the building, plant and equipment are maintained to a high standard. Corridors are wide enough in all areas to allow residents to pass each other safely. Safety rails are secure and are appropriately located; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; and floor surfaces and coatings are maintained in good order.

There are external areas available as well as an enclosed courtyard that some of the bedrooms have direct access to that are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside including safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes.

Staff receive education in the safe use of medical equipment by suitably qualified personnel and there is a system in place to review staff competency for specific equipment, including a hoist competency. This was confirmed during interview of staff and review of staff education records. Care staff interviewed confirm that they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.

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

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All bedrooms have full ensuite facilities and there are adequate numbers of toilet and shower facilities available throughout all areas of the facility.

Visual inspection provides evidence that toilet; shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions). Documentation reviewed indicates that if the hot water temperatures exceed the recommended temperatures, that corrective action is taken to address the issue.

All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and washbasin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence.

##### **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:**

Visual inspection provides evidence that the bedrooms allow for easy access for mobility aids. All bedrooms provide single accommodation although some of the rooms are able to provide accommodation for two residents and are counted as double bedrooms. Some of the bedrooms (hospital) have double leaf doors to allow for easy access of mobility aids. The bedrooms are large enough to allow residents and staff to move around within the room safely and adequate personal space is provided. This finding was confirmed during interviews of staff and residents. Eight of the bedrooms have been converted to four care suites and have a separate lounge with kitchenette as well as a separate bedroom with full ensuite.

Resident’s bedrooms are personalised to varying degrees.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

Visual inspection provides evidence that adequate access is provided to lounges (three) and dining rooms (two). Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

All laundry is washed at St Johns Wood for this facility and another Oceania facility in Taupo (Wharerangi). The BCM advises that from 20 October 2014 laundry for Wharerangi will be transferred back to Wharerangi and washed in the laundry at Wharerangi.

There is good dirty / clean flow and laundry personnel interviewed describe the management of laundry including transportation from Wharerangi to St Johns Wood and back to Wharerangi. They also describe processes for managing laundry within St Johns Wood including transportation, sorting, storage, laundering, and return to residents.

Visual Inspection provides evidence that cleaning and laundry processes are implemented. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and monthly visits from the chemical company representative. Reports from the chemical company representative and completed audits for the laundry and cleaning are reviewed. Cleaning staff are interviewed and they describe the management of the cleaning processes including the use of personal protective equipment.

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

Residents interviewed state the cleaning and laundry service is adequate. This finding is confirmed during review of completed family and resident satisfaction surveys.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

A New Zealand Fire Service (NZFS) letter dated 05 August 2009 is sighted advising the fire evacuation scheme is approved. The last trial evacuation was held on 25 August 2014.

Registered nurses, senior health care assistants and personnel who drive the van with residents in it are required to complete first aid training. Oceania policy requires that there are at least two designated staff members on each shift with appropriate first aid training. All staff are supported to complete first aid training as part of their Career pathway. CPR education is provided for clinical staff during the annual compulsory inservice education day.

Staff interviews and review of files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals.

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

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

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

An appropriate call system is in place. Call bells are accessible / within reach, and are available in resident areas (e.g. bedrooms, ablution areas, ensuite toilet/showers). Residents interviewed confirm they have a call bell system in place which is accessible and staff response times are adequate. Response times to call bells are able to be audited to ensure that staff respond to the call bells in a timely manner.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**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:** 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 1.4.7.6 (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 provides evidence that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. 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 has overarching risk and quality management systems in place that demonstrate compliance with the restraint minimisation and safe practice (RMSP) standard. The definition of restraint and enabler is congruent with the definition in NZS 8134.0.The process of assessment and evaluation of enabler use is recorded. Documented systems are in place to ensure the use of restraint is actively minimized.

There are four residents utilising restraint and four residents using enablers at the facility on audit days. The staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. The staff education in challenging behaviour and de-escalation is provided for non- clinical staff during the compulsory in-service programme last provided in May 2014. The challenging behaviour, de-escalation and restraint education and training is provided for clinical staff during the compulsory in-service programme last conducted in May 2014.The staff competency registers record restraint competencies for all clinical staff are current.

##### **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.)*

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.1: Restraint approval and processes **(**HDS(RMSP)S.2008:2.2.1)

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has systems in place for determining the restraint approval processes. The staff interviewed and the residents' files sampled evidence responsibilities are identified and known. The residents' files sampled evidence residents and /or family input into the restraint approval processes. There is a documented, formal process for the approval of specific restraint processes at the policy/procedure level. The restraint coordinator position is delegated to suitably skilled and experienced service provider, the clinical manager /RN. Interviews with the restraint co-ordinator is conducted.

The clinical staff interviewed are aware of the restraint co-ordinator’s responsibilities. RMSP policy/procedures define approved restraints and alternatives to restraint. There are policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement. The orientation/induction programme includes overview of RMSP policies/procedures. The staff education programme includes on-going RMSP training, conducted in May 2014.

The District Health Board contract requirement is met.

##### **Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)**

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint 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 2.2.2: Assessment **(**HDS(RMSP)S.2008:2.2.2)

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

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

**Attainment and Risk:** FA

**Evidence:**

Systems are in place to ensure assessments of residents is undertaken prior to restraint usage being implemented. The residents' files sampled demonstrate restraint assessment and risk processes are being followed. The policies relate to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement.

The residents' files sampled evidence restraint assessment risks are documented and evaluated on a regular basis and include resident and/or family input. The multidisciplinary reviews evidence restraint assessment risks are reviewed.

The District Health Board contract requirement is met.

##### **Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)**

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

**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 2.2.3: Safe Restraint Use **(**HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

Appropriate systems are in place to ensure the service is using restraint safely. The restraint policies and procedures identify risk processes to be followed when a resident is being restrained. The residents' files sampled evidence evaluations / review of restraint goals / interventions. The restraint reviews /evaluations evidence current reviews.

The residents' files sampled demonstrate appropriate alternative interventions are implemented and de-escalation attempted prior to initiating restraint. The restraint consent by resident and/or family are current. The residents' files sampled demonstrate the details of the reasons for initiating the restraint, alternative interventions attempted or considered prior to the use of restraint, any advocacy/support offered, provided, or facilitated. The service provider's documentation evidences a restraint register is established that records sufficient information to provide an auditable record of restraint use. On the days of the audit there are four residents utilising restraint and four residents utilising enablers.

The District Health Board contract requirement is met.

##### **Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)**

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

**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 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

**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 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)**

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint 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 2.2.4: Evaluation **(**HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation processes are documented in the restraint minimisation and safe practice policy. The residents' files sampled evidence that each episode of restraint is being evaluated and based on the risk of the restraint being used. The residents' files sampled demonstrate residents' care plan evaluations and multidisciplinary meetings are current. Evaluation of restraint is conducted every two months, sighted restraint meeting minutes for 2014.

The District Health Board contract requirement is met.

##### **Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)**

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:  
(a) Future options to avoid the use of restraint;  
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;  
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);  
(d) Whether the desired outcome was achieved;  
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;  
(f) The duration of the restraint episode and whether this was for the least amount of time required;  
(g) The impact the restraint had on the consumer;  
(h) Whether appropriate advocacy/support was provided or facilitated;  
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;  
(j) Whether the service's policies and procedures were followed;  
(k) Any suggested changes or additions required to the restraint education for service providers.

**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 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

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

**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 2.2.5: Restraint Monitoring and Quality Review **(**HDS(RMSP)S.2008:2.2.5)

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

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

**Attainment and Risk:** FA

**Evidence:**

The restraint reviews occur on a regular basis and cover all the necessary components. The outcomes of the reviews are documented and reported on, as well as being discussed at meetings. The RMSP policies and procedures include monitoring and quality review processes. The national restraint authority group meeting minutes sighted, (February 2014) and evidence Oceania national data in relation to restraint reduction from 2013 to 2014.

Restraint audit completed in July 2014, records 100% compliance.

The District Health Board contract requirement is met.

##### **Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)**

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:  
(a) The extent of restraint use and any trends;  
(b) The organisation's progress in reducing restraint;  
(c) Adverse outcomes;  
(d) Service provider compliance with policies and procedures;  
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;  
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;  
(g) Whether changes to policy, procedures, or guidelines are required; and  
(h) Whether there are additional education or training needs or changes required to existing education.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection prevention and control (IC) policy meets the needs of the organisation and provides information and resources to inform the service providers on infection prevention and control. The staff interviewed confirm the infection control management systems provide them with adequate guidance.

The delegation of infection control matters throughout the organization is documented along with an IC co-ordinator’s’ job description. There is documented evidence of infection related issues by regular reporting systems. Visual inspection evidences staff provide additional infection management precautions. The IC programme was last reviewed in 2014.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme meets the needs of the organisation and provides information and resources to inform and guide staff. The IC co-ordinator is a qualified health professional with relevant skills, expertise and resources necessary to achieve the requirements of this standard, the clinical manager /RN. The IC co-ordinator report access to DHB / microbiologist / GP & other health care professionals, as required.

The IC co-ordinator has access to relevant and current information which is appropriate to the size and complexity of the organization, including: IC manuals, internet, access to experts (DHB and Lab), and on-going in-service education.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The policies and procedures on the prevention and control of infection include written material that is relevant to the organisation and reflects current accepted good practice and relevant legislative requirements. The policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel and identify links to other documentation in the organisation e.g. health & safety, quality and risk. The staff interviewed confirm infection control policies and procedures are freely available for them.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Infection control is part of the on-going in-service education programme. The IC co-ordinator education/ training in IC matters is current. The IC co-ordinator and other staff interviewed advise that clinical staff identify situations where IC education is required for a resident such as; hand hygiene, cough etiquette, multi-resistant micro-organisms and this is conducted.

The staff education on IC was provided in June 2014 as part of the compulsory in –service programme. All education sessions have evidence of staff attendance and content of the presentations.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The IC programme / policy details surveillance processes, including the surveillance objectives, priorities and methods at a level of detail relevant to the service setting and its complexity. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes.

The infection control monthly data is completed for each resident and includes type of infection, lab results, sensitivities, antibiotics prescribed, dose, duration, intervention, review and outcome. Infection logs are maintained. The numbers of infections are collated at the end of each month and reported as a clinical indicator Oceania head office via intranet and to staff and quality meetings. The care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, short term care plans and handovers.

Infection control compliance audit was completed in May 2014, results show 100% compliance. The ICC states there have been no outbreaks at the facility since the last audit.

##### **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.)*