Oceania Care Company Limited - Wharerangi Care Centre

Current Status: 6 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

Wharerangi Care Centre (Wharerangi) provided residential care for up to 47 residents who required hospital, rest home and dementia level care. Occupancy on the day of the audit was 40. The facility is operated by Oceania Care Company Limited.

A new business and care manager was appointed in November 2013 and is leaving in October 2014. The business support administrator will be assuming the role of acting business and care manager until a permanent appointment is made. A new clinical manager was appointed in April 2013. There have been no changes to the building since the last audit. Seven areas were identified as requiring improvement during this audit relating to quality and risk management, human resource management and resident care planning.

Audit Summary as at 6 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

Indicator	Description	Definition
	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 6 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 6 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 low risk.

Continuum of Service Delivery as at 6 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 6 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 6 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 6 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 6 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 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 were respectful of their needs; communication was appropriate; and they have 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 have time for consultation and that they were fully informed. Time was provided if discussions and explanation was 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 was the governing body and was responsible for the service provided at Wharerangi. 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 Wharerangi 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 a registered nurse with aged care experience. The business and care manager was supported by a clinical manager, who was appointed to this position in October, is a registered nurse and is responsible for oversight of clinical care provided. The business and care manager has resigned and their last day on site at Wharerangi is 10 October 2014 before taking two weeks leave and resigning from 24 October 2014. The business support administrator has been appointed to the position of acting business and care manager for a three month period while Oceania recruit a replacement business and care manager.

The Oceania Care Company Limited quality and risk management systems were implemented at Wharerangi although improvements were required as corrective action plans were not consistently developed and implemented to address shortfalls identified. Improvements were also required because resident and family meetings were not held on a regular basis and feedback from resident / family satisfaction surveys had not been provided to residents and family members.

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. Adverse events were documented on accident/incident forms as well as on an electronic database that was able to be reviewed by personnel from Oceania's support office. 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. Improvements were required as not all of the staff files reviewed had evidence of reference checking, criminal vetting, a current performance appraisal and evidence of completion of an orientation.

In-service education was provided for staff as part of the annual compulsory education day that all staff were 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 business and care manager and/or the clinical manager were 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

Wharerangi Care Centre had a documented entry criteria, which was communicated to residents, family and referral agencies.

The systems were implemented that evidence each stage of service provision had 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 demonstrated that consultation and liaison was occurring with other services.

A sampling of residents' clinical files validates the service delivery to the residents. The residents' care plan were 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 is different from expected, the service responds 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 were areas identified as requiring improvement around service delivery timeframes and care plan evaluations to record the degree of achievement towards meeting the residents' needs.

The planned activities were appropriate to the group setting. 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.

There was an appropriate medicine management system in place. 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-administer 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 had 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 had a central kitchen and on site staff that provide the food service. The kitchen staff had completed food safety training.

Safe and Appropriate Environment

The facility had two wings: one secure dementia wing and one combined rest home wing and hospital wing. With one exception, all of the bedrooms provided single accommodation. With one exception, all of the bedrooms had wash hand basins and some had private 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 within each of the two wings. External areas were available for sitting and shade was provided and a secure external area was provided in the dementia unit. 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 to ensure the residents' physical environment was safe, and facilities were fit for their purpose. Laundry was currently washed off site at another Oceania facility in Taupo but was to be transferred back to Wharerangi by the end of October 2014. Cleaning and laundry systems included appropriate monitoring systems to evaluate the effectiveness of these services. Staff had completed appropriate training in chemical safety. There were safe and hygienic storage areas for soiled linen.

Restraint Minimisation and Safe Practice

The service had an overarching risk and quality management system that demonstrates 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.

The facility was using two restraints and no 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. 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 are familiar with infection control measures at the facility.

Surveillance for residents who develop infection was 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 - Wharerangi Care Centre

Designated Auditing Agency:	Health Audit (NZ) Limited

Types of audit:	Certification Audit			
Premises audited:	Wharerangi Care Centre			
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)			
Dates of audit:	**Start date:**	6 October 2014	**End date:**	7 October 2014

Proposed changes to current services (if any):
Rest home dementia services are provided.

Total beds occupied across all premises included in the audit on the first day of the audit:	40

Audit Team

Lead Auditor	XXXXXXX	**Hours on site**	12	**Hours off site**	8
Other Auditors	XXXXXXXX	**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	XXXXXXXX			**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	11	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)	44	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Health Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Thursday, 23 October 2014

Executive Summary of Audit

General Overview

Wharerangi Care Centre (Wharerangi) provided residential care for up to 47 residents who required hospital, rest home and dementia level care. Occupancy on the day of the audit was 40. The facility is operated by Oceania Care Company Limited.

A new business and care manager was appointed in November 2013 and is leaving on 24 October 2014. The business support administrator will be assuming the role of acting business and care manager until a permanent appointment is made. A new clinical manager was appointed in April 2013. There have been no changes to the building since the last audit. Seven areas were identified as requiring improvement during this audit relating to quality and risk management, human resource management 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 were respectful of their needs; communication was appropriate; and they have 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 have time for consultation and that they were fully informed. Time was provided if discussions and explanation was 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 was the governing body and was responsible for the service provided at Wharerangi. 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 Wharerangi 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 a registered nurse with aged care experience. The business and care manager was supported by a clinical manager, who was appointed to this position in October, is a registered nurse and is responsible for oversight of clinical care provided. The business and care manager has resigned and their last day on site at Wharerangi is 10 October 2014 before taking two weeks leave and resigning from 24 October 2014. The business support administrator has been appointed to the position of acting business and care manager for a three month period while Oceania recruit a replacement business and care manager.

The Oceania Care Company Limited quality and risk management systems were implemented at Wharerangi although improvements were required as corrective action plans were not consistently developed and implemented to address shortfalls identified. Improvements were also required because resident and family meetings were not held on a regular basis and feedback from resident / family satisfaction surveys had not been provided to residents and family members.

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. Adverse events were documented on accident/incident forms as well as on an electronic database that was able to be reviewed by personnel from Oceania's support office. 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. Improvements were required as not all of the staff files reviewed had evidence of reference checking, criminal vetting, a current performance appraisal and evidence of completion of an orientation.

In-service education was provided for staff as part of the annual compulsory education day that all staff were 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 business and care manager and/or the clinical manager were 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.

Outcome 1.3: Continuum of Service Delivery

Wharerangi Care Centre had a documented entry criteria, which was communicated to residents, family and referral agencies.

The systems were implemented that evidence each stage of service provision had 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 demonstrated that consultation and liaison was occurring with other services.

A sampling of residents' clinical files validates the service delivery to the residents. The residents' care plan were 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 is different from expected, the service responds 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 were areas identified as requiring improvement around service delivery timeframes and care plan evaluations to record the degree of achievement towards meeting the residents' needs.

The planned activities were appropriate to the group setting. 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.

There was an appropriate medicine management system in place. 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-administer 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 had 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 had a central kitchen and on site staff that provide the food service. The kitchen staff had completed food safety training.

Outcome 1.4: Safe and Appropriate Environment

The facility had two wings: one secure dementia wing and one combined rest home wing and hospital wing. With one exception, all of the bedrooms provided single accommodation. With one exception, all of the bedrooms had wash hand basins and some had private 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 within each of the two wings. External areas were available for sitting and shade was provided and a secure external area was provided in the dementia unit. 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 to ensure the residents' physical environment was safe, and facilities were fit for their purpose. Laundry was currently washed off site at another Oceania facility in Taupo but was to be transferred back to Wharerangi by the end of October 2014. Cleaning and laundry systems included appropriate monitoring systems to evaluate 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 demonstrates 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.

The facility was using two restraints and no 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. 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 are familiar with infection control measures at the facility.

Surveillance for residents who develop infection was 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	94	0	3	4	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 and family meetings are not being held on a regular basis.	Provide evidence that resident and family 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	There is no documented evidence that feedback has been provided to residents and family following the satisfaction survey completed in July 2014.	Provide evidence that feedback has been provided to residents and family following the satisfaction survey completed in July 2014.	60
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	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	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				person/s responsible for developing and/or implementing the corrective action plan/s, and timeframes, are not consistently documented.	responsible and the timeframes are clearly documented.	
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	(i)Four of seven staff files have no evidence of reference checking; three of seven staff files no evidence of criminal vetting; and there is no evidence the clinical manager has a recent performance appraisal.	Provide evidence that all new staff have reference and criminal vetting undertaken as part of their pre-employment screening; and that the clinical manager has a performance appraisal completed.	90
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Moderate	There is no documented evidence that the clinical manager has received an orientation that is specific to the role of clinical manager.	Provide evidence the clinical manager receives an orientation to the role of clinical manager.	60
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	PA Moderate	i) Six of nine residents' files evidence the long term care plans are not recorded within the three weeks of residents' admission	Provide evidence that each stage of service provision is provided within timeframes that safely meet the needs of the residents.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		within time frames that safely meet the needs of the consumer.		to the facility. ii) Six of nine residents' file evidence the risk assessments are not conducted within specified timeframes. iii) Three of nine residents' files evidence the GP initial assessments have not been conducted within the required timeframe.		
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.8.2	Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Moderate	Three of three residents' files evidence the care plan evaluations do not record the degree of achievement towards meeting the residents' needs.	Provide evidence the care plan evaluations record the degree of achievement towards meeting the residents' needs.	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 (three hospital and three rest home) and family members (two hospital and two dementia) are able to verify that services are provided with dignity and respect, privacy is maintained, and individual needs and rights are upheld. These findings are also confirmed during review of the resident and family survey that was completed in July 2014. The overall satisfaction rate is 76% and there is no evidence that a corrective action plan has been developed and implemented to address the shortfalls identified in the feedback received from residents and their family (see criterion 1.2.3.8)

Interviews with staff (the business and care manager, clinical manager, the business support administrator, two registered nurses, three 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, three dementia and two 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 survey 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 (three hospital and three rest home) and family members (two hospital and two dementia).

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 (three dementia, two 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 five 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 a representative from the local iwi as well as from the local District Health Board. 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 (e.g. 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 survey completed in July 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 in-service 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 has been one allegation of theft by a staff member that has been dealt with through the courts. This person was convicted and is no longer employed at Wharerangi.

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 and registered nurses (two) 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, three dementia and two hospital) provide evidence that communication with family members is being documented in residents' records. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, on family communication sheets, and in the individual resident's files.

Residents and family interviewed confirm that staff communicate 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, three dementia and two 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 (three health care assistants, two RNs, the business and care manager and the clinical manager) demonstrate a good understanding of informed consent processes.

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

Residents' files reviewed demonstrate written and verbal discussions on informed consent have occurred and residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the Code of Rights as part of the compulsory in-service 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 Right, 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 Taupe 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 six 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, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. Interview of the business and care manager indicates there has been one allegation of theft in November 2013 by a staff member that has been dealt with through the courts. This person was convicted and is no longer employed at Wharerangi.

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 (three hospital and three rest home) and family (two hospital and two dementia) 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 manger'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 displayed on the noticeboard 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 Wharerangi Care Centre (Wharerangi). The Oceania quality and risk management systems are implemented at Wharerangi and the documented scope, direction, goals and vision are reviewed.

Systems are in place for monitoring the service provided at Wharerangi 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 a registered nurse who has been in this position since November 2014. The BCM has been employed by Oceania for the two years prior to this as facility manager at another site, and for the three years prior to this as a clinical manager by another organisation. The BCM has resigned and their last day on site at Wharerangi is 10 October 2014. The Business Support Administrator (BSA) has been appointed to the position of Acting BCM for a three month period while Oceania recruits a replacement BCM. The BSA is receiving a one week orientation from the BCM and is scheduled to receive a one week orientation at Oceania support office.

The BCM is supported in their role by a clinical manager (CM) who was appointed to this position in October 2013. The CM has worked at Wharerangi as a registered nurse (RN) since October 2007. The CM is responsible for oversight of the clinical care provided to residents at Wharerangi.

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

Wharerangi is certified to provide hospital (medical and geriatric), rest home level care and dementia level care and have contracts with the District Health Board (DHB) to provide aged related residential care (rest home, dementia and hospital), aged respite care, long term support - chronic health conditions services, and with the Ministry of Health to provide residential non-aged services. On day one of this audit there are 15 residents assessed as requiring dementia level rest home care, 12 residents assessed as requiring rest home level care and 13 assessed as requiring hospital 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 the BCM or 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 Taupe 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. Both the BCM and CM are 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, BSA 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. Care staff also advise 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 2013 and 2014 are reviewed during this audit. Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. Review of the quality improvement data provides evidence the data is being collected, collated, evaluated, and analysed to identify trends and that this data is being reported to staff and to the governing body. However, improvements are required as although the resident and family satisfaction survey has been collated, the results of this survey have not been reported to family and residents (see criterion 1.2.3.6). Improvements are also required as resident and family 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 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:

Rest home resident meeting minutes (March 2014 and May 2014) are reviewed along with meeting minutes for families of dementia residents (March 2014).

Finding:

Resident and family meetings are not being held on a regular basis.

Corrective Action:

Provide evidence that resident and family 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 July 2014 are reviewed. Print outs of clinical indicators from the Oceania intranet are reviewed attached to staff meeting minutes in a folder in the staff room 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:

There is no documented evidence that feedback has been provided to residents and family following the satisfaction survey completed in July 2014.

Corrective Action:

Provide evidence that feedback has been provided to residents and family following the satisfaction survey completed in July 2014.

Timeframe (days): 60 *(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:

Collated results for a resident/family satisfaction survey completed in July 2014 are reviewed and areas requiring improvement are identified.

Internal audits have a section at the end for staff to record the problems identified, the actions required, 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.

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: FA

Evidence:

There is an adverse event reporting system in place. All accident/incidents are recorded on an 'Incident/Accident Reporting Form'. The business and care manager (BCM) and/or the clinical manager (CM) also enters these accidents and incidents on the Oceania intranet as part of the reporting of monthly clinical indicators. Incidents recorded include but are not limited to incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse. An 'Incident/Accident' internal audit was last conduced in September 2014.

Resident files reviewed provide evidence that incident accident forms are completed as well as general observations being recorded for residents following falls. 'Neurological Observation Chart' and 'Fall – Post Assessment Form' are also completed for residents who have falls. 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.

Communication with families following adverse events, or any change in resident's condition is evidenced in the residents' files reviewed. This is confirmed during interview of family members. 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.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The clinical manager and business and care manager (BCM) are responsible for oversight of the in-service education programme at Wharerangi. 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 have been provided five times since November 2013. Education records for each staff member is reviewed on staff files.

Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the 'Oceania Certificate in Residential Care' programme. Eight of twenty two health care assistants (HCAs) have completed the dementia specific unit standards; seven HCAs and one activities co-ordinator are currently completing the dementia specific unit standards. Seven of the twenty two HCAs do not work in the dementia unit and five HCAs have been employed for less than six months and are yet to enrol. The BCM advises that none of the HCAs work in the dementia unit unless they have completed the dementia unit standards.

Staff are required to attend the compulsory Oceania education sessions each year to progress through the Oceania career pathway programme. In-service education plans, staff competency registers and staff education records are maintained and are reviewed for 2013 and 2014. Individual records of education are maintained for each staff member.

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 (six of seven), criminal vetting (three of seven), completed orientations(six of seven) and competency assessments. Improvements are required with management of reference checking; criminal vetting and completion of orientations (see criteria 1.2.7.3 and 1.2.7.4)

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, dietitian, pharmacists, and general practitioners (GPs) is occurring. An appraisal schedule is in place and with the exception of the clinical manager, current staff appraisals sighted on staff files reviewed (see criterion 1.2.7.3).

Three of three health care assistants interviewed working morning and afternoon shifts in both areas and two RNs working all shifts in both areas 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.

Not all of 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: PA Low

Evidence:

Seven staff files reviewed and there is evidence of employment agreements on six of seven staff files. The business and care manager's staff file is held off site at Oceania support office so unable to view their employment agreement, reference checking, and criminal vetting.

Signed copies of the 'Oceania Code of Values and Conduct', staff confidentiality agreement, reference checking (three of seven) and criminal vetting (three of seven). One of the staff members without evidence of criminal vetting started in 2010, one started in 2013, one started in 1998 and the other one (the business and care manager) is held off site.

The BCM completed a performance appraisal of the CM during this audit.

Criminal vetting was undertaken for the three staff that did not have these on their files during this audit. The BSA has a spreadsheet of all staff that indicates which staff members have had criminal vetting and reference checking completed. Appraisal due dates are now logged on to Time Target as a reminder to staff and management.

Finding:

(i)Four of seven staff files have no evidence of reference checking; three of seven staff files no evidence of criminal vetting; and there is no evidence the clinical manager has a recent performance appraisal.

Corrective Action:

Provide evidence that all new staff have reference and criminal vetting undertaken as part of their pre-employment screening; and that the clinical manager has a performance appraisal completed.

Timeframe (days): 90 *(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: PA Moderate

Evidence:

With the exception of the clinical manager, all staff files reviewed have evidence that an orientation has been provided.

Role specific orientation workbooks are provided for staff and staff have up to three months to complete these. Competency assessments are completed, as appropriate, during the orientation phase.

With the exception of the clinical manager, care staff and household staff interviewed report they have received an orientation.

Finding:

There is no documented evidence that the clinical manager has received an orientation that is specific to the role of clinical manager.

Corrective Action:

Provide evidence the clinical manager receives an orientation to the role of clinical manager.

Timeframe (days): 60 *(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). One HCA is based in the dementia unit and the other HCA and RN are based in the rest home and hospital area. The BCM and/or the CM are on call after hours.

Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. Residents and family members interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit 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 business support administrator interview confirms access and entry processes are followed. This facility operates 24/7. 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. Resident information pack was sighted and contains all relevant information.

The residents' files sampled demonstrate all needs assessments are completed for either rest home, hospital or dementia levels of care. Sighted written information provided to the family of residents' with dementia recording the practices particular to the dementia unit.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The 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 business support administrator. The business support administrator 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 (three rest home and three hospital) and four of four family (two hospital and two dementia) interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews.

Six of six clinical staff (two registered nurses (RN), three health care assistants, one physiotherapist) 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, two hospital and three dementia) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations.

Family communication sheets are maintained, sighted in all nine residents' files reviewed.

The auditor evidenced verbal briefing from am to pm shift.

GP interview was conducted and confirms that staff inform the GP of any resident medical issues and concerns in 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 Hospital District 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.

Tracer methodology-dementia

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

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

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

Attainment and Risk: FA

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:

The residents' files evidence that each stage of service provision has been developed with resident and/or family input and the service is coordinated to promote continuity of service delivery. Resident and family interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews. The staff interviews confirm residents and/or family members are involved in all stages of service provision.

Finding:

i) Six of nine residents' files evidence the long term care plans are not recorded within the three weeks of residents' admission to the facility.

ii) Six of nine residents' file evidence the risk assessments are not conducted within specified timeframes.

iii) Three of nine residents' files evidence the GP initial assessments have not been conducted within the required timeframe.

Corrective Action:

Provide evidence that each stage of service provision is provided within timeframes that safely meet the needs of the residents.

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 (three rest home and three hospital) and four of four family (two hospital and two dementia) 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 6 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 April 2014 with 81% compliance, 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 (three rest home and three hospital) and four of four family (two hospital and two dementia) 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 the AC has been employed at the facility for over two years. There are three activities programmes provided at the facility: one for the rest home residents; one for the residents with dementia and one for the hospital residents. The business and care manager states the activities programmes are reviewed and signed off by a diversional therapist, sign off sighted.

The AC confirms the activities programmes meet the needs of the service group and the service has appropriate equipment. The AC is employed Monday to Friday each week from 9 am to 5 pm. 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. Interview with the health care assistants confirm they conduct activities with residents' with dementia during sun downing and in the weekends.

An interview with the physiotherapist is conducted and confirms the physiotherapist is contracted for two hour a week per fortnight and has 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 for 2014 of meetings held in May and July 2014 for rest home and hospital residents. The dementia family meeting was last conducted in March 2014 (refer to 1.2.3.1 and 1.2.3.6).

The activities audit was conducted in November 2013, results show 94 % compliance, with corrective actions addressed.

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: PA Moderate

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.

There is an area requiring improvement around care plan evaluations to record the degree of achievement towards meeting the residents' needs.

The District Health Board contract requirements are not fully 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: PA Moderate

Evidence:

Nine of nine residents' files sampled (four rest home, two hospital and three dementia). Six of nine residents' files sampled are of residents admitted to facility within the last six months and not requiring care plan evaluations at time of audit. Three of nine residents' files sampled are of residents admitted to the facility over the six month period and requiring care plan evaluations.

Finding:

Three of three residents' files evidence the care plan evaluations do not record the degree of achievement towards meeting the residents' needs.

Corrective Action:

Provide evidence the care plan evaluations record the degree of achievement towards meeting the residents' needs.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

The residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. 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 medicine 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 conducted and these include; insulin administration; oxygen administration; nebuliser use, sighted on competency registers. The staff education in medicine management was conducted as part of the compulsory in-service days in November and December 2013 and in May 2014.

Twenty medicine charts are sampled (five rest home, five hospital and ten dementia). All 20 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. An interview with one resident who self-administers medicines is conducted and evidences the resident is competent and aware of the responsibilities with self-administration of medicines.

Sighted medication audit results for July 2014, showing 93% compliance, with corrective actions addressed.

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 on site for this facility and for Oceania's other facility, St Johns Wood Trust Life care, confirmed at business and care manager and the head cook 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 Trust Life care. 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 head cook is aware of residents who have been identified with weight loss and the residents' individual dietary needs. The residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review. There are current copies of residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the head cook. The food safety training for kitchen staff have been conducted. 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 nutrition and hydration education is also provided as part of the compulsory in-service days for clinical staff, last occurred in May 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, report their individual preferences are well catered and adequate food and fluids are provided.

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

The kitchen services audit was conducted in April 2014 with 88% compliance, there is no recorded evidence of the corrective actions being addressed (refer to 1.2.3.8). The kitchen services audit in September 2014 records areas requiring improvements and these have been addressed. The food service risk audit was conducted in June 2014 with 100% compliance.

The resident satisfaction survey was conducted in May 2014 and the results show the meal service at 75 % compliance, however there is no recorded corrective action plan (refer to 1.2.3.8 and 1.2.3.6).

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 requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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 Wharerangi and St Johns Wood. This person is interviewed during this audit 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 31 May 2015.

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 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 in the rest home / hospital area as well as in the dementia unit 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 (e.g., 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 (e.g. hoists 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:

There are an adequate number of toilet and shower facilities available throughout all areas of the facility. With one exception, all bedrooms have wash hand basins. Five of the bedrooms (two in the dementia unit and three in the hospital / rest home area) have full ensuite facilities.

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.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Visual inspection provides evidence that the bedrooms allow for easy access for mobility aids. With the exception of three bedrooms, double leaf doors are provided on all doors in the rest home and hospital area to allow for easy access of mobility aids. The bedrooms are varying sizes and 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. There is one couple in the hospital area who are sharing two rooms and have set one room up as their bedroom and one room as their lounge.

Resident's bedrooms are personalised to varying degrees.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Visual inspection provides evidence that adequate access is provided to lounges and dining rooms throughout the dementia area and the rest home and hospital area. The dining room in the dementia unit is on the small side and staff have managed this by creating a separate dining area for four residents. The dining area in the hospital and rest home area is large. 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.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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 off site at St Johns Wood which is another Oceania facility. The BCM advises that from 20 October 2014 laundry will be brought back on site and washed in the laundry at Wharerangi.

There is adequate dirty / clean flow and laundry personnel interviewed at St Johns Wood describe the management of laundry including transportation from Wharerangi to St Johns Wood and back as well as transportation within the facility, 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 02 October 2009 is sighted advising the fire evacuation scheme is approved. The last trial evacuation was held on 1 September 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 in-service 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.

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 two residents utilising restraint and no residents using enablers at the facility. 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 conducted 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..

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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. Interview 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:

The systems are in place to ensure assessment of the resident 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 were two residents utilising restraint and no 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 conducted in July 2014, records 100% compliance.

Managing challenging behaviours audit conducted in March 2014, records 86% compliance, however there is no recorded evidence of corrective actions (refer to 1.2.3.8)

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

The staff education on IC was provided in May 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. The infection logs are maintained. The numbers of infections are collated at the end of each month and reported as a clinical indicator Oceania support 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.

IC compliance audit was conducted in May 2014, however there is no recorded evidence of corrective action plan (refer to 1.2.3.8).

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.)*