

Okere House Limited

Current Status: 20 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

Okere House provided residential care for up to 26 residents who required dementia rest home level care and occupancy on day one of this audit was 22. A District Health Board (DHB) appointed registered nurse manager was appointed in late January 2014 to oversee the management of Okere House in conjunction with the facility manager who had been appointed by the governing body. The facility manager left in April 2014 and a new facility manager was appointed in April 2014 to replace them. Significant improvements in service delivery had been made since the last audit in January 2014. The facility was operated by Okere House Limited.

Five areas were identified as requiring improvement during this audit relating to quality and risk management documentation, residents documentation, calibration of medical equipment and the currency of the infection control co-ordinator's education.

Audit Summary as at 20 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 20 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.
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Organisational Management as at 20 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.
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Continuum of Service Delivery as at 20 October 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 20 October 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Restraint Minimisation and Safe Practice as at 20 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.
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Infection Prevention and Control as at 20 October 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.
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Audit Results as at 20 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' (if able) and their families on admission to the facility. Family members interviewed confirmed that their family member's rights were met during service delivery that staff were respectful of their family member's needs, communication was appropriate, and they had a clear understanding of their family member's rights and the facility's processes if these were not met.

During interview family confirmed that consent forms were provided to them prior to admission to ensure they had time for consultation and were informed. Family also advised that time was provided if discussions and explanation were required. Family interviewed provided positive feedback on the improvements to service delivery and care provided.

The facility manager was responsible for the management of complaints and a complaints register was maintained.

Organisational Management

Okere House Limited was the governing body and was responsible for the service provided at Okere House. Planning documents reviewed included a business and quality plan with goals as well as a mission statement, values, and philosophy. The director usually visits the facility monthly for one and a half days during which time they review the manager's monthly reports service and discuss progress towards meeting the business plan. A new facility manager, who was not a registered nurse, was appointed in April 2014.

The facility manager was supported by two registered nurses who were responsible for oversight of clinical care. The manager and the registered nurses were supported by the registered nurse manager who was appointed by the District Health Board in early 2014 and who had maintained a consultancy role and visits monthly to review service delivery. Registered nurse cover was provided seven days a week.

Significant improvements with quality and risk management were noted during this audit. There was evidence that quality improvement data had been collected and collated and that this

information had been reported to staff. However, improvements were required as this data had not been comprehensively analysed and evaluated to identify trends. There was an internal audit programme in place and internal audits had been completed. Improvements were required as corrective action plans had not been developed to address all areas identified as requiring improvement. Adverse events had been documented on accident/incident forms.

Staff meetings were held monthly and there was documented evidence of reporting on numbers of various clinical indicators and quality and risk issues. Resident and family meetings were held monthly and monthly newsletters were sent to family members.

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

There was a documented rationale for determining staffing levels and skill mix and the minimum number of staff was provided during the night shift and consisted of two care givers. The registered nurses share the after-hours on call and were available if required. 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.

Continuum of Service Delivery

Okere House had a documented and implemented entry criteria. Systems were implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) had been developed with family input and coordinated to promote continuity of service delivery. Family interviewed confirmed their input into assessments, care planning and evaluation and that interventions noted in their family members care plans were consistent with meeting their needs. A sampling of residents' clinical files validated service delivery to residents. Evaluations of care plans were within stated timeframes and reviewed more frequently if a resident's condition changes. Where progress was different from expected, the service responded by initiating changes to the care plan. There was an area identified as requiring improvement around documentation to be signed by the GP to indicate the resident is stable and therefore is exempt from monthly reviews.

Staff training records detailed appropriate qualifications and/or experience and staff interviewed confirmed they are trained and in their view competent to perform expected tasks.

Planned activities were appropriate to the group setting. Family interviewed confirmed satisfaction with the activities programme. Residents' files evidence individual activities were provided either within group settings or on one-on-one basis.

The medication system evidenced compliance with respective legislation, regulations and guidelines. Policies and procedures clearly detailed service provider's responsibilities. Staff

responsible for medicine management had attended medication in-service education and had current medication competencies.

Okere House had a central kitchen and on site staff that provided the food service. Kitchen staff had completed food safety training. The menu had been reviewed by a dietitian. Residents' dietary needs were identified, documented and reviewed on a regular basis. There was positive feedback from family about the food service.

Safe and Appropriate Environment

With one exception, accommodation for residents was provided in single bedrooms and all bedrooms had wash hand basins. Residents' rooms were observed to be of various sizes.

There were lounges and a dining area available for residents and residents were observed moving freely within these areas. A secure external area was available for sitting and shading was provided in this area. An appropriate call bell system was available and security systems were in place.

Visual inspection evidenced 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. An area requiring improvement relating to performance verification of biomedical equipment was identified during this audit.

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

Restraint Minimisation and Safe Practice

There were no restraint or enablers used by residents at the facility on audit days. Documentation of policies and procedures and staff training demonstrated residents were experiencing services that were least restrictive. The service had policies and procedures for determining restraint approval and restraint processes. Staff interviews and staff records evidenced current training and restraint competency assessments

Infection Prevention and Control

There were infection prevention and control (IC) policies and procedures for the prevention and minimisation of infection and cross infection, and contain all requirements in the standard and 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 the facility meetings. Staff interviewed were familiar with infection control measures at the facility. Surveillance for residents who develop infection was occurring and this was collated monthly and reported to staff at staff meetings. There was an area identified as requiring improvement around the infection control co-ordinator's training and education in infection control matters.

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:	Okere House Limited	
Certificate name:	Okere House Limited	
Designated Auditing Agency:	Health Audit (NZ) Limited	
Types of audit:	Certification Audit	
Premises audited:	Okere House	
Services audited:	Dementia care	
Dates of audit:	Start date: 20 October 2014	End date: 21 October 2014
Proposed changes to current services (if any):		
Total beds occupied across all premises included in the audit on the first day of the audit:	22	

Audit Team

Lead Auditor	XXXXXXX	Hours on site	12	Hours off site	9
Other Auditors	XXXXXXX	Total hours on site	10	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXX			Hours	3

Sample Totals

Total audit hours on site	22	Total audit hours off site	16	Total audit hours	38
Number of residents interviewed	1	Number of staff interviewed	10	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	27	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	1			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 Friday, 31 October 2014

Executive Summary of Audit

General Overview

Okere House provides residential care for up to 26 residents who require dementia rest home level care. Occupancy on day one of this audit was 22. A District Health Board (DHB) appointed registered nurse manager was appointed in late January 2014 to oversee the management of Okere House in conjunction with the facility manager who had been appointed by the governing body. The facility manager left in April 2014 and a new facility manager was appointed in April 2014. Significant improvements in service delivery had been made since the last audit in January 2014. The facility is operated by Okere House Limited.

Five areas were identified as requiring improvement during this audit relating to quality and risk management documentation, residents documentation, calibration of medical equipment and the currency of the infection control co-ordinator's education.

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' (if able) and their families on admission to the facility. Family members interviewed confirmed that their family member's rights were met during service delivery that staff were respectful of their family member's needs, communication was appropriate, and they had a clear understanding of their family member's rights and the facility's processes if these were not met.

During interview family confirmed that consent forms were provided to them prior to admission to ensure they had time for consultation and were informed. Family also advised that time was provided if discussions and explanation were required. Family interviewed provided positive feedback on the improvements to service delivery and care provided.

The facility manager was responsible for the management of complaints and a complaints register was maintained.

Outcome 1.2: Organisational Management

Okere House Limited was the governing body and was responsible for the service provided at Okere House. Planning documents reviewed included a business and quality plan with goals as well as a mission statement, values, and philosophy. The director usually visits the facility monthly for one and a half days during which time they review the manager's monthly reports service and discuss progress towards meeting the business plan. A new facility manager, who was not a registered nurse, was appointed in April 2014.

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Significant improvements with quality and risk management were noted during this audit. There was evidence that quality improvement data had been collected and collated and that this information had been reported to staff. However, improvements were required as this data had not been comprehensively analysed and evaluated to identify trends. There was an internal audit programme in place and internal audits had been completed. Improvements were required as corrective action plans had not been developed to address all areas identified as requiring improvement. Adverse events had been documented on accident/incident forms.

Staff meetings were held monthly and there was documented evidence of reporting on numbers of various clinical indicators and quality and risk issues. Resident and family meetings were held monthly and monthly newsletters were sent to family members.

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

There was a documented rationale for determining staffing levels and skill mix and the minimum number of staff was provided during the night shift and consisted of two care givers. The registered nurses share the after-hours on call and were available if required. 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.

Outcome 1.3: Continuum of Service Delivery

Okere House had a documented and implemented entry criteria. Systems were implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) had been developed with family input and coordinated to promote continuity of service delivery. Family interviewed confirmed their input into assessments, care planning and evaluation and that interventions noted in their family members care plans were consistent with meeting their needs. A sampling of residents' clinical files validated service delivery to residents. Evaluations of care plans were within stated timeframes and reviewed more frequently if a resident's condition changes. Where progress was different from expected, the service responded by initiating changes to the care plan. There was an area identified as requiring improvement around documentation to be signed by the GP to indicate the resident is stable and therefore is exempt from monthly reviews.

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Outcome 1.4: Safe and Appropriate Environment

With one exception, accommodation for residents was provided in single bedrooms and all bedrooms had wash hand basins. Residents' rooms were observed to be of various sizes.

There were lounges and a dining area available for residents and residents were observed moving freely within these areas. A secure external area was available for sitting and shading was provided in this area. An appropriate call bell system was available and security systems were in place.

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

Outcome 2: Restraint Minimisation and Safe Practice

There were no restraint or enablers used by residents at the facility on audit days. Documentation of policies and procedures and staff training demonstrated residents were experiencing services that were least restrictive. The service had policies and procedures for determining restraint approval and restraint processes. Staff interviews and staff records evidenced current training and restraint competency assessments

Outcome 3: Infection Prevention and Control

There were infection prevention and control (IC) policies and procedures for the prevention and minimisation of infection and cross infection, and contain all requirements in the standard and 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 the facility meetings. Staff interviewed were familiar with infection control measures at the facility. Surveillance for residents who develop infection was occurring and this was collated monthly and reported to staff at staff meetings. There was an area identified as requiring improvement around the infection control co-ordinator's training and education in infection control matters.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	41	0	4	0	0	0
Criteria	0	88	0	4	1	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: 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 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality improvement data is not being comprehensively analysed to identify any trends.	Provide evidence that quality improvement data is being comprehensively analysed to identify trends.	90
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas	PA Moderate	Internal audits and meeting minutes	Provide documented evidence that	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		requiring improvement in order to meet the specified Standard or requirements is developed and implemented.		reviewed do not consistently have corrective action plan documented to address all shortfalls identified; and do not always have a timeframe/s and person/s responsible documented.	corrective action plans are documented and implemented to address all shortfalls identified and the person/s responsible and timeframe/s for implementation are documented.	
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 Low			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The GP three monthly exceptions are not being completed in the residents' files.	Provide evidence the three monthly GP exceptions are completed as per ARC contract D16.5ei1.	90
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	There is no evidence that the biomedical equipment has been performance	Provide documented evidence that all biomedical equipment, including the scales,	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				verified/calibrated, and the sit on scales were due for performance verification/calibration in September 2014.	have current performance verification / calibration reports.	
HDS(IPC)S.2008	Standard 3.4: Education	The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	PA Low			
HDS(IPC)S.2008	Criterion 3.4.1	Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.	PA Low	There is no recorded evidence that the ICC has completed training and education in IC matters.	Provide evidence the ICC has completed training and education in IC.	180

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 training in the Code of Health and Disability Services Consumers' Rights' (the Code of Rights) was last provided in July by the local Health and Disability Advocate. Staff education records reviewed indicates this education was attended by 16 members of staff. Education records reviewed indicate that staff receive training in resident rights as part of their orientation.

Care staff are observed interacting respectfully and communicating appropriately with residents. Staff encourage residents to make choices demonstrating their knowledge of residents' rights.

Family members of five dementia residents 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 individual responses in the completed family survey questionnaires that were completed in August 2014. The collated results indicate the majority of the respondents are 'satisfied' or 'very satisfied' with service delivery.

Interviews with staff (the registered nurse consultant, the facility manager, two registered nurses, two care givers working morning and afternoon shifts, one activities co-ordinator) 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. This information is provided as part of the pre-admission and information packs.

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

The families 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 five admission agreements are reviewed as part of the review of resident's files and all are found to contain this level of information.

Family members interviewed confirm they have access to an advocate and one may be appointed if needed. Family / resident meetings are held monthly and review of these meeting minutes indicates family and residents are aware of their rights. A family / resident satisfaction survey was completed in August 2014 and the completed questionnaires reviewed indicate family are aware of their rights. Family members interviewed and review of the satisfaction survey indicates the family appreciate the fact that meetings are being held and find these meetings very helpful.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)**

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

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

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

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

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

Attainment and Risk: FA

Evidence:

During interview the facility manager advises there have been two allegations of inappropriate behaviour by staff members. As a result of the investigations of these allegations one staff member has been dismissed. Documentation relating to these allegations and investigations was reviewed during this audit.

Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of family members and during review of the collated results of the completed family satisfaction survey questionnaires completed in August 2014.

Staff have received training on abuse / neglect as part of the annual in-service programme. Education was last provided in June 2014 and was attended by 13 members of staff. Staff are observed keeping doors closed while attending to residents. Care staff demonstrate an awareness of residents' rights and the maintenance of professional boundaries.

With one exception, bedrooms provide single accommodation. The manager advises during interview that the two residents who are sharing a bedroom are doing so at the request of the family members. This was confirmed during interview of one of the family members.

Church services are held on site as part of the activities programme. Values, beliefs and cultural aspects of care are recorded in the five residents' clinical files reviewed.

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 three residents in the facility that identify as Māori and the file for one of these residents is reviewed. A cultural assessment is completed as part of the care plan and is reviewed on the resident's file. Family are able to be involved in the care of their family members and there is evidence of this in the file reviewed.

Access to Māori support and advocacy services is available if required via members of staff and some of the staff speak Te Reo Māori. Access to support and advice is also available from a local provider of Māori services.

A hangi for residents, family members and staff was provided on site in August 2014 and was well attended. The activities programme also included a visit from a kohanga in September 2014 and a Kapa Haka group is scheduled to perform in October 2014.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

Review of the completed questionnaires for the resident/relative satisfaction survey completed in August 2014 indicates that resident's culture, values and beliefs are being respected, and their spiritual needs are met. Church services are held on site as part of the activities programme.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

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

During interview the facility manager and the registered nurse consultant describes the process for managing residents' 'comfort account' funds.

A review of the accident/incident reporting system, complaints register and interview of the facility manager indicates there have been two allegations made alleging unacceptable behaviour and one staff member was dismissed as a result (see link 1.1.3).

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

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

Education is provided by specialist educators and District Health Board (DHB) education programmes as part of the in-service education programme. This is confirmed during review of education records and interviews of the facility manager, the registered nurse consultant and two registered nurses who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators and access to internet research.

The facility manager and registered nurse consultant advise that the registered nurses (RNs) attend education at the DHB and are currently completing the professional development recognition programme (PDRP) via the DHB.

Staff interviewed confirm understanding of professional boundaries and practice.

The District Health Board contract requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families and are reviewed. Five residents' files reviewed 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.

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

The facility manager advises access to interpreter services is available if required via the local community if required. They also advise there is currently one resident who has English as a second language and occasionally reverts to their mother tongue, so they have had prompt cards made with key phrases that are kept in the resident's room for staff to use when required.

Family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Five admission agreements are reviewed and this is 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 family members of residents 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 facility manager, the registered nurse consultant and the registered nurses (RNs) report informed consent is discussed and is recorded at the time the resident is admitted to the facility.

Family members of residents are provided with various consent forms on admission for completion as appropriate and these are reviewed on five resident's file. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these are reviewed on resident's files.

Staff interviewed (two care givers, two RNs, one activities co-ordinator, the facility manager and the registered nurse consultant) demonstrate a good understanding of informed consent processes.

Family interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these are reviewed. The facility manager advises that a local organisation, 'Supporting Families', is available as an advocate if required; visits the facility monthly and attends the monthly family/residents' meetings.

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

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)**

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

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

Attainment and Risk: FA**Evidence:**

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

Family members interviewed confirm they can have access to their relatives who are residents in the facility and confirm their relatives are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a van is available to take residents on community visits. Residents are observed being taken out in the van during this audit. Some residents go out with family and friends on a regular basis.

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

The District Health Board contract requirements are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA**Evidence:**

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes three complaints for 2014, including one from the Health and Disability Commissioner. The Health and Disability Commissioner complaint was originally received in October 2013. A letter from the Health and Disability Commissioner dated 7 October 2014 is reviewed advising the care was 'largely appropriate' and there were some shortfalls and that 'no further action' would be taken. The complaints register is reviewed during this audit.

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

Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure family members are advised on entry to the facility of the complaint processes and the Code. Family interviewed demonstrate an understanding and awareness of these processes. Family/resident meetings are held monthly and

family members are able to raise any issues they have during these meetings. This is confirmed during interview of family members and review of family/resident meeting minutes.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

A business and quality plan is reviewed and includes goals. Also reviewed is a mission statement, values, vision and objectives. A District Health Board (DHB) appointed registered nurse manager was appointed in late January 2014 to oversee the management of Okere House because of risks identified during audits. The DHB appointed registered nurse manager has a contract with the governing body (Okere House Limited) to provide registered nurse consultancy services at Okere House. During interview the registered nurse consultant advises they visit monthly and reviews clinical care and residents' files. They also advise they provide support for the facility manager, who was appointed in April 2014 following the resignation of the previous nurse manager in April 2014, and for the two registered nurses who were appointed in February 2014. Significant improvements in service delivery have been made since the last audit in January 2014.

The facility manager, who is not a registered nurse, is supported by two registered nurses (RNs) who are responsible for oversight of clinical care. The RNs each have been allocated different areas of responsibility, which are reviewed in their personal files. Registered nurse (RN) cover is provided seven days a week between 7am and 4.30pm as well as after-hours via an on-call roster shared between the two RNs. The personal files and annual practising certificates for the two RNs are reviewed on their personal files and are current. The facility manager has a diploma in business and is new to aged care management. The facility manager has previous experience as an office manager, a caregiver and a recreation therapist in an aged care facility.

The facility manager (FM) provides monthly reports to the director and a selection of these are reviewed during this audit. The director usually visits the facility monthly for one and a half days during which time they review the manager's monthly reports service and discuss progress towards meeting the business plan.

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

Okere House Limited is certified to provide dementia level rest home care and has contracts with the DHB to provide dementia level rest home, carer relief and long term support chronic health conditions. There are 22 residents on day one of this audit and one of these residents is aged less than 65 years and assessed as requiring dementia 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 facility manager or either of the registered nurses be absent. One of the registered nurses fills in for the facility manager and the registered nurses fill in for each other in their absence. The registered nurse consultant and director are also available for support and advice if required.

Interviews of the facility manager, the registered nurses (RNs) and the registered nurse consultant confirms their responsibility and authority for this role. Also reviewed are job descriptions for the facility, the two RNs with their respective areas of responsibility, and a contract for the registered nurse consultant.

Services provided meet the specific needs of the resident group within the facility. There are 22 residents assessed as requiring dementia level care, one of these is aged less than 65 years of age and is assessed as requiring dementia level care.

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:

Significant improvement with quality and risk management systems are noted, however, there are still two areas identified as requiring some improvement (see criteria 1.2.3.6 and 1.2.3.8).

A business and quality plan that was reviewed in August 2014 by the facility manager and director, is reviewed and is used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme in place and completed internal audits for 2014 are reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A Health and Safety manual is available that includes relevant policies and procedures.

The facility manager is responsible for ensuring the organisations quality and risk management systems are maintained. Two weekly clinical and quality meetings are held and are attended by the facility manager and the registered nurses (RNs).

Clinical indicators and quality improvement data is recorded on various registers and forms and these are reviewed as part of this audit. There is documented evidence quality improvement data is being collected, collated and reported to staff. Improvements are required as there is minimal documented evidence of analysis of quality improvement data to identify any trends (see criterion 1.2.3.6).

Staff meetings are held monthly and copies of meeting minutes, new / revised policies, accident / incident summary sheet, completed audits and other quality improvement data is put in to a folder for staff to read and sign. This folder is kept in the staff office and review of the folder indicates staff are signing off documents as having been read.

Staff interviewed report they are kept informed of quality and risk management issues. Internal audits completed in 2014 and meeting minutes for meetings held in 2014 are reviewed and although there has been an improvement with the recording of corrective action plans to address shortfalls identified, improvements are still required as these are not being consistently completed (see criterion 1.2.3.8).

Monthly staff meetings, health and safety meetings and infection control meetings are held and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues identified in these meetings. Adverse events are documented on accident/incident forms and are retained in the resident's files.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service reflects current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed during interviews that they are advised of updated policies and they confirm the policies and procedures provide appropriate guidance for the service delivery.

A Health and Safety Manual is available that includes relevant policies and procedures and there is a hazard reporting system available and a hazard register. Chemical Safety data sheets are available that identify the potential risks for each area of service. A planned maintenance programme is in place and is reviewed. Electrical safety stickers are observed 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: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

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

Attainment and Risk: FA**Evidence:**

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

A folder in kept in the staff office that includes copies of update policies and procedures, meeting minutes, an 'Accident and Incident Summary' sheet, 'Monthly Risk Identification' sheet, 'Monthly Quality Indicators' sheet and completed audits. These summary sheets provide evidence that quality data is being collated and reported as total numbers for each type of event and the analysis that has been completed is rudimentary and tends to focus on a particular resident.

Staff are required to read and sign these documents and there is evidence of this in the documents reviewed. Staff interviewed report that quality improvement data is reported back to them in their monthly staff meetings and this is confirmed during a review of the staff meeting minutes.

Meeting minutes and various registers/summary sheets reviewed indicates there has been significant improvement in this area since the last audit, although improvements are still required.

Resident and family meetings are held monthly and there is evidence of reporting back of the August 2014 satisfaction survey results in the meeting held 17 September 2014.

Finding:

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

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:**Finding:****Corrective Action:**

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Completed internal audits, meeting minutes and adverse event forms reviewed indicate a significant improvement has been made with recording of corrective action plans since the last audit, however, improvements are still required.

A template 'Corrective Action Following Audit' is attached to some of the internal audits and has columns for recording timeframes and 'actioned by', however, these are not consistently attached to and/or completed for all internal audits.

Several of the internal audits have 're-audit' written as a corrective action.

'Accident/Incident & Investigation Report' is used to record adverse events and the RN is responsible for recording the investigation and preventative measures taken and the adverse event forms reviewed have these sections completed as appropriate.

Finding:

Internal audits and meeting minutes reviewed do not consistently have corrective action plan documented to address all shortfalls identified; and do not always have a timeframe/s and person/s responsible documented.

Corrective Action:

Provide documented evidence that corrective action plans are documented and implemented to address all shortfalls identified and the person/s responsible and timeframe/s for implementation are 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:

Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Registered nurses (RNs) are advised of all adverse events and are responsible for investigating the event as well as for documenting any corrective actions required. The on call RN visits the facility and assesses any resident if there is an injury or if the staff are concerned. There is an RN on site seven days a week between 7am and 4.30pm and they assess all incidents that occur during these hours. Neurological observations are completed for all suspected head injuries. Education has been provided for staff on falls prevention in April 2014.

Resident files reviewed provides documented evidence of communication with family and GP on the accident/incident form, in resident progress notes, and in whanau/family communication sheets. There is also evidence reviewed during this audit of notification to family of any change in the resident's condition. This finding is confirmed during interviews of family members. There is an open disclosure policy.

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

Staff confirm during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions; policies and procedures; and staff education, which is confirmed via review of documentation. Staff also confirm they are completing accident / incident forms for adverse events. An accident and incident audit was completed in August 2014 as part of the internal audit programme and a corrective action plan was developed and implemented to address the shortfall identified.

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

The facility manager advises they have advised the Ministry of Health of two reportable events.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

The facility manager is responsible for oversight of the in-service education programme and during interview they advise education is provided at least monthly. This finding is confirmed during review of staff education records and during interviews of staff. The education planner for 2014 is reviewed and provides evidence that ongoing education is provided and there is good attendance by staff at the education. A competency register is maintained and competencies are reviewed during this audit and indicate staff have current competencies in place as appropriate.

An external contractor, who is an Aged Care Education (ACE) assessor, is contracted to support staff complete the ACE modules. All staff are required to complete the ACE dementia specific modules and 14 of the 17 caregivers have completed these. The three caregivers who have not completed these modules are working towards completing this programme. Individual records of education are maintained for each staff member and copies are reviewed in staff files. An appraisal schedule is in place and current staff appraisals are sighted on all staff files reviewed.

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

Care staff interviewed (two caregivers working morning and afternoon shifts), one activities co-ordinator, the two registered nurses, the facility manager, and the cleaner/laundry person confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and the currency of their performance appraisals.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a documented rationale (Staffing Policy) in place for determining service provider levels and skill mixes in order to provide safe service delivery at Okere House.

Registered nurse (RN) cover is provided seven days a week between 7am and 4.30pm as well as being available on call after hours. The minimum amount of staff on duty is between 12 midnight and 7am and consists of two caregivers as well as one of the registered nurses (RN) being on call. The facility manager advises that staff hours are adjusted according to resident occupancy and dependency levels.

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

Family members interviewed report staff provide their relatives with adequate care.

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 facility manager confirms the resident details are entered onto 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 residents' clinical record is made on each shift and entries are 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.

Clinical staff interviewed including caregivers, the RNs, an activities co-ordinator and the facility manager confirm they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible.

The District Health Board contract requirements are 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:

There are systems and processes implemented to ensure resident's entry into the service has been facilitated in a competent, equitable, timely and respectful manner. The manager interview confirms access and entry processes are followed. This facility operates 24 hours a day seven days a week. Policies and procedures for entry to the service are recorded and implemented.

The service's philosophy of care and mission statement are recorded and communicated to all concerned. The service provides information to potential referral sources. Okere House information booklet is sighted and contains all relevant information. The family are provided with written information particular to dementia service. Residents' files sampled demonstrate all needs assessments are completed for dementia level of care. The admission agreement defines the scope of the service and includes all the contractual requirements, sighted. All five residents' admission agreements sampled evidence the family or resident's representative and facility representative sign off.

Five of five family interviews confirm the admission process was conducted by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted. Admission procedure audit was completed in April 2014 with 100% compliance

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:

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 the family in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by management. The resident will be declined entry if not within the scope of the service or if a bed is not available at the time and 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 Low

Evidence:

In all five of five resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with family input and the service is coordinated to promote continuity of service delivery.

Five of five clinical staff (two registered nurses (RN), two care givers and one RN /consultant) interviews confirm the family members are involved in all stages of service provision. Five of five family interviews confirm their input into service delivery planning, care evaluations and multidisciplinary reviews.

Five of five residents' files sampled demonstrate the care plans are developed by the RN, signed off by the family member, meet appropriate timeframes and demonstrate team approach into reviews and evaluations. Family communication sheets are maintained, sighted in all five residents' files reviewed.

Documented handovers between shifts are sighted and the auditor evidenced verbal briefing from am to pm shift. GP interview is conducted and confirms the RN notifies the GP of resident's clinical concerns in timely manner and GP treatments are followed.

Staff competency assessments are current, sighted in staff records sampled and on the staff competency register.

There is an area identified as requiring improvement around completion of documentation signed by the GP to indicate the resident is stable and therefore is exempt from monthly reviews.

The District Health Board contract requirements are not fully met.

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 Low**Evidence:**

Five residents' files sampled evidence three of five files do not have documentation signed by the GP to indicate the resident is stable and therefore is exempt from monthly reviews.

Finding:

The GP three monthly exceptions are not being completed in the residents' files.

Corrective Action:

Provide evidence the three monthly GP exceptions are completed as per ARC contract D16.5ei1.

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:**

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

Residents' files sampled evidence residents' discharge/transfer information from DHB are available, where appropriate. The facility has appropriate resources and equipment. The RN interview confirms that assessments are conducted in a safe and appropriate setting including visits from the doctor. Family interviews confirm their involvement in their assessments, care planning, review, treatment and evaluations of care.

Five of five residents' files evidence risk assessments on admission are conducted and recorded on care plans. Initial care plans are recorded on admission and the long term care plan is recorded within the required timeframe and evaluated at six monthly intervals or when resident's condition alters.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)**

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

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

Attainment and Risk: FA**Evidence:**

All five residents' files sampled evidence residents' care plans are individualised and up-to-date. The long-term and short-term goals are identified and reviewed at regular intervals, at least six monthly or as needs change. Family members have input into care planning and review, confirmed at family interviews. Five of five clinical staff interviews confirm that care plans are accurate and up to date.

All residents' files sampled evidence the clinical care/treatment/support or interventions that is to be provided by the staff is current, the risk assessment findings are recorded on the care plans and there is evidence of discussions and sign off by family members. The facility ensures access to regular GP care, sighted in all residents' files on GP progress notes.

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:**

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

All five 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 GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement.

The family interviews confirm the residents' current care and treatments they are receiving meet their needs. Family communication sheets record family communications, sighted in all five 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:

Family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. The activities weekly plan is sighted and evidences activities are provided Monday to Saturday by the activities staff and Sunday activities are provided by care staff, confirmed at care staff interviews.

There is evidence the management provided a family education and support meeting in March 2014, attended by 15 family members. Family interviews confirm this meeting was supportive and informative. Family / resident meeting minutes sighted for April, May, June, July, August and September 2014. Family and friends newsletter is sighted for April, May, June, July, August and September 2014. The newsletter informs the family of activities provided at the facility.

Five of five residents' files sampled demonstrate the individual activities plans are current, individualised and record how best to manage episodes of challenging behaviours over a 24 hour period. Residents' activities assessments are sighted in all five residents' files sampled. Activities attendance records are maintained and are sighted.

Interview with the activities officer, who is completing education towards diversional therapy qualification, confirms the activities programme meets the needs of the residents and the service has appropriate equipment.

Family interviews confirm their family members' past activities are considered and their enjoyment of the activities they choose to participate in. Family satisfaction survey is sighted (conducted in August 2014 with corrective actions addressed). Sighted the recreational programme audit conducted in April 2014 with 98% compliance.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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.

All five residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Evaluation are conducted by the RNs with input from the family, care staff, activities staff and GPs. Family are notified of any changes in resident's condition, evidenced in all five residents' files sampled and confirmed at family interviews. Short term care plans are completed for short term problems, sighted in residents' files with short term problems identified.

There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. Residents' files evidence referral letters to specialists and other health professional.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Service provider's documentation evidences appropriate processes are in place to provide choices to family in accessing or referring to other health and/or disability services. Residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required.

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:

Resident files sampled evidence appropriate communication between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. The resident transfer forms contain all relevant information. Resident care plan is sent with the resident upon transfer, confirmed at RN interview. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files where appropriate.

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:

Visual inspection of the medication area in the facility evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. There is one controlled drug storage in the facility and this is secure. The controlled drug register is maintained and evidences weekly checks and six monthly physical stock takes. Medication fridge temperatures are monitored, sighted.

Residents' medicines charts list all medications a resident is taking (including name, dose, frequency and route to be given). Medication round was observed and there is evidence staff are signing 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. Staff education in medicine management was conducted in February and September 2014.

Ten medicine charts are sampled. All 10 medicine charts demonstrate residents' photo identification, medicine charts are legible, as required medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs.

Medication procedure audit was conducted in September 2014 with 98 % compliance. Review of quality indicators and incident forms for medication errors occurred during the period of April to July 2014 indicating five medication errors during this period with corrective actions addressed. There are no residents who self-administer medicines and staff state this is the facility policy.

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:

Food service policies and procedures are appropriate to the service setting with a new five weekly seasonal menu. The menu is developed by a dietitian and was last reviewed in May 2014.

Resident's individual dietary needs are identified, documented and reviewed on a regular basis as part of the care plan review. Kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the kitchen manager. Copies of dietary profiles reviewed in the kitchen and in residents' files.

Residents' files sampled demonstrate monthly monitoring of individual resident's weight. Family interviewed state satisfaction with the food service provided, report their family member's individual preferences are well catered and adequate food and fluids are provided. Food temperatures are recorded, sighted. Fridge and freezer temperatures are recorded, sighted

Nutritional compliance audit conducted in August 2014 with two corrective actions that have been addressed. Kitchen services audit conducted in August 2014 with 95% compliance with corrective actions addressed.

Food safety training was provided for staff in April 2014, signed on in-service training calendar and confirmed at kitchen staff interview.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There are documented processes in place for the management of waste and hazardous substances. Policies and procedures specify labelling requirements. Material safety data sheets provided by the chemical representative are available and are accessible for staff. Education was last provided on chemical safety for staff in October 2013. Staff interviewed report they receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

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

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)**

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

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

Attainment and Risk: PA Low**Evidence:**

A maintenance person is employed for 20 hours a week and is interviewed during this audit. Significant improvements with management of the facility since the last audit are observed.

Planned and reactive maintenance systems are in place and are reviewed during this audit along with electrical safety tags are viewed on electrical items. Improvements are required as current calibration/performance verified stickers are not observed on medical equipment and calibration/performance verified reports are not available for review (see criterion 1.4.2.1)

Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 1 June 2015.

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

A secure external area is provided for residents and residents are protected from risks associated with being outside (e.g., provision of adequate and appropriate seating; provision of shade; and ensuring a safe area is available for recreation or evacuation purposes).

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

Not all 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: PA Low

Evidence:

A maintenance person is employed for 20 hours a week and is interviewed during this audit. The maintenance person advises during interview that since starting in April 2014 they have repainted the front of building, replaced the retaining wall at the front of the building and some of the wooden fencing at the back, and they have repainted three bedrooms.

The director is interviewed and advises they have a plan in place relating to ongoing refurbishment of the facility. This is reviewed in the business plan and includes timeframes and evidence of sign-off as aspects are completed.

The maintenance person advises that external contractors are used for plumbing, electrical and other specialist areas. During interview the maintenance person and the manager confirm there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. This finding is confirmed during visual inspection and review of maintenance documentation.

A calibration report is reviewed for the sit on scales indicating the scales were last calibrated 13 September 2013. The manager advises during interview that with the exception of the report for the scales, they have not been able to locate any calibration certificates for any other biomedical equipment. Electrical cords are observed to have current electrical testing tags in place and a report for recent electrical testing and tagging is reviewed.

Finding:

There is no evidence that the biomedical equipment has been performance verified/calibrated, and the sit on scales were due for performance verification/calibration in September 2014.

Corrective Action:

Provide documented evidence that all biomedical equipment, including the scales, have current performance verification / calibration reports.

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

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

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

Attainment and Risk: FA

Evidence:**Finding:**

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

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

Toilets have appropriate access for residents based on their needs and abilities. Communal toilets and showers have a system that indicates if it is vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (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:**

With one exception, all bedrooms provide single accommodation. The bedroom that is used as a double bedroom has adequate privacy and the facility manager advises this room is shared at the request of the family members. A family member confirmed this during interview. The facility manager advises that long term, this room will be used as a single bedroom.

Visual inspection provides evidence that bedrooms are of various sizes and adequate personal space is provided in bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and family.

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 maneuver with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)**

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA**Evidence:**

Visual inspection evidences adequate access is provided to the lounge, the quiet lounge and dining room area. Residents are observed moving freely within these areas.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA**Evidence:****Finding:**

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

All linen is washed on site and although the laundry is small the dirty / clean flow is adequate. The cleaner / laundry person is responsible for the laundry and along with the facility manager they describe the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.

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

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

Family interviewed state the cleaning and laundry service is adequate and this finding is confirmed during review of the collated satisfaction survey results.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

New Zealand Fire Service letter dated 12 January 2001 is reviewed that advises the evacuation scheme is approved, is sighted during this audit. The last trial evacuation was held on 27 August 2014 and education was provided for staff on 28 August 2014.

Registered nurses, senior care givers, activities personnel and all staff who drive the van are required to have a current first aid certificate and there is at least one staff member on duty with a current first aid certificate. Evidence of current first aid certificates is reviewed. Emergency and security management education is provided as part of the in-service education programme and staff interviewed confirm this.

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

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

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

There is a call bell system in place that is used by the family or staff members to summon assistance if required and is appropriate to the resident group and setting. Most of the residents are unable to use the call bells.

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/family feedback in relation to heating and ventilation, wherever practicable. Family interviewed confirm the facility is maintained at an appropriate temperature.

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

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The service has processes in place for determining restraint approval and restraint processes. The residents' files sampled evidence family input into care assessment, care planning and evaluation of care.

The clinical staff interviews evidence awareness restraint policy/procedures 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 restraint policies and procedures. Staff education programme includes on-going restraint training. Challenging behaviour and de-escalation training and restraint was presented in May and November 2014.

Restraint competencies sighted on staff register and individual staff files. There are no residents who use restraint or enablers at the facility on audit days.

Management of disturbing behaviour audit was conducted in April 2014 with 100% compliance.

The District Health Board Contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

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

The delegation of infection control matters is clearly documented. Clinical staff interviewed confirm the infection control management systems provide them with adequate guidance. There is documented evidence of reports on infection related issues by regular reporting systems. Visual inspection evidences staff provide additional infection management precautions. The IC programme is reviewed in July 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 service and provides information and resources to inform and guide staff. Monthly IC meetings sighted for 2014. The meeting minutes are available for staff to read, sighted signatures of staff who have read the minutes.

The IC co-ordinator / RN interview confirms they have relevant skills, expertise and resources necessary to achieve the requirements of this standard (refer to 3.4.1). The IC co-ordinator has access to health care professionals regarding infection control matters. There is 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.

Hand washing audit conducted in July 2014 with 100% compliance.

The District Health Board contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures on the prevention and control of infection include written material that is relevant to the service and reflects current accepted good practice and relevant legislative requirements. The policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel. The IC policies and procedures are developed and reviewed regularly. The clinical 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: PA Low

Evidence:

Service provider's documentation evidences that infection control education is provided to all staff, as part of their initial orientation and as part of the on-going in-service education programme. Staff education in IC was provided in March 2014, along with staff IC competencies. All education sessions have evidence of staff attendance and content of the presentations.

The IC training in March 2014 was conducted by the ICC and included infection prevention and control, review of staff IC competencies and results of the hand washing audit, and attended by 16 staff.

There is an area identified as requiring improvement around the infection control co-ordinator to attend training and education in infection control and has an ICC signed position description.

The District Health Board contract requirement is not fully 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: PA Low

Evidence:

Interview with the ICC confirms previous experience in infection control co-ordination prior to their employment at this facility. They also state they are able to access all relevant IC information and consultation is available from IC experts at DHB. The ICC staff file does not evidence IC training and education has been conducted since their appointment to this position.

Finding:

There is no recorded evidence that the ICC has completed training and education in IC matters.

Corrective Action:

Provide evidence the ICC has completed training and education in IC.

Timeframe (days): 180 (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 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.

Infection control resident assessment form /infection register includes all relevant data around residents' infections. Numbers of infections are collated at the end of each month and reported at facility's meetings. Care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, and daily handovers. Evidenced at the handover. The IC data half yearly report (February to July 2014) is sighted.

Management and clinical staff interviews confirm there have been no outbreaks at the facility since the last audit.

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

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

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

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

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