**Bupa Care Services NZ Limited - Waireka Care Home**

**Current Status:** **29-May-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Provisional audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Waireka Home provides hospital/medical and rest home level care for up to 59 residents. On the day of audit there were 35 rest home residents and 22 residents.

Bupa is currently in negotiations to purchase Waireka Home. Bupa's overall vision is "Taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. There is a week by week transition plan established around the purchase, including establishing Bupa systems with the current management and staffing team. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

This audit identified improvements required around aspects of care planning and medication management and documentation.

Waireka Home

Bupa Care Services NZ Ltd

Provisional audit - Audit Report

Audit Date: 29-May-13

**Audit Report**

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Bupa Care Services NZ Ltd |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Waireka Home | Halls Road |       | Pahiatua |

|  |
| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
|       |

|  |  |
| --- | --- |
| **Type of Audit** | Provisional audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 29-May-13 **End Date:** 29-May-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

**Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXX | RN, Auditor Cert. | 8.00 | 8.00 | 29-May-13 |
| Auditor 1 | XXXXXX | RN, Auditor Cert | 8.00 | 6.00 | 29-May-13 |
| Auditor 2 | XXXXXX | RN, RM, ADN, BNurs, MBS, Lead Health Auditor Cert | 8.00 | 6.00 | 29-May-13 |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXX |       |       | 2.00 |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 24.00 | **Total Audit Hours off site** *(system generated)* | 22.00 | **Total Audit Hours** | 46.00 |
| **Staff Records Reviewed** | 9 of 53 | **Client Records Reviewed** *(numeric)* | 8 of 57 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 8 |
| **Staff Interviewed** | 10 of 53 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 4 |
| **Consumers Interviewed** | 11 of 57 | **Number of Medication Records Reviewed** | 18 of 57 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

**Declaration**

I, (full name of agent or employee of the company) XXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 11 day of June 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

**Services and Capacity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Waireka Home | 59 | 57 |       | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Executive Summary of Audit**

*General Overview*

Oceania Waireka Home has well developed systems, processes, policies and procedures that are structured to provide quality care for up to 59 residents including residents that require hospital/medical and rest home level care. There are two GP funded beds. On the day of audit there were 35 rest home residents and 22 residents (including one occupied GP bed) at the facility.

The facility is managed by a facility manager who is a registered nurse. The facility manager is supported by a clinical leader (registered nurse), regional operations manager and the management team and support staff at Oceania head office.

The service provides regular training sessions and competencies are completed by staff. There is a comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit identified improvements required around aspects of care planning and medication management and documentation.

Bupa is currently in negotiations to purchase Oceania Waireka Home. Bupa's overall vision is "Taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. There is a week by week transition plan established around the purchase, including establishing Bupa systems with the current management and staffing team. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

*1.1 Consumer Rights*

Residents and their families/whānau are informed of their rights as part of the resident information pack. Residents stated that health care assistants always respected their privacy. Initial and on-going assessment includes gaining details of people’s beliefs and values. Interventions to support these are identified and evaluated. Residents are encouraged to continue with their spiritual activities. Cultural awareness training occurred as part of the annual training programme. There is Maori Health Plan. There are currently no residents who identify as Maori.

Residents and relatives spoke positively about care provided at Oceania Waireka Home. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents’ rights. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

*1.2 Organisational Management*

Oceania Waireka Home has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported to the organisation's management team. There is an active health and safety committee. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice.

There is a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

*1.3 Continuum of Service Delivery*

Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. The Clinical Leader and registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified in the 'person centred care plans' and these are reviewed within the required timeframes with evidence of resident and/or family/whanau input. Person centred care plans demonstrate service integration. Person centred care plans are reviewed six monthly, or when there are changes in health status. There is an improvement required around providing detail for nursing management interventions for active medical conditions.

Person centred care plans - short term are used for acute episodes or short term needs. There is an improvement required around wound care. Resident files include notes by the GP and allied health professionals.

 The activities programme is facilitated by a diversional therapist who runs the programme in the hospital and rest home. The activities programme provides varied options and activities are enjoyed by the residents. The community including various churches visit the premises and community outings are arranged on a regular basis.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration. There is an improvement required around one aspect of medication management.

Food is prepared and cooked on site. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented and residents and relatives are satisfied with the food service.

*1.4 Safe and Appropriate Environment*

Staff maintain a safe environment. Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. There are spacious lounge's and smaller quiet areas throughout the facility. There are dining rooms in each area. Bedrooms vary in size. External areas are safe and well maintained. The facility has a van available for transportation of residents. Staff transporting residents have valid driving licenses and hold current first aid certificates. There are adequate toilets and showers for residents. Fixtures fittings and flooring are appropriate and toilet/shower facilities are easy to clean. Cleaning and laundry services are well monitored through the internal auditing system. There is appropriate training, information and equipment for responding to emergencies. There is an approved evacuation scheme and emergency supplies for at least three days are held on site. The facility is heated by electricity with a mix of under floor heating and radiators. Temperatures are maintained at a comfortable level

*2 Restraint Minimisation and Safe Practice*

Oceania Waireka Home has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option. There are no residents requiring the use of an enabler and four residents requiring the use of a restraint (bedrail or lap belt). Staff receive training on restraint minimisation and managing residents' behaviours that can be challenging. Review of restraint use is discussed at monthly clinical, staff and quality improvement meetings and annually at Oceania's national restraint authority group meetings. Evaluation of restraint use occurs three monthly.

*3. Infection Prevention and Control*

The infection prevention and control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control coordinator is a registered nurse who is responsible for coordinating/providing education and training for staff. The coordinator has attended external training and is well supported by Oceania management. Infection prevention and control training is provided at orientation and is on-going throughout the year. The infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines. The coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility and surveillance of infections. The service engages in benchmarking with other Oceania facilities and has a low rate of infections.

**Summary of Attainment**

* 1. ***Consumer Rights***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

|  |
| --- |
| Consumer Rights Standards (of 12): N/A:0 CI:0 FA: 12 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA:23 PA:0 UA:0 NA: 0 |

* 1. ***Organisational Management***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

|  |
| --- |
| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:22 PA:0 UA:0 NA: 0 |

* 1. ***Continuum of Service Delivery***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | PA Moderate | 0 | 1 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Moderate | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

|  |
| --- |
| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 9 PA Neg: 0 PA Low: 0 PA Mod: 3 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:18 PA:3 UA:0 NA: 0 |

* 1. ***Safe and Appropriate Environment***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | FA | 0 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 5 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

|  |
| --- |
| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 8 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:17 PA:0 UA:0 NA: 0 |

1. ***Restraint Minimisation and Safe Practice***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

|  |
| --- |
| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:9 PA:0 UA:0 NA: 0 |

1. ***Infection Prevention and Control***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | FA | 0 | 1 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

|  |
| --- |
| Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

|  |
| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 47 **PA Neg:** 0 **PA Low:** 0 **PA Mod:** 3 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 98 **PA:** 3 **UA:** 0 **N/A:** 0 |

**Corrective Action Requests (CAR) Report**

Provider Name: Bupa Care Services NZ Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:29-May-13 End Date: 29-May-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.5 | 1.3.5.2 | PAModerate | **Finding:**One person centred care plan reviewed lacked detail regarding the reporting of signs and symptoms for hypoglycaemia or hyperglycaemia and management of insulin dependent diabetic. The resident has a previous history of a hyperglycaemic episode requiring hospitalisation. **Action:**Ensure that care plans document the management/treatment of medical conditions that include reporting requirements.  | 3 months |
| 1.3.6 | 1.3.6.1 | PAModerate | **Finding:**)There are no wound assessments for two of three wounds in the hospital area. There is no evidence of RN review in the wound management plan or the resident progress notes for rest home residents with wounds.**Action:**1) Ensure there are wound assessments in place for all wounds. 2) Ensure the RN reviews are documented.  | 3 months |
| 1.3.12 | 1.3.12.5 | PAModerate | **Finding:**Six residents (five rest home and one hospital) are self-administering medications as assessed by a registered nurse. There was no evidence of RN monitoring of medications being self-administered by the residents as to compliance. There is no evidence of GP review as to the residents continued competence to self-administer medications at three monthly review.**Action:**Ensure residents who are self-administering medications are reviewed to ensure competence/compliance and that GP documents resident is self-administering medications in medical notes | 3 months |

**Continuous Improvement (CI) Report**

Provider Name: Bupa Care Services NZ Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:29-May-13 End Date: 29-May-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXX

**1. 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**

Consumers receive services in accordance with consumer rights legislation.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Oceania policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumer Rights. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at orientation and through on-going in-service training and competency questionnaires. Interviews with four health care assistants (HCAs) (two hospital, two rest home) showed an understanding of the key principles of the code of rights. Resident rights/advocacy training was provided November 2012. Residents interviewed (seven rest home and four hospital) and relatives (two hospital, two rest home) confirmed that staff respected privacy, obtained daily consent and choice.

The new owners Bupa advise that clients are to be made aware of their rights e.g. through reading material offered on admission, made available within the facility and discussed with them at intervals during their admission e.g. right to complain / right to support and the independent advocacy services available.

Relevant other acts include Privacy of information. Understanding how the information collected about them may be used / access to this.

The right to open disclosure – informed of incidents/serious events.

Advised that all key staff and care staff will attend annual training on the Code of Rights.

**Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is a welcome information folder that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and as appropriate their legal representative. Advocacy pamphlets are clearly displayed at the facility entrance and on noticeboards throughout the facility. Large print posters are also displayed throughout the facility. Code of rights, advocacy information on complaints and compliments is brought to the attention of residents and families at admission, in the information pack and via the two monthly resident/family meetings. Residents interviewed (seven rest home and four hospital) and relatives (two hospital and two rest home) confirmed that information has been provided around the code of rights. The facility manager has an open door policy for concerns or complaints.

D6.2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. The facility manager and registered nurses described discussing the information pack with residents/relatives on admission.

D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The facility provides physical, visual, auditory and personal privacy for residents. During the audit, staff demonstrated gaining permission prior to entering resident rooms.

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. Four health care assistants (HCAs) interviewed described knocking on residents' rooms doors before entering to respect resident's privacy and dignity.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with four HCAs described providing choice during daily cares. Interview with eleven residents (seven rest home and four hospital) all stated staff provided a respectful service and were very approachable and friendly. There is an abuse and neglect policy that is implemented and staff are required to complete education on abuse and neglect. Abuse and neglect training is included as part of the HCA study days. There is a competency question included in the orientation programme around abuse and neglect which staff have completed. Discussions with residents and family members were extremely positive about the care provided.

D4.1a Eight resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and is integrated with the residents' Person Centred Care Plans (PCCP). This includes cultural, religious, social and ethnic needs. Interviews with eleven residents confirmed that their values and beliefs were considered.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

**Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.4 Recognition Of Māori Values And Beliefs**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The policy is cross referenced to Tikanga Recommended Best Practice Policy-Auckland District Health Board. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. Cultural needs is addressed in sexuality/spirituality/intimacy heading of the care plan. There are no residents in the facility who identify as Maori.

D20.1i The service has developed a link with iwi. Cultural training was last provided for staff 13-Jun-12 (nine staff attended). The Maori health plan identifies the importance of whānau Interviews with four HCAs, clinical leader and two registered nurses discussed the importance of family involvement.

Bupa advise that organisational policies including the Māori Health plan will be implemented.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Oceania has policies and procedures to guide staff practice. There is a Maori health plan, Culturally competent services policy and spirituality and counselling policy. Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family involvement and is integrated into residents' person centred care plans. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if any changes are required in delivery of service and care plans. Family are invited to attend. Interviews with four family members (two hospital and two rest home) and eleven residents confirmed they are involved in the care planning process and review.

D3.1g The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. There are multi-cultural staff available and interviews with eleven residents (four hospital and seven rest home) confirmed that cultural values and beliefs were considered and discussed during preparation and review of the care plan.

Spirit and Culture is one of the seven elements of Oceania's Connect Model of Care. The model assists facilities to celebrate residents' spiritual identity and cultural differences.

D4.1c Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

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

ARHSS D16.5e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The Code of Conduct is included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. There are policies to guide staff practice including; Discrimination, Coercion, Harassment and Financial Exploitation; Code of Conduct and Gifts policy. The monthly clinical meeting for registered and enrolled nurses includes any discussions on professional boundaries and concerns. Advised that management provide guidelines and mentoring for specific situations. Interviews with the clinical leader and two registered nurses described professional boundaries.

D16.5e: Health care assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with four HCAs could describe how they build a supportive relationship with each resident.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Oceania has robust quality and risk management systems and these are implemented at the facility supported by a number of meetings held on a monthly basis including (but not limited to); quality improvement, health and safety, clinical, domestic and staff meetings. Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of a robust education programme. Extensive annual education programme in place, including internal and external education sessions, core competency assessments and orientation programmes have been implemented. Oceania has its own Aged Care Education Programme in place which is NZQA accredited. Competencies are completed for key nursing skills, registered and enrolled nurses regularly access training and are supported to attain PDRP at the DHB. All RN's are completing their level 1 professional recognition development portfolio (PRDP). Oceania run a HCA training day, which is repeated to capture all staff. There is a strong commitment to staff development by way of education and in-service training. Education is supported for all staff and a number of HCAs have enrolled or completed a national qualification. At an organisational level, there is a General Manger Clinical and Quality to maintain 'best practice' guidelines/procedures. Implementation of evidenced best practice and legislation requirements are reflected in clinical policies. Care planning is holistic and integrated. Benchmarking via the monthly clinical indicators provided to Oceania Support Office gives meaningful data and report results are provided to each facility and regional operations manager. Quality Improvement alerts are identified to minimise potential risks occurring and the facility is required to complete an action plan. Waireka Home is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. Services are provided at Waireka Home that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for HCAs, registered and enrolled nurses and household staff. There are clear ethical and professional standards and boundaries within job descriptions.

Oceania has implemented its Connect Model of Care throughout its facilities. Connect is made up of seven elements that are specific to the essential parts of care within a facility. The elements can be applied individually or together. The seven elements of the model of care are;

Resident: Creating a range of choice and activities of daily living for residents.

Family: Building on existing relationships with residents families, loved ones and friends.

Spirit and Culture: Facilitating the individual spiritual connection of residents and celebrating their spiritual identity and cultural differences.

Body: Understanding the physical needs and limitations of residents and ensuring exercise programmes are developed to cater to resident’s capabilities and maintain mobility/movement.

Team: Creating understanding of Oceania's values of respect, excellence, passion and deliver.

Community: The expansion of relationships with the community.

Provider: This is about each facility being linked to all the providers in their region that support an aged care facility.

Waireka Home has completed three elements of the model of care. Improvements to residents quality of life and how these are achieved by implementing and engaging staff residents, family/whanau and community in each module are documented and videos and accounts of residents, family staff and community involvement with each element are shared with other Oceania facilities.

**Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. The clinical leader and registered nurses interviewed (2) demonstrated their responsibility to notify family/whānau of any incident/accident that occurs and contact with family/next of kin is recorded. D16.4b Four relatives (two hospital and two rest home) stated that they are always informed when their family members health status changes. Access to interpreter services is identified through the local DHB.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D11.3 The information pack is available in large print and advised that this can be read to residents.

D16.1bii; The information pack and admission agreement included payment for items not included in the services. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.10 Informed Consent**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Oceania Waireka Home has policies in place for advanced care planning, informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights.

There is an End of Life Decisions Policy and Informed Consent policy which help to guide staff practice and promote informed choices made by residents.

Review of eight resident files, all included appropriately signed resuscitation forms, general consent forms and evidence that advance directives are actively discussed with residents and family.

Discussions with the clinical leader and two registered nurses identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

D13.1 there were eight admission agreements sighted and all had been signed on the day of admission.

D3.1.d Discussion with four family identified that the service actively involves them in decisions that affect their relatives lives.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Advocacy policy and procedure provides definitions of advocacy and states that information on advocacy is made available. Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the facility manager and clinical leader, described how residents are informed about advocacy and support.

Interviews with 11 residents (seven rest home and four hospital) confirmed that they are aware of their right to access advocacy.

D4.1d: discussion with four family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.

D4.1e: eight resident’s files reviewed included information on resident’s family/whanau and chosen social networks.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service has a policy maintaining links with family and community, identifies assistance with the electoral process and visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported by activity staff to access the community as required and the service maintains key linkages with other community organisations.

D3.1h; Discussion with four family (two hospital and two rest home) that they are encouraged to be involved with the service and care.

D3.1.e; Discussion with staff across the facility and four family members confirmed that residents are supported and encouraged to remain involved in the community and external groups such as church visits, own GP and shopping. This also links with Oceania's Connect model of care.

**Criterion 1.1.12.1 Consumers have access to visitors of their choice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights . D13.3h. a complaints procedure is provided to residents within the information pack at entry. The complaints register for 2012 -13 ( two written) were tracked, indicating that they had been actioned according to investigation/follow-up letter timeframes and all identified resolution. The monthly staff and quality meetings identified discussion of complaints and outcomes. Discussion with eleven residents ( seven rest home and four hospital) and four relatives (two hospital and two rest home) confirmed they were provided with information on complaints and complaints forms.

D13.3h. a complaints procedure is provided to residents within the information pack at entry.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Oceania's overall vision is "To provide excellent contemporary care that reflects our residents' individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life". There are four key values that are displayed on the wall in the main reception area. There is a site specific business plan that is compiled on consultation with the facility manager and Oceania's regional operations manager (ROM). Business Plan Project Status Report 2012-13 was sighted. The plan is separated into four sections; Physical Product, Services and Choice, Relationships and Market Presence and Financial Performance. The report provides visibility to all aspects of the facility Business Plan, agreed actions and key performance indicators. Additionally, each Oceania facility develops an annual quality plan.(sighted).

Oceania Waireka Home provides hospital, medical, rest home level care for up to 59 residents. There are two GP funded beds. There were 35 rest home residents and 21 hospital residents and one of two GP funded beds was occupied at the time of audit. There were no residents at the facility receiving care under a medical contract.

The facility manager (registered nurse) has been in the role for one year. She is supported by a clinical leader (RN). There are job descriptions for both positions that include responsibilities and accountabilities. Managers and clinical managers attend annual organisational forums and regional forums six monthly.

There is a regional operations manager who is available to support the facility and staff. Advised by the facility manager that the regional operations manager visits at least four -six weekly and is available to be contacted by telephone or email as required.

Clinical indicators completed monthly and forwarded electronically by the facility manager to Oceania support office are part of the benchmarking programme which can highlight/alert areas for improvement.

Policies and procedures are developed at an organisational level with input from staff and external specialist expertise where required.

D17.3di (rest home) & D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

Bupa is currently in negotiations to purchase Waireka Home. Bupa's overall vision is "Taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. There is a week by week transition plan established around the purchase, including establishing Bupa systems (Bupa Quality Programme / annual audit schedule /incident & accident reporting processes and policies / annual education schedule / staff competencies /formal orientation process will be implemented) with the current management and staffing team. The new owners stated that support will be provided through the transition process and any additional resources identified will be provided.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

During a temporary absence, the clinical leader covers the facility manager's role. There is registered nurse cover 24/7. The service is supported by the regional operations manager and Oceania's support office. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. There is a quality plan 2013 which includes consumer rights, quality and risk management (which includes infection control and health and safety), restraint minimisation, service delivery, education and training, work place culture and dementia specific objectives. The manager provides a monthly report to Oceania support office which includes a wide range of quality indicators in accordance with the quality plan and these are benchmarked against other Oceania services/facilities as part of the benchmarking programme.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

**Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Oceania Waireka Home has a well-established quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings..

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The facility has a master copy on computer of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. Discussion regarding policy development/revision occurs at staff meetings. Release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all facility managers and clinical nurse leaders identifying a brief note of which documents are included at that time. These is a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. Key components of the quality management system link to the monthly quality improvement meetings. There is a standing agenda for monthly quality improvement meetings which are held on the third Monday of each month. These include discussion of residents care issues, clinical updates, benchmarking indicators, audit results and corrective action plans, improvement projects, complaints/compliments, policies and reviews, staff training, supplier performance and any other business. Monthly reports by facility manager to the regional operations manager and quality indicator reports to Oceania support office provide a coordinated process between service level and organisation. Clinical indicator reports that are completed monthly include the following: Abuse, absconder, choking, complaint, sentinel event, falls, infection control, medication, restraint, weight loss and wounds.

There are monthly accident/incident benchmarking reports completed by the clinical leader that break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents. Monthly facility manager reports include complaints. Monthly reports from facility managers cover infection control. Infection control is also included as part of benchmarking across the organisation. Health and safety committee meets monthly and Health and safety is also an agenda item at the quality improvement meetings. Health and safety and incident/accidents, internal audits are completed. Annual analysis of results is completed and provided across the organisation.

The monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Oceania analyses data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided to the facility via graphs and benchmarking reports. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality Improvement forms are utilised and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated.

D19.3:There is a comprehensive H&S and risk management programme in place.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Strategies and equipment available to minimise falls risk are hi low beds, floor sensor mats, walking frames, gutter frames, nurse call bells and mobility aids.

The Bupa organizational goals will be introduced at the care home. Many of these are captured using Bupa's benchmarking process and regular reporting systems. The goals are; 10% reduction in incidents where staff are harmed by residents; 70% of CGs enrolled or completed a national qualification (Level 2 and 3); 20% of qualified nurses on the Bupa PDRP: No more than 20% of our residents on antipsychotics; All residents on the new Care plan by end of Q1 2014; Roll out of new CG orientation programme. Identification of any KPI that is high – work to reduce. Introduction of BUPA Policies and forms will be phased in over coming weeks. The care home will continue to use any existing policies /procedures and forms until each is superseded by the Bupa documents as they are rolled out during the acquisition plan. As each new Bupa policy is rolled out – the existing policies /procedures and forms must be removed from circulation and destroyed.

Where there are obvious gaps or areas of risk - Bupa will implement relevant policies /documents immediately.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and H&S meeting reflect a discussion of results.

A sample of incident/accident forms were reviewed for April 2013 from each unit, and all identified that the next of kin were contacted or if family did not wish to be contacted. The incident forms reviewed were 16 falls, (five hospital and eleven rest home) and one medication error. There is evidence of assessment and first aid provided, registered nurse follow up including clinical observations, post fall assessment forms, development of short term care plans and review of risk assessments, review by GP and referral as appropriate. Contact is documented on either the progress notes or family contact sheet.

D19.3b; there is an incident/accident and sentinel event policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing

One fall included a resident who fell from the van hoist/ lift. Regional operations manager (ROM) was informed of the event. Post falls assessment form was evidenced completed and clinical observations recorded. GP was also informed of the incident and communication with family is documented. DHB and Department of labour were informed. Van hoist safety rails were installed on the van hoist/lift on 24-April-13 as per invoices and van hoist /lift sighted. Changes to practice were immediately implemented and policy is awaiting review by Oceania. (link to 1.3.7)

Medication error - A resident was given another residents medication. RN was informed and the resident and following assessment and consultation with GP was transferred to public hospital for monitoring. A sentinel event form was evidenced completed and ROM and family were informed of the incident. The staff member involved has undergone a review of their medication administration practice and has been assessed as competent.

The above incidents were evidenced discussed in staff meeting minutes sighted dated 14-May-13 and in Clinical meeting minutes dated 29-Apr-13.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Register of registered nurses' practising certificates is maintained. Website links to the professional bodies of all health professionals have been established and are available on the computers and in training folder.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Nine files reviewed files (two registered nurses, one clinical leader, one cleaner, three HCAs, cook, diversional therapist) and seven of nine files have up to date performance appraisals. Two staff were recently employed and annual staff appraisals are not yet due. All staff files included a personal file checklist.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. New staff are buddied for a period of time (e.g. HCA one week, RN one week or longer if required), during this period they do not carry a clinical load. Completed orientation booklets are on staff files. Staff interviewed (clinical leader, two registered nurses and four HCAs) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. One RN interviewed had recently commenced employment at the facility and reported that the orientation process was thorough, with on-going support being provided by the staff including the clinical leader and manager. There is an annual education schedule that is being implemented. External education is available via the DHB and Oceania. There is evidence on RN staff files of attendance at internal and external training days.

Two staff have completed the Oceania NZQA education programme. Thirteen HCAs have completed Wellcare education programme and six staff are enrolled on Oceania education programme.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the staff meetings.

A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.

D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, restraint, wound management, CPR, and T34 syringe driver.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is an Interim RN shortage Policy that aligns with contractual requirements and includes skill mixes. There is good registered nurse cover. Nursing/caring hours per resident day for the various client groups are documented. There is a facility manager (RN) who works Monday-Friday 08.30-17.00hrs.

The clinical leader works Monday-Friday 08.00-16.30hrs. The facility manager and clinical leader provide on call cover. There is either an enrolled nurse or a senior health care assistant on duty each shift in the rest home. There is a registered nurse on duty on each shift seven days per week. Interviews with relatives and residents all confirmed that staffing numbers were good. Health care assistants and registered nurses interviewed (including one RN who works night duty) stated that staffing ratio to residents is good, that they have input into the roster and management were supportive around change when times are busier.

Staff rosters were sighted.

In planning staffing levels and safe skill mixes, Bupa refer to the Safe staffing Guidelines document which has helped to shape “WAS” as a tool to manage staffing levels. There are no changes to current staffing planned. The organisation has relieving FM/CM’s that are placed throughout the country as needs determine. Operations Manager is covered by another colleague when on leave.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure locked room at the nurses' station in each unit/department. Archived files are kept in a secure external storage area.

Policies contain service name. All resident records contain the name of resident and the person completing the entry.

Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.

D7.1 Entries are legible, dated and signed by the relevant HCA, registered or enrolled nurse including designation.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Residents and/or family /whanau are provided with an information pack on entry to the service. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the services provided. There is a criterion for entry to the facility. The Facility Manager (FM) or Clinical Leader (CL) requires an approval for rest home or hospital level of care. A Support link needs assessment (NASC) is required prior to entry. There is an admission policy, resident admission and orientation procedure and checklist. Residents (four hospital and seven rest home) and relatives (two rest home and two hospital) interviewed received sufficient information on the services provided and a service agreement. Internal audit on resident admission procedure was completed in February 2013.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

D14.1 exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.2 Declining Referral/Entry To Services**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service has an accepting/ declining entry to service policy. The referral agency and potential resident and/or family member is informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available and if the client did not meet the level of care the facility provided. The client and family/whanau/referrer would be advised if no beds that they could be placed at another facility while awaiting a vacancy. If the client did not meet the level of care the facility provided the referrer would be contacted. The clinical leader interviewed advised there was a hospital level resident waiting to transfer to Waireka Home from another facility when a hospital bed becomes available.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

D.16.2, 3, 4: The eight files reviewed (four hospital, four rest home) identified that an initial assessment is completed within 24 hours which also included an RN resident clinical risk assessment. Information gathered on admission from Support link needs assessment, discharge summaries, GP health records and letters, allied health notes, staff progress notes and discussion, resident/family/whānau participation and feedback provide the basis for the person centred care plan - long term (PCCP). All eight files reviewed identify that the person centred care plan - long term (PCCP) is completed within three weeks. There is documented evidence that the care plans are reviewed by a registered nurse and amended when current health changes. Five of eight care plans evidenced written evaluations with multidisciplinary (MDT) and resident/family/whanau participation are reviewed at least six monthly. Two residents PCCP review is not yet due, and the other client was currently in a GP bed waiting for interRAI assessment.

Spirituality, cultural values and beliefs are included in the initial assessment and long term PCCP. A cultural assessment is completed on admission. Activity assessments are completed by the activities person. Residents interviewed (seven rest home and four hospital) and relatives (two hospital and two rest home) stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files (four hospital and four rest home ) included family contact details and communication form which recorded documented discussions with family/whānau regarding changes to health, incidents, upcoming PCCP reviews/care planning and GP visits.

D16.5e: Seven of eight resident files reviewed identified that the GP had seen the resident within two working days. One resident had been seen before discharge from Midcentral DHB to a GP bed. It was noted in seven permanent resident files reviewed that the GP has examined the resident at least three monthly. More frequent medical review was evidenced occurring in files of residents with more complex conditions or acute changes to health status.

The Pahiatua medical centre has two GP's who provide medical services for the rest home and hospital. One of the GP's interviewed has two thirds of the residents enrolled with her practice and visits her patients on Thursday mornings. The other practice GP visits Thursday afternoons. Routine three monthly visits are carried out and any other RN resident concerns are discussed and residents seen as required. The GP's initiate referrals required for physiotherapy, dietitian and other allied health professionals and specialists. There is an interRAI assessor linked to the practice which has improved the assessment process and ensures timely interventions for provision of care. There is good communication between the GP's, the Older Health specialists and psychiatric nurse case manager. The GP's beds are well utilised and the GP's are responsible for the medical care of their patients. Both GP's provide 24 hour cover for the rest home and hospital. The GP interviewed stated there are good communication channels between the practice, management, clinical leader and the RN's. The GP commented that the RN's are very capable and the level of care is outstanding. A range of assessment tools where completed in eight resident files on admission and reviewed at least six monthly if applicable including (but not limited to); a) Tinetti falls risk, mobility, balance and gait assessment, b) Waterlow pressure area risk assessment, c) continence and bowel assessment (and bowel chart), d) oral assessment, e) dietary assessment and mini nutritional assessment (if required), f) pain assessment or Abbey pain assessment, g) wound assessment, and h) challenging behaviour assessment if applicable.

Clinical staff have undertaken education and training in all areas of clinical care such as safe handling of residents and safe use of transfer equipment, skin and pressure area management, continence management and palliative care. Education sessions are followed up with clinical internal audits. Staff could describe a verbal handover with written handover sheets at the end of each duty that maintains a continuity of service delivery. Handover observed between morning and afternoon shift covered all the areas required to ensure continuity of care for the residents. All resident files (eight) reviewed identified integration of allied health and a team approach.

The clinical leader is qualified to do venepuncture and is able to take blood samples on GP request and for residents on Warfarin. There is an arrangement with Medlab for the phlebotomist to visit the facility monthly to take routine blood samples required.

Eight resident files were reviewed: four hospital residents and four rest home residents.

Tracer Methodology: Rest home resident

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

Tracer Methodology: Hospital level resident

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

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Information obtained on admission interview includes (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, family/whānau support, activities preferences, food and nutrition information. Informed consents and resuscitation or end of life information is obtained in a timely manner.

Person centred care plans viewed in the rest home and hospital areas reflect the assessments which are used as a basis for care planning. Residents and their family are made aware of the contents of the care plan and this information is available to other health professionals as needed Residents (seven rest home and four hospital) advised on interview that assessments were completed in the privacy of their single room. A range of assessment tools where completed in resident files on admission and reviewed at least six monthly or earlier if health needs changed including (but not limited to); a) Tinetti falls risk, mobility, balance and gait assessment b) Waterlow pressure area risk assessment, c) continence and bowel assessment (and bowel chart), d) oral assessment e) dietary assessment, mini nutritional assessment f) pain assessment and Abbey pain assessment g) wound assessment and h) challenging behaviour assessment. Baseline observations of blood pressure, pulse, temperature and weight are recorded. Desired outcomes and goals of residents are identified. The RN completes an initial person centred care plan within 24 hours of admission. Continuing needs/risk assessments are carried out by a registered nurse.

Notes by GP and allied health professionals are evident in eight of eight residents integrated files sampled. Families interviewed (two hospital and two rest home) are complimentary of the clinical and medical care provided and confirm they are kept informed of any significant events, changes in health status and are involved in the care planning.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Moderate

The RNs develop the person centred care plan (PCCP) - long term from information gathered over the first three weeks of admission. The PCCP - long term care plan is focused on the resident with nursing interventions and support documented to meet the resident’s desired outcomes and to promote wellbeing and independence. The long term care plan includes the residents medical diagnosis and any alerts. Nursing assessments included in the long term care plan are as follows: communication; orientation/mental and emotional needs; mobilisation assessment and interventions (including physiotherapy/occupational therapy) ; personal hygiene and skin care; oral hygiene; sleep; eating/drinking; elimination; controlling pain including location/type and medications required; respiratory; restraint/enabler if applicable; maintaining safe environment; interests and goals; spirituality; cultural values and beliefs; expressing sexuality; grieving/death/dying. All eight care plans viewed evidenced resident or family/whanau involvement in the care planning process and reviews six monthly when due. Residents interviewed (seven rest home and four hospital) and relatives (two hospital and two rest home) stated that they and/or their family were involved in care planning. The resident file also contains the care progress notes; medical notes; referral letters; discharge summaries, risk assessment tools; observation recordings form; weight monitoring, laboratory results. Activities assessments and progress notes are contained within the integrated file. Allied health professionals record visits in their progress notes in the integrated resident file.

Person centred care plans - short term are used to document any changes in health needs with interventions, management and evaluations.

Examples sighted were for unexplained weight loss, skin tear, chest infection, pre-diabetic nursing plan and interventions.

Liverpool care pathway end of life care is provided. There is a spacious palliative care room available which accommodates the resident and family requirements and privacy needs.

Person centred care planning internal audit was conducted April 2013.

D16.3k; Short term care plans are in use for changes in health status.

D16.3f; D16.5f eight resident files reviewed identified that family were involved.

**Criterion 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.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

The RNs develop the person centred care plan (PCCP) - long term from information gathered over the first three weeks of admission. The PCCP - long term care plan is focused on the resident with nursing interventions and support documented to meet the residents desired outcomes and to promote wellbeing and independence. The long term care plan includes the residents medical diagnosis and any alerts. Nursing assessments included in the long term care plan are as follows: communication; orientation/mental and emotional needs; mobilisation assessment and interventions (including physiotherapy/occupational therapy) ; personal hygiene and skin care; oral hygiene; sleep; eating/drinking; elimination; controlling pain including location/type and medications required; respiratory; restraint/enabler if applicable; maintaining safe environment; interests and goals; spirituality; cultural values and beliefs; expressing sexuality; grieving/death/dying. All eight care plans viewed evidenced resident or family/whanau involvement in the care planning process and reviews six monthly when due. Residents interviewed (seven rest home and four hospital) and relatives (two hospital and two rest home) stated that they and/or their family were involved in care planning. The resident file also contains the care progress notes; medical notes; referral letters; discharge summaries, risk assessment tools; observation recordings form; weight monitoring, laboratory results. Activities assessments and progress notes are contained within the integrated file.

**Finding Statement**

One person centred care plan reviewed lacked detail regarding the reporting of signs and symptoms for hypoglycaemia or hyperglycaemia and management of insulin dependent diabetic. The resident has a previous history of a hyperglycaemic episode requiring hospitalisation.

**Corrective Action Required:**

Ensure that care plans document the management/treatment of medical conditions that include reporting requirements.

**Timeframe:**

3 months

**Criterion 1.3.5.3 Service delivery plans demonstrate service integration.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Moderate

Care delivery is recorded by the RN and/or health care assistants on each shift. Changes are followed up by registered nurses (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurses initiate a review and if required a GP consultation and referral to the appropriate health professional. Four health care assistants and two RN's interviewed stated that they have all the equipment referred to in PCCP's necessary to provide care, including standing and lifting hoists, pressure relieving mattresses and cushions, shower chairs, shower trolley, commodes, high rise toilet seats, walking frames, transfer belts, slide sheets (slippery sams), wheelchairs, sensor mats, specialised lounge chairs on wheels, gloves, aprons and masks. All staff report that there are always adequate continence supplies and dressing supplies. Supplies of continence, wound care products and adequate linen supplies is seen in each area.

AD18.3 and 4 Dressing supplies are available. The hospital treatment room has a good supply of dressings, catheterization products, oxygen tubing and masks. Wound care folder in the rest home shows there are three skin tears and a lesion being treated. In the hospital there are two wounds (one chronic) and two reddened areas that are being monitored with appropriate interventions. There are no wound assessments for the two wounds in the hospital area. There are wound management plans in place which detail dates, dressings, interventions and evaluations. Chronic wounds are linked to the Person centred care plan. Short term care plans are used for minor wounds (abrasions and skin tears). The enrolled nurse carries out dressing treatments in the rest home area. There is no evidence of RN review in the wound management plan or the resident progress notes. There is an improvement required around wound assessments and RN reviews of wounds in the rest home. Internal audits for wound care March-13 and skin and pressure area care April-13 were completed. Five staff completed education for pressure wounds May 2013.

Monitoring charts such as blood sugar levels, food and fluid intake charts, bowel charts and behaviour monitoring charts are in use.

Weight monitoring is carried out monthly and any weight loss actively managed with a PCCP - short term, GP notification, mini nutritional assessment, weekly weighs, supplementary fluids and monitoring of food and fluid intake. Care plans and monitoring charts sighted. Standing and platform scales are available and due for calibration October 2013.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed. Staff attended continence education April 2013. An internal audit was conducted on continence management February 2013.

Residents requiring oxygen therapy are assessed by the Respiratory nurse. A portable oxygen saturation monitor is available. The clinical leader interviewed stated there is emergency oxygen, suction, ambu bag and airways (sighted) in the hospital area available for emergencies. The local ambulance and fire services respond to their medical emergencies.

Pain assessments are completed for all residents receiving regular or prn pain relief. Pain management forms are held in the medication folder for prn pain relief detailing time, type of pain, pain score, medication given. The monitoring of the effectiveness of pain relief is written in the progress notes. The GP is informed within a timely manner of any resident requiring pain relief or review of current pain management regime.

Resident falls are recorded in the progress notes, reported to RN/CL and on accident/incident forms, family notified, GP notified, PCCP-short term with interventions (example sighted - sensor mats, mobility aids, ensure call bell within reach) and ongoing evaluations by RN. Falls alert stickers are placed on the PCCP. Falls are linked to the PCCP - long term care plan. Short term care plans are used to document recent falls. Internal audits on transferring equipment and safe manual were conducted in January 2013. Twenty staff attended manual handling in May 2013. A physiotherapist is available through the midcentral DHB by referral as required.

The podiatrist visits three monthly and records visits and treatments in the allied health professional notes.

HCA's interviewed (four) were kept informed of residents care and health changes at handover and read the PCCP's. There is a handover period (observed) between shifts and regular staff meetings. Daily resident progress notes are maintained.

**Criterion 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.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

Wound care folder in the rest home shows there are three skin tears and a lesion being treated. In the hospital there are two wounds (one chronic) and two reddened areas that are being monitored with appropriate interventions. There are no wound assessments for two of the three wounds in the hospital area. There are wound management plans in place which detail dates, dressings, interventions and evaluations. Chronic wounds are linked to the person centred care plan. Short term care plans are used for minor wounds (abrasions and skin tears). The enrolled nurse carries out dressing treatments in the rest home area. There is no evidence of RN review in the wound management plan or the resident progress notes for rest home residents with wounds.

**Finding Statement**

)There are no wound assessments for two of three wounds in the hospital area. There is no evidence of RN review in the wound management plan or the resident progress notes for rest home residents with wounds.

**Corrective Action Required:**

1) Ensure there are wound assessments in place for all wounds. 2) Ensure the RN reviews are documented.

**Timeframe:**

3 months

**STANDARD 1.3.7 Planned Activities**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is one diversional therapist employed full time Monday to Friday. She is assisted by two health care assistants who work alternate afternoons from 1 pm to 3 pm in the hospital wing to increase the amount of recreation time for these residents. Activities are provided in both the large lounge areas and in the small lounges. Activities are provided individually in residents rooms when required. Residents participate in a variety of activities. A group of rest home men enjoy chatting in their 'Man Cave", which is a small lounge at the end of the men's wing in the rest home. A group of women enjoy knitting together in seats by the main entrance. The programme is developed monthly and displayed in large print on white boards. The programme is comprehensive and designed for high end and low end cognitive functions and caters for individual needs. There is a wide range of activities offered that reflect the resident needs in the rest home and in the hospital setting. The programme includes but is not limited to: music, housie, current affairs, hangman, balloon tennis, indoor bowls, gentle exercise, CDs & DVDs, skittles, the facility owns its own eight seat van. The van has a hoist. There was an incident in March 2013 when a resident who was using a walker to stabilise herself while being hoisted into the van fell off the hoist. The diversional therapist was operating the hoist by herself at the time as was normal practice but no one was standing on the hoist platform with the resident. Management issued an interoffice memorandum on the same day as the incident implementing a new procedure on the loading of residents into the van and now two staff must load residents into the van and wheelchairs must be used. New stability grab rails have been welded to the hoist. (link to CAR 1.2.4)

All residents have an initial social and activities assessment within three weeks of admission in keeping with the Oceania Group recreation activities programme policy. Assessments are completed by the diversional therapist. The assessment includes a complete history of past and present interests, career, and family relationships. Individual plans are developed for the resident and documented and integrated within the resident's person centred care plan (PCCP). Activities attended by the resident are then recorded in a monthly attendance record. A summary of the resident's involvement in activities is recorded within the progress notes. The effectiveness of the plan is evaluated six monthly at the multi-disciplinary PCCP review (sighted).

Participation in all activities is voluntary and residents enjoy the programme (confirmed in discussion with all 11 residents (seven rest home and four hospital).

**Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Initial Person centred care plans (PCCP's) are evaluated within three weeks of admission. PCCP's - long term are reviewed and evaluated by the registered nurses six monthly or when changes to care occur. Six of eight PCCP's evidenced evaluations completed at least six monthly. Two had been residing at the facility for less than six months. There is a written evaluation completed by the multidisciplinary team (MDT) and includes the CL, RN, DT, pharmacist, resident or relative. Four HCA's and two registered nurses interviewed confirmed they are involved in any changes to changes to residents care and review of PCCP's. The review is discussed with the GP at their routine review of the resident three monthly. Members of the MDT team sign the written evaluation. The registered nurses make changes to the PCCP - long term.

There are PCCP's - short term care to focus on acute and short-term issues. Changes to the PCCP- long term are made as required and at the six monthly review if required. Examples of PCCP's - short term use included; unexplained weight loss, skin tear and chest infection. Monitoring charts such as fluid balance charts and food intake charts, bowel charts and behaviour monitoring charts were evidenced in use.

Pain assessments are completed for all residents receiving regular or prn pain relief. Pain management forms are held in the medication folder for prn pain relief detailing time, type of pain, pain score, medication given. The monitoring of the effectiveness of pain relief is in the progress notes.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated. The GP interviewed stated that she is informed within a timely manner of any concerns the registered nurses have regarding changes in residents conditions. Medical notes evidenced the GP is notified for acute events such as falls, suspected infections, non-healing wounds, unexplained weight loss.

D16.3c: All initial care plans are evaluated by the registered nurse within three weeks of admission.

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.9 Referral To Other Health And Disability Services (Internal And External)**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation, reports, follow up required, investigations and results are maintained on resident files. Examples of referrals sighted were to: Support links needs assessment team, Community Elder Health, podiatrist, community diabetes nurse, urology department, ophthalmologist, colonoscopy clinic, surgical clinic, district nursing service, Arohanui Hospice, hospice social worker, respiratory service, Rheumatologist and dietitian. All referrals are discussed with the resident and family and recorded in the family contact form. The GP offers choice and options for treatment. Allied health professionals record their visits in the allied health progress notes and referral specialist reports, investigations and results are evident in the residents record.

D16.4c; There is evidence of a rest home resident re-assessed for a higher level of care and transferred into the hospital unit in December 2012. A rest home resident has been referred to the interRAI assessor outside of the region (documents sighted) and the inter-home transfer occurred on the day of audit.

D 20.1 discussion with two RN's and clinical leader identified that the service has access to a physiotherapist, podiatrist, dietitian, wound care nurse, continence nurse and hospice nurse. The GP is consulted regarding resident needs for allied health professional referrals.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer**

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

ARC D21 ARHSS D21

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The clinical leader described the document and nursing requirements as per the policy for discharge and transfers. The documentation required includes transfer form and copies of the PCCP, advance directive, drug chart and any other relevant information. The family are informed of any transfers and this is recorded on the family contact form . Previous transfer documentation was sighted in a residents file. All relevant information is documented and communicated to the receiving health provider or service. An inter-NASC transfer occurred on the day of audit and there was evidence of interRAI assessment and communication with Tararua Health group (Tamaranui). All photocopied information going to the receiving provider was sighted. Follow ups occur to check that the resident is settled, or in the case of death, communication with the family is made and this is documented

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Moderate

Medication management policies and procedures cover each stage of safe administration of medicines including, delivery, storage, medicine reconciliation, medicine administration and returns. The pharmacy supply robotic roll medications and other pharmaceuticals to the facility. Two RN's check medications on delivery and report any discrepancies to the pharmacy. There is a medication reconciliation form used by the RN to check in all medications for residents on admission, transferring or returning from hospital. There are two safes in the hospital unit; one being for the controlled drugs (CD's) for the hospital and rest home. The second safe is for the Liverpool care pathway end of life medications. Currently there are no residents in the rest home on controlled drugs. There are no standing orders. There is a verbal order form for use and the GP signs all verbal orders given within 48 hours (sighted).

A weekly stocktake of CD's is carried out by the RN's/Enrolled nurse or pharmacist. The rest home and hospital have locked medications rooms where the medication trolley is kept. A two weekly robotic roll for each resident is stored in the medication trolley with photo identification. Medications in all the trolleys including GTN sprays, ointments and eye drops are not expired. There are medication fridges in the hospital and rest home units. Both fridges are monitored daily and temperatures are within acceptable ranges.

All returns to the pharmacy are held in the hospital medication room and records kept of returns. There are approved biohazard containers available for the safe disposal of sharps. There are memo alerts with the resident drug chart regarding location of specific medication, precautions (example - cytotoxic) or changes to medications. Pain assessment forms are with the resident drug chart where applicable. All medication competent staff are responsible for medication administration in their areas. All Health Care Assistants (HCA's) ENs and RN's undergo annual medication competencies completed April 2013. Medication management education was provided July 2012. Other education includes diabetes, insulin pens and taking of blood sugar levels April 2013 . RN's attend annual syringe driver education and competency sessions provided at Arohanui Hospice in Palmerston North were last attended April 2012. Two RN's and clinical leader interviewed have current syringe driver competencies.

Medication charts are legible and meet prescribing requirements. Each drug chart has a photo ID’s. There are special instructions for administration or precautions if applicable with the resident drug chart. There are 'alert' , allergy, duplicate name and additional pack stickers used where required. Administration signing sheets for regular and prn medications given are signed correctly. The medication folders include a current list of specimen signatures. Controlled drugs given are signed by two medication competent staff. Internal medication management audits were carried out Jan and April 2013. Corrective actions were implemented.

Six residents (five rest home and one hospital) are self-administering medications as assessed by a registered nurse. There was no evidence of RN monitoring of the dose, frequency and times of medications being self-administered by the resident. There is an improvement required around the monitoring of self-medicating residents and GP review at regular intervals.

D16.5.e.i.2; Sixteen medication charts (eight hospital, eight rest home) were sampled. Fifteen medication charts identified that the GP had reviewed and signed the medication chart at least three monthly. One medication chart was not due.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

There are policies and procedures to guide staff to facilitate the safe self-administration of medications where appropriate.

**Finding Statement**

Six residents (five rest home and one hospital) are self-administering medications as assessed by a registered nurse. There was no evidence of RN monitoring of medications being self-administered by the residents as to compliance. There is no evidence of GP review as to the residents continued competence to self-administer medications at three monthly review.

**Corrective Action Required:**

Ensure residents who are self-administering medications are reviewed to ensure competence/compliance and that GP documents resident is self-administering medications in medical notes

**Timeframe:**

3 months

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service employs two cooks (one who works full time Tuesday to Saturday and another who works Sunday and Monday). In addition it employs four kitchen hands. The kitchen is staffed from 6.30 am to 6.30 pm, 7 days a week. A change in hours has occurred in response to a number of residents' dissatisfaction about the evening meal being reheated and then served. This relates to the Oceania Connect concept model of care where an attempt was made to introduce restaurant style choice for residents in their evening meal. The innovation proved to be unsuccessful as some residents could not remember what they ordered and dissatisfaction increased. Therefore this arrangement was cancelled. The main meal is served at lunch time. The evening meal is the lighter of the two meals and contains soup, a savoury, bread, and a sweet. Management and the cook are aware of the issues and are attempting to resolve the unhappiness related to food. Four of the 11 residents interviewed expressed dissatisfaction with the food. The other residents were satisfied with the food service. There is no evidence of significant weight loss or low weight issues amongst the residents as sighted by residents weights recorded. Weight loss is one of a range of clinical indicators that is included in the manager's monthly report to Oceania support office. The kitchen supplies meals for each area. The main cook has completed a food safety certificate, which is displayed on the wall and the relieving cook is booked in to complete training. There is a cleaning schedule on display on the wall. The menu is a four weekly, seasonal menu that has been developed by Oceania in consultation with a dietitian (last reviewed March 2013). Recipes are available. Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. The kitchen is part of the internal audit programme (last audit was conducted on 3 April 2013. All residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of their care plan review. Changes to residents’ dietary needs are communicated to the cook. Special diets are noted on the kitchen notice board, which is able to be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets and diabetics. The kitchen staff makes up supplementary drinks. Meals are well presented and served on hot plates when appropriate. Alternative meals are availed as required. Special feeding and drinking equipment is available (eg lipped plates, special spoons, straws, and feeding cups). Food is delivered by contracted agencies. Food is prepared on site.

Additional food is available at all times. Staff have access to food in the chiller if needed.

D19.2 The cooks have been trained in safe food handling.

It is recommended that the new owner monitors whether the change in operation in the kitchen improve resident and relative satisfaction with the food service.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**STANDARD 1.4.1 Management Of Waste And Hazardous Substances**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Oceania has a range of policies and procedures on the management of waste and the prevention of infection. Management of waste and hazardous substances is covered during orientation of new staff and refresher education occurs (eg, education on infection control last occurred 25 May 2013. Education on health and safety is ongoing through the work of the quality team. The chemicals used on the site are supplied by Ecolab and are clearly labelled with manufacturers labels. Material Data Safety sheet information is available. Sharps containers are available and meet the hazardous substances regulations for containers. These are easily identifiable. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, gumboots and over boots for showering are available for staff protection. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a maintenance person employed who works a total of 37.5 hours per week. Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider (last checked in February 2013). The building holds a current warrant of fitness which expires 11 August 2013. Electrical equipment is checked at least two yearly. All medical equipment including hoists and electric beds are checked annually by BV Medical (last checked in Oct 2012). The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. The corridors are carpeted and there are hand rails. Resident bedrooms are carpeted. The facility is fully equipped with low electric beds and two 'low-low' beds for hospital and five electric beds in rest home. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens are attractive with plenty of setting and shade cloths. There is wheelchair access to all areas.

ARC D15.3; A range of equipment is available including pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids. There is adequate equipment to meet needs (confirmed in discussions with two of two registered nurses and four of four health care assistants.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The facility has seven wings ( three hospital and four rest home wings). There are showers and toilets throughout the facility. Two rooms have ensuites in the hospital and the rest share communal facilities. There is one shower and toilet for every two rooms in the hospital area. In the rest home area residents share communal showers and toilets. There is a separate toilet for visitors and staff have separate toilet facilities. Communal toilets and bathrooms have appropriate signage. Hot water temperatures are tested monthly and the temperatures range from 43 to 44.7 degrees Celsius. Privacy is maintained at all times (confirmed in interview with 11 residents (four hospital, and seven rest home).

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The rooms vary in size and hospital rooms are spacious. Walkers, wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Staff have sufficient space to provide cares. Residents can manoeuver walkers and wheelchairs in rooms safely. The corridor sizes vary through the facility and are of sufficient width to permit emergency transfers if needed.

**Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

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

Evaluation methods used: D 🞏 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There are a number of lounge and quiet areas throughout the facility. There are separate dining rooms for rest home and hospital residents.

All lounge and dining rooms are also accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents confirm they can move around the facility freely and easily (confirmed in discussions with 11 residents) and staff assist them if required.

**Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There are policies to guide staff doing the cleaning and laundry, which are produced by Oceania. The Laundry manual includes the laundry policy, the transporting of laundry procedure, the soiled linen procedure, the washing procedure, wool washing procedures, the drying procedure, the processing procedure, the storage procedure, the speciality linen procedure, the cleaning procedure and the chemical handling procedure. The manual has links to infection prevention and control policies and the health and safety policies. Material Safety Data Sheets are available to guide staff. Chemicals are supplied primarily by Ecolab. All laundry (ie, bedding and towels) are laundered off site except for personal laundry and "greenies" which are green towels and face cloths that are used for personal use. Soiled laundry is able to be soaked overnight. The laundry has clear dirty and clean separation. Laundry and cleaning service audits are completed (last audit was done on 29 March 2013 and the CARs that were identified have been addressed).The facility has two commercial washers, one commercial dryer and one drying room. There is clear dirty to clean separation in the laundry. The laundry is staffed 8.30 am to 3 pm (Tuesday to Friday) and 8.30 am to 4 pm on Mondays. The weekends are covered by health care assistants, which laundry staff report is not a problem as all non-personal laundry is washed offsite.

Oceania have a cleaning handbook which contains a range of information which includes how to clean floors, furniture, fittings, equipment, toilets, showers, hand basins. There is one cleaner on duty each day between 8.30 am to 4 pm and they clean according to the cleaning schedule.

The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in locked areas when not in use. All chemicals are labelled with manufacturer’s labels. There is sluice area for the disposal of soiled water or waste. `

All 11 of 11 residents and four of four relatives expressed satisfaction with both cleaning and laundry services.

**Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service has a Oceania Emergency plan which includes a disaster and emergency management plan to ensure they can cope in an emergency situation. Appropriate training, information, and equipment for responding to emergencies is provided (staff training in fire safety occurred on 15 may 2012). Fire drills are held. The last fire drill was held on 13 March 2013, and the time taken to evacuate 59 residents was 6 minutes. There is a civil defence infection control kit (containing additional PPE and chemicals) which is readily accessible in a locked cupboard by the laundry. There is an up-to-date register containing a list of all residents. There is an approved evacuation scheme, dated 1 July 1999. The facility is well prepared for civil emergencies. It has emergency lighting, alternate sources of power, BBQ’s, and landline telephones. A large store of emergency water is kept in a storage area called "the tower" in 60 (20 litre) containers, which are replenished every six months. In addition there are six large water supply tanks up in the ceiling. The kitchen has access to both gas and electric power for cooking. Emergency food supplies are held which are considered by the cook to be sufficient for at least three days. There are a number of tools and torches in the shed. Hoists have battery backup. Oxygen cylinders are available. There is a list of names and contact details of staff in the in-house phone book so that they can easily be contacted in an emergency. The call bell system has indicator panels in all areas. Residents have easy access to call bells and call bells are answered in a timely manner (observed and confirmed in discussions with 11 of 11 residents and four of four relatives. The facility has 24/7 registered nurse cover to ensure residents receive access to first aid as needed.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.8 Natural Light, Ventilation, And Heating**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The facility has plenty of natural light in communal areas and plenty of natural light in resident’s rooms (observed). The building has a central heating system. There is under floor heating in the hospital area and the rest home is heated by radiators. Ventilation is managed by opening and closing windows. Facility temperatures are monitored by staff. The heating can be adjusted to suit the time of year or resident preference. There is a dedicated internal smoking area in a side sunroom which is ventilated by an external extraction fan. Staff have an outside gazebo which is located some distance from the building for smoking. All 11 of 11 residents interviewed stated the temperature of the facility was comfortable.

**Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Restraint policy states their philosophy is 'We are committed to the delivery of good care. Fundamental to this is our intention to reduce restraint usage in all its forms. Restraining a resident has a hugely negative impact on the resident’s quality of life however we acknowledge that there may be occasions when a resident’s ability to maintain their own or another’s safety may be compromised and the use of restraint may be clinically indicated.

There is a National Oceania Restraint Authority Group at an organisation level that reviews restraint practices. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures.

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has no residents requiring the use of an enabler. The service currently has four residents requiring a bed rail or lap belt in the hospital assessed as restraint. A register for each restraint is also completed that includes a monthly evaluation.

There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits, monthly staff and quality meetings, three monthly restraint meetings and at an organisational level.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Assessments are undertaken by a registered nurse in partnership with the resident and their family/whanau. A registered nurse is the restraint coordinator. A job description in place and is signed and dated.

**Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Assessments are undertaken by a registered nurse in partnership with the resident and their family/whanau. A registered nurse is the restraint coordinator. A job description in place and is signed and dated. All staff complete a restraint competency assessment.

Restraint assessments are based on information in the person centred care plan, resident discussions and on observations of the staff. There is a restraint assessment authorisation and plan available and this completed for the residents requiring the use of a restraint or enabler. The person centred care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. Assessments are completed as required and to the level of detail required for the individual residents. A restraint assessment form is completed for those residents requiring restraint. Two restraint files were reviewed in the hospital, (one lap belt and one bed rail). All files included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed monthly (written evaluation sighted).

**Criterion 2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:**

 (a) Any risks related to the use of restraint;

 (b) Any underlying causes for the relevant behaviour or condition if known;

 (c) Existing advance directives the consumer may have made;

 (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

 (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

 (f) Maintaining culturally safe practice;

 (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

 (h) Possible alternative intervention/strategies.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is a registered nurse and is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whanau and the facility restraint coordinator. Restraint use is reviewed at least three monthly and also as part of monthly restraint register reviews and monthly clinical meetings. Monthly clinical indicators reported to Oceania support office by the manager benchmark the use of restraint and can highlight is there are any issues corrective actions. Any restraint incidents/adverse events are discussed at the clinical, staff and quality meetings and corrective actions initiated. Monitoring and observation process is included in the restraint policy. Advised by the restraint coordinator that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is being implemented.

The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of three hospital residents with restraint identified observations and monitoring occurring within the prescribed timeframes documented on individual residents’ restraint assessment. Restraint use is reviewed through the three monthly assessment evaluation, monthly clinical and staff meetings Three monthly restraint meetings and six multi-disciplinary meeting and includes family/whanau input. A restraint register is in place. This has been completed for all residents requiring restraint.

**Criterion 2.2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:**

 (a) Only as a last resort to maintain the safety of consumers, service providers or others;

 (b) Following appropriate planning and preparation;

 (c) By the most appropriate health professional;

 (d) When the environment is appropriate and safe for successful initiation;

 (e) When adequate resources are assembled to ensure safe initiation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:**

 (a) Details of the reasons for initiating the restraint, including the desired outcome;

 (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

 (c) Details of any advocacy/support offered, provided or facilitated;

 (d) The outcome of the restraint;

 (e) Any injury to any person as a result of the use of restraint;

 (f) Observations and monitoring of the consumer during the restraint;

 (g) Comments resulting from the evaluation of the restraint.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations have occurred three monthly as part of the on-going reassessment for the residents on the restraint register, and as part of care plan review. Families are included as part of this review. A review of two files identified that evaluations are up to date and have reviewed (but not limited to); a) whether the desired outcome was achieved, b) whether the restraint was the least restrictive option and c) the impact. Restraint is reviewed on a formal basis three monthly through restraint register review, monthly clinical indicators reported to Oceania support office and at the national Restraint Authority Group which meets annually. Evaluation timeframes are determined by risk levels.

**Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:**

 (a) Future options to avoid the use of restraint;

 (b) Whether the consumer's service delivery plan (or crisis plan) was followed;

 (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

 (d) Whether the desired outcome was achieved;

 (e) Whether the restraint was the least restrictive option to achieve the desired outcome;

 (f) The duration of the restraint episode and whether this was for the least amount of time required;

 (g) The impact the restraint had on the consumer;

 (h) Whether appropriate advocacy/support was provided or facilitated;

 (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

 (j) Whether the service's policies and procedures were followed;

 (k) Any suggested changes or additions required to the restraint education for service providers.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Individual approved restraint is reviewed at least three monthly and as part of six monthly multidisciplinary review with family/whanau involvement. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the National Restraint Authority Group and information is disseminated throughout the organisation. The organisation and facility are very proactive in minimising restraint usage. There is an Oceania National Restraint Authority Group which meets annually.

**Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:**

 (a) The extent of restraint use and any trends;

 (b) The organisation's progress in reducing restraint;

 (c) Adverse outcomes;

 (d) Service provider compliance with policies and procedures;

 (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

 (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

 (g) Whether changes to policy, procedures, or guidelines are required; and

 (h) Whether there are additional education or training needs or changes required to existing education.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**STANDARD 3.1 Infection control management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The scope of the infection prevention and control programme and infection prevention and control programme description are available. There is a signed job description for the infection prevention and control coordinator which includes clearly defined guidelines (signed 03-May-12). The infection prevention and control committee includes a cross section of staff all areas of the service. The committee and the governing body is responsible for the development of the infection prevention control programme and its review. There is an IPC programme in place, which includes training, surveillance, internal auditing, and oversight of the cleaning and laundry schedules. The programme is developed by the IPC. The plan is outlined in the infection control policies and procedures manual, which was last reviewed Feb 2012. The Committee has access to professional advice within the organisation and has developed close links with the GP's, local laboratory, the infection prevention and control and public health departments at MidCentral DHB and district nurses. There are monthly infection control meetings. The monthly quality meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and staff meetings. Minutes are available for staff on display on wall in the staff room and staff sign the minutes off when they read them. The facility has signage if they need to use it for outbreaks which can be displayed and there is signage at reception advising unwell people to not visit. Alcohol based hand gels are available at reception and at various points around the facility. Communal toilets and bathrooms have hand hygiene notices in large print. There is a staff health policy. There have been no recent infectious outbreaks within the last three years.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection prevention and control committee is made up of a cross section of staff from all areas of the service including; the infection prevention and control coordinator who is the chair, one registered nurse, one enrolled nurse, three health care assistants, one cleaner, one person from the laundry and one cook, who drive the programme. Meetings are held monthly (minutes sighted). The facility also has access to infection prevention and control nurses from MidCentral DHB, public health nurses, GP's, MedLab staff, district nurses and can consult with Oceania's clinical quality managers for opinions and guidance. The coordinator can access the laboratory for results if and as needed and has access to ongoing education as needed (last attended 7 hours of infection control training through Bug Control in November 2012). She disseminates her knowledge to the committee.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D 19.2a: The infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The Oceania infection prevention and control policies and procedures manual include a range of policies which include hand hygiene, standard precautions, transmission-based precautions, prevention and management of infections, antimicrobial usage, outbreak management, cleaning of equipment, single use items and renovations and construction and other policies. There is also policy on waste disposal, and notification of diseases and other infection related topics. Infection prevention and control procedures developed and contained in the kitchen, laundry and the cleaning manuals incorporate the principles of infection prevention and control.

Policy development is primarily developed at corporate level. The infection prevention and control coordinator and the committee contribute feedback to the Oceania management team.

**Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection prevention and control coordinator is responsible for coordinating/providing education and training to staff. The coordinator has attended education in infection prevention and control initially in September 2012. She is a registered nurse with a background in ICU nursing having been employed by MidCentral DHB and worked in the community with the PHO for four years. She organises the training and organises external speakers. She engages outside resources (eg public health for outbreak management on 22 May 2013). There are internal and external seminars available for training. Education was last provided for staff on pandemic training in 30 April 2013. This was attended by 11 staff and staff evaluated the training. The results evidenced satisfaction. The orientation package includes specific training around hand washing and standard precautions. Resident education is expected to occur as part of providing daily cares. Staff educate the residents and relatives on influenza seasonally.

**Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection prevention and control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections including asymptomatic and symptomatic, plus those treated with antibiotics and those not treated. Data are entered into the log from the form and then the form is filed in the resident's file. Infections are included on a monthly register and a monthly report is completed by the infection prevention and control co-ordinator. Information is noted on the facility report which goes to head office. Definitions of infections are in place appropriate to the complexity of service provided. Infection prevention and control data are collated monthly and reported at the quality meetings. The surveillance of infection data assists in evaluating compliance with infection prevention and control practices. remedies are developed when needed and corrective actions (CARs) are put in place. Internal audits occur (last audit was done May 2013 with no CARs identified). There is close liaison with the local health group of GPs that advise and provide feedback and or information to the service. Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. Infection numbers are counted each month and graphed. The numbers of infections per month per area are reasonably low. Oceania benchmarks infection rates between facilities using standardised data. A Flu vaccination programme is in place. Residents were vaccinated on 10 April 2013 (with 57 % uptake). Staff are offered free vaccinations (the uptake rate was 42%).

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**