**Bupa Care Services NZ Limited - Longwood Rest Home**

**Current Status:** **19-Aug-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**

This provisional audit was undertaken to assess the preparedness of the proposed new owner (Bupa) to provide the service and to establish the level of conformity prior to the facility being purchased. The home is managed by a registered nurse with many years nursing and management experience in the sector he is supported by a clinical leader and stable workforce.

Longwood provides care for rest home, hospital and dementia level care. The service has 14 dedicated rest home beds and 28 hospital beds that are all certified for either rest home or hospital level care. The dementia unit has 10 beds.

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.

There are improvements required around care planning documentation and medication management.

**Longwood Lifestyle Village**

Bupa Care Services NZ Ltd

Provisional audit - Audit Report

Audit Date: 19-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Longwood Lifestyle Village | 10 Albany Street | Riverton North | Riverton |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| **Type of Audit** | Provisional audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 19-Aug-13 **End Date:** 20-Aug-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 | XXXXXXXX  | RN, Dip HEd, BSc, Health Auditor | 14.00 | 7.00 | 19-Aug-13 to 20-Aug-13 |
| Auditor 1 | XXXXXXXX | NZCS Paramedical Lead auditor, MBA | 14.00 | 3.00 | 19-Aug-13 to 20-Aug-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXXX |       |       | 2.00 |       |

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| **Total Audit Hours on site** | 28.00 | **Total Audit Hours off site** *(system generated)* | 12.00 | **Total Audit Hours** | 40.00 |
| **Staff Records Reviewed** | 8 of 56 | **Client Records Reviewed** *(numeric)* | 8 of 50 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 8 |
| **Staff Interviewed** | 14 of 56 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 13 |
| **Consumers Interviewed** | 11 of 50 | **Number of Medication Records Reviewed** | 20 of 50 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXXX (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 16 day of September 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

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|  |  |  |  | **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** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Longwood Lifestyle Village | 52 | 50 | 28 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Oceania Longwood provides rest home, hospital and dementia level care and has currently one resident at dementia hospital psychogeriatric level care with the agreement from the DHB funding and planning portfolio manager. The service has 14 dedicated rest home beds and 28 hospital beds that are all certified for either rest home or hospital level care. The dementia unit has 10 beds. Currently there are 22 rest home level residents, 19 hospital residents, eight dementia rest home level and one hospital psychogeriatric level care resident in the dementia unit.

This provisional audit was undertaken to assess the preparedness of the proposed new owner (Bupa) to provide the service and to establish the level of conformity prior to the facility being purchased. The home is managed by a registered nurse with many years nursing and management experience in the sector he is supported by a clinical leader and stable workforce.

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.

There are improvements required around care planning documentation and medication management.

1.1 Consumer Rights

Longwood Lifestyle Village has a clear focus on maintaining resident rights during service delivery. Residents who enter the service are informed of their rights before taking up residence. Staff receive training on resident rights as part of their orientation. This is reinforced through professional training and on-going through in service training. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the role of health advocates is described in the admission information and is also on display throughout the home. Complaints and suggestions are welcomed by the home. Where a complaint is received it is followed up within timeframes by the management. Residents and families interviewed said they were aware of their rights and knew how to complain if they were unhappy with the service they received. Normal living patterns for residents are maintained by the home through inclusion in community activities and open visiting. A Maori health plan has been developed to ensure Maori residents have their cultural needs met.

The home ensures good practise through regular audits, professional development of staff and the use of Oceania's corporate resources. Residents and family members are given documented information around cares provided at a level that is appropriate for the clientele.

1.2 Organisational Management

The home is managed by a registered nurse with many years nursing experience in the sector. The manager has been in this role for four years. When the manager is away the clinical leader deputises. Longwood Lifestyle Village is supported by the Oceania Group leadership and management systems. There is a business plan that includes quality objectives and risk management strategies. Support to the manager through Oceania regional meetings occurs regularly. Management resources are provided to the home's management team. Documented procedures issued and controlled by Oceania are available to staff.

Staff are recruited using standardised procedures. They receive an orientation on starting work and continue to attend training throughout the year. Records of training and professional qualifications and certificates are kept on file by the manager.

There is a rigorous internal audit programme in place. Where an issue is identified it is followed up through the corrective action process. Incidents accidents and events are recorded if they occur. Corrective action is taken and the registered staff follow up wherever this is necessary. Residents and their families are kept informed throughout the process. The home participates in Oceania's benchmarking programme.

Resident notes are kept in an integrated record. Staff and health professionals make notes in residents files daily. The files are kept securely in the nurses’ station.

1.3 Continuum of Service Delivery

The service has an admission process and policies. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. There is an improvement required around person centred care planning. Care plans are reviewed with the resident and/or family/whanau input. Person centred care plans demonstrate service integration and guide staff in residents cares. Care plans are reviewed at least six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals.

Medicines are managed and policies reflect legislative requirements. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around an aspect of medication management.

The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. Each resident has an individualised plan. Community activities are encouraged, van outings are arranged on a regular basis.

All food is cooked on site by the chef. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented and the menu plans have been reviewed by a dietitian.

1.4 Safe and Appropriate Environment

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme.

The service provider's documentation determines appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Buildings, plant and equipment comply with legislation. There is documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family members. Residents interviewed state their room and facility equipment is well maintained and that they are able to move freely around the facility.

Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. There are alternative energy and utility sources, an appropriate call bell system and security systems are in place.

2 Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently nine residents requiring restraints and one resident using an enabler. Staff are trained in restraint minimisation and challenging behaviour.

3. Infection Prevention and Control

Longwood Lifestyle Village has an active infection control programme based on the Oceania infection control manual. The manual covers topics such as hand hygiene, standard precautions, outbreak management, needle stick injuries and surveillance methods. The programme is administered by an infection control coordinator who receives support from the clinical leader, the DHB and Oceania management. Regular training and reinforcement of infection control principles is provided to staff through orientation as they start employment, and on-going in service training.

Surveillance methods describe how infections are to be monitored throughout the home and corrective action to be taken should an outbreak occur. There have been no recent outbreaks in the home.

The efficacy of the infection control programme is monitored through internal audits of the programme and the infection control procedures.

Summary of Attainment

* 1. Consumer Rights

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **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 |

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| 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

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|  |  | **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 |

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| 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

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|  |  | **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 Low | 0 | 1 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 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 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 10 PA Neg: 0 PA Low: 1 PA Mod: 1 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:19 PA:2 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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|  |  | **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 |

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| 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

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|  |  | **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 |

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| 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

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|  |  | **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 |

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| 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 |

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| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 48 **PA Neg:** 0 **PA Low:** 1 **PA Mod:** 1 **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:** 99 **PA:** 2 **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:19-Aug-13 End Date: 20-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.5 | 1.3.5.2 | PALow | **Finding:**One resident was on a PEG feed. The care plan (PCCP) did not contain the following information regarding care of the PEG feed: a) skin care to PEG site, b) full flush instructions, c) rate of administration, d)instruction if PEG feed tube falls out. On interview the clinical leader was able to describe the process around these issues and has commenced a corrective action plan to redress this issue. One resident was discharged in March 2013 from secondary services with ESBL documented in the hospital discharge summary. There is no information in the residents’ PCCP, assessments, review, GP review, referral or lab reports regarding the ESBL. The facility had documentation that universal precautions for the resident had been put in place in May 2013 and then precautions were subsequently removed with no recording in the PCCP. On interview all staff were aware that the resident had ESBL.**Action:**Ensure the corrective action plan is completed around PEG feed instructions in the PCCP. Ensure chronic infections are documented in the PCCP. | 3 months |
| 1.3.12 | 1.3.12.1 | PAModerate | **Finding:**(i) In August 2013, two consecutive readings for the medication fridge were out-with the documented normal temperature range. There was no documentation of the issue being identified or that a corrective action occurred. (ii) One of twenty medication charts reviewed had a short term steroid course prescribed in a decreasing administration method starting at 20mg and decreasing to 5 mg over several weeks. The prescription of 20 mg dose had no commencement or discontinuation date noted by the GP. The 20mg dose was commenced on 15 August 2013. There is no signature documenting that the medication was given the next day and no reason noted in the medication chart or progress notes. The medication was signed as administered the next day on 17 August 2013. **Action:**(i) Ensure staff are aware of the requirements around medication fridge monitoring and reporting issues. (ii) Ensure staff sign medication charts or document why medication was not administered. | 1 month |

# Continuous Improvement (CI) Report

Provider Name: Bupa Care Services NZ Ltd

Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date:19-Aug-13 End Date: 20-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

**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. The service provides families and residents with information on entry to the service and this information contains details relating to the Code. Staff receive training about rights at orientation and through on-going in-service training and competency questionnaires. Interviews with five health care assistants (HCAs) showed an understanding of the key principles of the code of rights. Resident rights/advocacy training was last provided June 2013. Residents interviewed (eleven) and relatives (thirteen) 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.

**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

Thirteen family members discussed the information they were provided as the admission was carried out. All said they received sufficient information to understand the process and the rights a person has in the home. A compendium is located in each room that also has information about advocates and the code of rights. This allows residents and their families to refer to the information if they have any questions.

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

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. On-going opportunities occur via regular contact with family. 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. Eleven residents (five rest home and six hospital) and 13 family members (four rest home, five hospital and four dementia unit), interviewed confirmed that information has been provided around the code of rights and they can talk to the manager at any time. The facility manager has an open door policy for concerns or complaints.

**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

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.

E4.1a Four of four families from the dementia unit stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

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 five HCA's described providing choice during daily cares. Interview with eleven residents 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 (three rest home, three hospital and two dementia), 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 all eleven residents confirmed that their values and beliefs were considered.

**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

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

A3.2 There is an Oceania 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 two residents in the facility that identify as Maori and the care plans reviewed document appropriate culturally safe practices.

D20.1i The service has developed a link with local iwi. Cultural training was last provided for staff in March 2013. The Maori health plan identifies the importance of whānau Interviews with five HCAs from across all areas, the clinical leader and enrolled nurses discussed the importance of family involvement. Discussion with 13 family members (four rest home, five hospital and four dementia unit),confirm that they are regularly involved.

**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 13 family members 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 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.

**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. Enrolled nurses work under the direction and supervision of registered nurses.

There are policies to guide staff practice including; discrimination, coercion, harassment and financial exploitation; code of conduct policy. Qualified nurses meeting (monthly) includes any discussions on professional boundaries and concerns. Minutes of these meetings were sighted. Advised that management provide guidelines and mentoring for specific situations.

Interviews with the clinical leader, three registered nurses (RN’s) and one enrolled nurse (EN) 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 five HCA's 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. 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 HCA's have enrolled or completed a national qualification.

At an organisational level, there is a clinical manager and a facility manager 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.

Oceania Longwood lifestyle village is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. Services are provided at Longwood Lifestyle Village that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D17.7c There are implemented competencies for HCA's, 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 residents 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. Longwood lifestyle village 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.

A2.2: Services are provided at Longwood 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.

**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

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

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 demonstrated their responsibility to notify family/whānau of any incident/accident that occurs and contact with family/next of kin is recorded.

D16.4b Thirteen relatives stated that they are always informed when their family members health status changes. Access to interpreter services is identified through the Southern 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. A site specific Introduction to Dementia unit booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new residents handbook providing practical information for residents and their families.

Twenty nine of 29 incident forms reviewed for the months of May and June 2013 identified that family were notified.

**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

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

D3.1.d Discussion with 13 of13 family members (four rest home, five hospital and four dementia unit), identified that the service actively involves them in decisions that affect their relatives lives.

Oceania Longwood lifestyle care and village 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 an informed consent policy which help to guide staff practice and promote informed choices made by residents.

Review of eight resident files, (three rest home, three hospital and two dementia unit), 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 nurse leader, three RN's and one EN, identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

**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

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

ARC D4.1e: 1f: The resident file includes information on resident’s family/whanau and chosen social networks

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 and advocacy pamphlets on entry. Interviews with the facility manager and clinical leader, described how residents are informed about advocacy and support. The policy advocacy policy and procedure, issued June 2012 describes the processes staff are to use.

Interviews with all eleven residents confirmed that they are aware of their right to access advocacy.

**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

D3.1h: Discussion with thirteen family that they are encouraged to be involved with the service and care.

D3.1.e Discussion with staff and relatives state that they are supported and encouraged to remain involved in the community and external groups such as churches and local artists visit. This also links with Oceania's connect model of care.

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.

**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

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

E4.1biii.There is written information on the service philosophy and practices particular to the unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights .

All complaints in the complaints register for 2012 -13 (there have been four in the last year) 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 11 residents and 13 relatives confirmed they were provided with information on complaints and complaints forms.

**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

ARC E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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 which was developed 9 October 2012. 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 Longwood lifestyle village provides hospital, medical, rest home and dementia level care for up to 52 residents. There were 22 rest home residents and 19 hospital residents and 8 dementia level care residents at the time of audit. There was also one resident who fits the psychogeriatric criteria. There is DHB approval for this resident to reside in the dementia unit.

Longwood lifestyle village has an experienced facility manager (registered nurse) who has been in the role for four years. He 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 two monthly or sooner if there is a request/need.

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.

ARC,D17.3di (rest home), D17.4b (hospital): The manager has maintained at least eight hours annually of professional development activities related to managing a rest home, hospital and dementia unit.

Bupa is currently in negotiations to purchase Longwood Lifestyle Care and Village. 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

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

The current manager has resigned to take another role within Bupa.

During a temporary absence, the clinical leader covers the facility manager's role. There is registered nurse cover 24/7 in the hospital wing and an enrolled nurse works in the rest home Monday-Friday. The clinical leader provides registered nurse input into the dementia unit. The service is supported by the regional operations manager and Oceania's support office.

**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 Longwood lifestyle village 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, through the communication book, and also to the trust board.

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 have 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. The organisation uses the Oceania issued documents. Documents issued by Oceania have a footer the identifies the issuer, the date of issue the title and the date of review and when the next review of the document is due. The process is described in The document control policy was issued February 2013. 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. Weekly 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 nurse leader that break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents. Weekly and monthly facility manager reports include complaints. Weekly 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. Corrective action plans are noted in the business status report. Other corrective action plans sighted at this assessment include the response to the last certification surveillance audit and the response to the Oceania faculty health check.

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.

The quality plan is described in the business report. This is updated at the annual conference and at the cluster meetings held amongst the southern Oceania homes of Dunedin, Gore, Invercargill and Riverton with the Regional Manager, the Quality Manager the human resources manager and the facility manager. The business status report for 2013-2014 was sighted. It covered topics such as finances, maintenance, health and safety, services and choice, relationships family surveys, satisfaction, values, and staff engagement. A risk rating of progress against key performance indicator is noted in the plan.

Risks for residents are recorded in the client file. Organisational risks are integrated into the business plan and strategies for management are monitored through the use of KPI monthly reporting.

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 organisational 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

The Oceania Group incident/accident and sentinel event policy which was issued March 2012 describes the processes to be followed by staff when an untoward event occurs.

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.

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 May 2013 from each unit. 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.

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

The facility employs qualified staff for lead clinical positions and care assistants. Where staff do not have the experience in the sector they attend ACE training to gain theoretical experience to support the practical experience. All staff in the dementia unit hold dementia unit standard qualifications.

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.

The home keeps a file of practising certificates that are updated each year. The file contained 10 current certificates for the RN's on site, two for the EN's and copies of the General Practitioners certificates, the podiatrist. pharmacists and the physiotherapist. The staff files for four caregivers who work in the dementia unit were reviewed. All contained a record of training and achievement of dementia unit standards.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Nine files reviewed files all had up to date performance appraisals. All staff files included a personal file checklist.

New service providers receive an orientation to the service when they start. One new staff member discussed the process, that consists of a buddy system and completion of an orientation booklet. The booklet covers all areas of operation in the facility and includes topics such as emergency management, health and safety, resident rights and infection control. The booklet also contains quizzes that the new staff member must complete. When completed the quizzes are marked and then filed in the staff file. Nine staff files were reviewed, all had records of orientation.

Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

The management team perform annual performance appraisals for all staff. Nine staff files were reviewed all contained a current performance appraisal. Appraisals are then entered onto the Oceania intranet, where they can be monitored and the information used for salary review. The appraisal identifies training required and if the person has missed any compulsory training, this is then provided if necessary. Training records for all staff were reviewed they show good attendance at a wide range of essential training. Attendance records are kept for each training session and each person has a separate training record. There is a staff member on every shift that holds a current first aid certificate, all staff are trained in CPR. Records of this are kept on the individuals training record and in the staff file.

There is an annual education schedule that is implemented. External education is available via the DHB and Oceania. There is evidence on RN and EN staff files of attendance at internal and external training days.

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. HCA, RN, EN, 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.

E4.5d The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

E4.5f There are five HCA's working in the dementia unit, all have completed the required dementia standards.

**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

The service provides 24 hr RN cover. Nursing/caring hours per resident day for the various client groups are documented.

Interviews with relatives and residents all confirmed that staffing numbers were acceptable. Health care assistants and enrolled nurses interviewed stated that staffing ratio to residents is acceptable, that they have input into the roster and management were supportive around change when times are busier. There are extra RN hours in the dementia unit to care for the hospital level dementia resident.

Rosters for August were reviewed, these reflected the practises described by staff.

Residents and relatives interviewed reporting staffing levels were acceptable and staff were available to assist when required.

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. The facility manager is covered by the clinical leader 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 filing cabinets at the nurses' station in each unit/department. Archived files are kept in a secure external storage area. Files are kept secure in the nurses’ station.

Person centred care plans reviewed (eight) documented the date they were completed. Policies contain the 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 health practitioners code. There is a criterion for entry to the facility. The facility manager (FM) or clinical leader (CL) require an approval of level of care from the NASC assessment agency prior to entry. There is an admission policy, a resident admission and orientation procedure and an admissions checklist.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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.

E3.1: Two resident files (including one hospital psychogeriatric level care resident) from the dementia unit were reviewed and both included a needs assessment as requiring specialist dementia care.

**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, 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 there are no beds and that the resident could be placed at another facility while awaiting a vacancy at the facility. If the client did not meet the level of care criteria the facility contacted the referrer regarding this. The clinical leader interviewed described a good working relationship with the NASC team.

**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 resident files (three rest home, three hospital and two dementia), reviewed identified that an assessment was completed within 24 hours which also included a registered nurse resident clinical risk assessment. Information gathered on admission from the NASC agency assessment, discharge summaries, GP health records and letters, allied health notes, staff progress notes and discussion, resident/family/whanau participation and feedback provide the basis for the person centred care plan - long term (PCCP).

Eight of eight files reviewed identify that the 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. All eight care plans evidenced written evaluations with multidisciplinary (MDT) and resident/family/whanau participation are completed at least six monthly.

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. Eleven residents interviewed (five rest home and six hospital)and 13 family members (four rest home, five hospital and four dementia unit),stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files reviewed included family contact details and a communication form which documented discussions with family/whanau regarding changes to health, incidents, upcoming PCCP reviews and GP visits.

D16.5e: Eight of eight files reviewed identified that the GP had seen the resident within two working days. It was noted in all eight resident files reviewed that the GP has assessed the resident as stable and were to be reviewed three monthly. More frequent medical review was evidenced occurring in files of residents with more complex conditions or acute changes to health status.

A range of assessment tools where completed in resident files on admission and reviewed at least six monthly if applicable including (but not limited to); a) 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, f) pain assessment g) wound assessment and h) challenging behaviour assessment.

Clinical staff have undertaken education and training in areas of clinical care such as safe handling of residents and use of transfer equipment safety, skin and pressure area management, continence management, palliative care and challenging behaviour within the last year. This is followed up with clinical competencies and 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. All eight resident files viewed identified integration of allied health and a team approach.

Tracer Methodology: Rest Home

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

Tracer Methodology: Hospital

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

Tracer Methodology: Dementia unit

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

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**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 interviews 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 from each of the rest home, hospital and dementia care units 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.

Eleven residents (five rest home and six hospital) stated 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) 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, 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. Continuing needs/risk assessments are carried out by a registered nurse.

Notes by GP and allied health professionals including orthopods, dietician, physiotherapy and the mental health team are evident in eight of eight residents integrated files sampled. Thirteen family members (four rest home, five hospital and four dementia unit) interviewed were complimentary of the care provided and confirm they are kept informed of any significant events, changes in health status and are involved in the care planning process.

ARC E4.2 One rest home dementia level care and one psychogeriatric level care (in the dementia unit) resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed.

**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 Low

An RN develops the person centred care plan (PCCP) which is a long term care plan. The PCCP is developed from information gathered over the first three weeks of admission. The PCCP focuses on the residents needs with nursing interventions and support documented to meet the residents desired outcomes to promote wellbeing and independence. Nursing assessments included in the PCCP's 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. There is an improvement required around documentation of infection status in one residents file viewed and there is an improvement required around PEG feed information in one residents file viewed.

Eleven residents interviewed (five rest home and six hospital), and 13 family members (four rest home, five hospital and four dementia unit), stated that they and/or their family were involved in planning their care. 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 also contained within the integrated file. Allied health professionals record their visits in progress notes in the integrated resident file.

The Liverpool care pathway is implemented for residents nearing end of life/palliative care. Staff receive palliative care education and have a key relationship with the local hospice. RN's attended care planning in-service training.

E4.3 Two resident files reviewed from the unit identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k: Short term person centred care plans are used to document any changes in health needs with interventions, management and evaluations. Examples sighted were for leg inflammation, infections and weight changes.

D16.3f: All eight care plans viewed (three rest home, three hospital and two dementia),evidenced resident or family/whanau involvement and input in the care planning process and reviews at least six monthly.

**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:** Low

The RN develops the person centred care plan (PCCP) which is a long term care plan. The PCCP is developed from information gathered over the first three weeks of admission. The PCCP focuses on the residents needs with nursing interventions and support documented to meet the residents desired outcomes to promote wellbeing and independence. Nursing assessments included in the PCCP's 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.

Eleven residents interviewed (five rest home and six hospital), and 13 family members (four rest home, five hospital and four dementia unit), stated that they and/or their family were involved in planning their care

**Finding Statement**

One resident was on a PEG feed. The PCCP did not contain the following information regarding care of the PEG feed: a) skin care to PEG site, b) full flush instructions, c) rate of administration, d)instruction if PEG feed tube falls out. On interview the clinical leader was able to describe the process around these issues and has commenced a corrective action plan to redress this issue. One resident was discharged in March 2013 from secondary services with ESBL documented in the hospital discharge summary. There is no information in the residents’ PCCP, assessments, review, GP review, referral or lab reports regarding the ESBL. The facility had documentation that universal precautions for the resident had been put in place in May 2013 and then precautions were subsequently removed with no recording in the PCCP. On interview all staff were aware that the resident had ESBL.

**Corrective Action Required:**

Ensure the corrective action plan is completed around PEG feed instructions in the PCCP. Ensure chronic infections are documented in the PCCP.

**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:** FA

The service provides services for residents requiring rest home, hospital and dementia level care. Currently there is one dementia psychogeriatric hospital level care resident in the dementia unit with the agreement of the DHB funding and planning portfolio manager. There are no dedicated psychogeriatric hospital level care units in the area.

Eight resident care plans (three rest home, three hospital and two dementia (one rest home level dementia and one psychogeriatric) were reviewed for this audit.

Care delivery is recorded by the RN, EN or HCA on each shift in progress notes. Changes are documented as followed up by registered nurses in progress notes (sighted). In eight of eight resident files viewed, when a resident's condition alters, the registered nurses initiate a review and if required a GP consultation or referral to the appropriate health professional.

The five caregivers (one rest home, three hospital and one dementia unit) 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, transfer belts, slide sheets (slippery sams), wheelchairs, weighing scales, gloves, aprons and masks.

The staff in dementia care unit have ready access to a hoist should this be required. All staff report that there are always adequate continence supplies and dressing supplies. Supplies of continence, wound care products and adequate linen supplies were sighted stored in each unit.

Monitoring charts such as blood sugar levels, food and fluid intake charts, weight monitoring and behaviour monitoring charts were evidenced in use.

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 and this could be described. Staff attended continence education as part of the in-service schedule. Training last occurred in May 2013. Internal continence audits are carried out as part of the annual audit schedule.

The clinical leader described the weight loss policy. Residents are weighed monthly and any loss is actively managed with frequent weighs, food charts, and supplementary fluids. The GP is notified in a week if there is no weight gain. A dietitian referral is initiated if required.

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.

Resident falls are recorded in the progress notes, reported to an RN or the clinical leader and on accident/incident forms that determine notification to family and GP's. Staff attended moving and handling education and falls management education. A physiotherapist referral is initiated if required. Physiotherapy reviews are documented in files.

HCA's interviewed (one rest home, three hospital and one dementia unit) were kept informed of residents care and health changes at handover and have access to read the PCCP's. There is a handover period between shifts and regular staff meetings. Daily resident progress notes are maintained.

AD18.3 and 4 Dressing supplies are available and a treatment rooms are well stocked for use. Wound assessment and wound management plans are in place for two residents who both have chronic leg/foot ulcers.

**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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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 are is a diversional therapist (DT) who works 30 hours a week over five days who manages activities in the dementia unit in the afternoons and there is an activities assistant who works 25 hours a week over five days.

The HCA's in the dementia unit follow the DTs instructions and PCCP plan to provide activities throughout the day. The dementia unit has its own activities programme. Residents in the dementia unit are able to participate in the rest home and hospital activities programme from time to time and participation is dependent on their mood and behaviour and the availability of staff to provide supervision. Activity programmes are developed monthly and displayed in throughout the facility.

 The rest home and hospital level programme includes (but is not limited to): exercises games, baking, one on ones, outings, self-directed activities, entertainers, crafts, darts , Tai-Chi bowls and special events. Staff match the programme to the health of the residents and their preferences/preferred choices. The facility has community links with organisations that come to the facility to interact with the residents including church groups, singing groups, primary school groups, Lions club and RSA.

Multi-denominational church services are provided at least once a week. On the day of audit residents in all three areas were observed being actively involved with a variety of activities both group and individual. Some residents choose to do activities in their own rooms.

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).

All 11 residents (five rest home and six hospital), and 13 family members (four rest home, five hospital and four dementia unit),stated they were happy with the activities programmes and that people were given choices regarding participation.

D16.5d Each resident has a written and implemented social and recreational programme which is reviewed when the PCCP is reviewed.

**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. In eight of eight files viewed PCCP's - long term are reviewed and evaluated by the registered nurses at least six monthly or when changes to care occur as sighted. There is a written evaluation completed by the multidisciplinary team (MDT) and includes the CL, RN,DT, pharmacist, resident or relative.

Enrolled nurses and HCA's interviewed confirmed they are involved in any 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 RN makes 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; infections, wounds and leg inflammation. Monitoring charts such as fluid balance charts and food intake charts and behaviour monitoring charts were evidenced in use.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated.

ARC D16.3c: All initial care plans were evaluated by the RN 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 and follow up required, investigations and results are maintained on resident files. Examples of referrals sighted were to the NASC agency, hospice, dietitian, podiatry and physiotherapy. Allied health professionals record their visits in the allied health progress notes.

D16.4c: The service provided examples of where rest home residents whose condition had changed and the residents were reassessed for a higher level of care and transferred to hospital care within the facility or transferred to another facility of the residents/family choosing.

D 20.1; Discussions with RN's and the clinical leader identified that the service has access to wound care nurse specialists, incontinence specialists, gerontology nurse specialists and dieticians. The clinical leader described the referral process should they require assistance from a wound specialist or continence nurse.

**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. Previous transfer documentation was sighted in a residents file. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs 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 administration of medicines including, delivery, storage, medicine reconciliation and returns. The pharmacy supply medico blister pack medications and other pharmaceuticals to the facility. Two RN's check medications on delivery and report any discrepancies to the pharmacy.

 A weekly stock take of CD's is carried out by the RN/EN and pharmacist. Each unit has a locked area where the medication trolley is stored.

There is a medication fridge. There is an improvement required around medication fridge temperature monitoring. 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. The medication folders include a list of specimen signatures, instructions for the treatment and management of hypoglycaemia and resident pain assessment forms where applicable. All medication competent staff are responsible for medication administration in all areas.

All staff who administer medication including HCA's undergo annual medication competencies. Medication management education was last provided in April 2013.

Medication charts have photo ID’s. There are special instructions for administration or precautions if applicable with the resident drug chart. There are 'alert' , allergy and duplicate name stickers used where required. There is an improvement required around medication chart signage. Controlled drugs given are signed by two medication competent staff. Telephone verbal orders are signed within two days (sighted). Internal medication management audits were carried out January 2013. Four residents self-administer inhaler medications and are assessed as competent annually by a registered nurse.

D16.5.e.i.2; Twenty of 20 medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed.

**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:** PA **Risk level for PA/UA:** Moderate

Medication management policies and procedures cover each stage of administration of medicines including, delivery, storage, medicine reconciliation and returns. The pharmacy supply medico blister pack medications and other pharmaceuticals to the facility. Two RN's check medications on delivery and report any discrepancies to the pharmacy.

 A weekly stock take of CD's is carried out by the RN/EN and pharmacist. Each unit has a locked area where the medication trolley is stored.

There is a medication fridge and the temperatures are monitored. 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. The medication folders include a list of specimen signatures, instructions for the treatment and management of hypoglycaemia and resident pain assessment forms where applicable.

**Finding Statement**

(i) In August 2013, two consecutive readings for the medication fridge were out-with the documented normal temperature range. There was no documentation of the issue being identified or that a corrective action occurred. (ii) One of twenty medication charts reviewed had a short term steroid course prescribed in a decreasing administration method starting at 20mg and decreasing to 5 mg over several weeks. The prescription of 20 mg dose had no commencement or discontinuation date noted by the GP. The 20mg dose was commenced on 15 August 2013. There is no signature documenting that the medication was given the next day and no reason noted in the medication chart or progress notes. The medication was signed as administered the next day on 17 August 2013.

**Corrective Action Required:**

(i) Ensure staff are aware of the requirements around medication fridge monitoring and reporting issues. (ii) Ensure staff sign medication charts or document why medication was not administered.

**Timeframe:**

1 month

**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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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

Staff are guided by the Oceania Group food safety and kitchen service policies and procedures dated August 2012. There is one kitchen that supplies meals for each area. All of the kitchen team have completed food safety certificates. There is a cleaning schedule in operation. The menu is a four weekly, seasonal menu that has been developed for Oceania by a dietitian (last reviewed March 2013 ). Kitchen fridge, food and freezer temperatures are monitored and documented daily. The kitchen is part of the internal audit programme (last audit occurred 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 the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted in residents files and noted in the kitchen. Staff know the likes and dislikes as do the cooks and chef. Staff are aware of those residents who are identified in the care plans as requiring specialist equipment (eg, special lipped plates, oval plates, dinner plates, special spoons, feeding cups, and straws). Special diets being catered for include soft diets, puree diets and diabetics. Meals in each area are service from bain maries.

On interview with 11 residents (five rest home and six hospital) and 13 family members (four rest home, five hospital and four dementia unit) stated that residents are happy with the meals provided. Meals are well presented. Alternative meals are offered as required

E3.3f: Staff can access additional nutritious snacks for residents anytime over the full 24 hour period. There is a fridge in the dementia unit which contains sandwiches, milk, protein drinks and puddings.

D19.2: Staff have been trained in safe food handling.

**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. Education on hazard management occurs and education on health and safety is on-going through the work of the quality team. The majority of 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

Maintenance is currently being carried out by the maintenance person and contractors when required. The facility manager, or the clinical leader communicate to the maintenance person if repairs are required. Reactive and preventative maintenance is carried out by the maintenance person (programme documentation sighted). Maintenance requests are recorded in a log system and requests are signed off when actions have been completed.

The building has a current warrant of fitness which expires 8 October 2013. Electrical equipment is checked annually. Fire equipment is checked by an external contractor. Hoists and medical equipment are checked, serviced and or calibrated. The living areas are carpeted. Vinyl surfaces exist in bathrooms/toilets, kitchen areas and observed in one bedroom. The dementia unit has a mix of linoleum flooring and carpeting. Resident rooms in the on the whole are carpeted. There is non-slip vinyl in ensuites, shared ensuites and communal bathrooms.

Residents in the dementia unit have a secure external area to wander which includes a garden area There is a range of outdoor furniture and shade is provided. There is wheelchair access to all areas.

Interviews with the five HCA's (one rest home, three hospital and one dementia unit), three RN’s, one EN, 11 residents (five rest home and six hospital) and 13 family members (four rest home, five hospital and four dementia unit), confirmed there was adequate equipment.

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids. Interviews with one HCA and one RN from the dementia unit confirmed there was adequate equipment.

**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 adequate ensuite, shared ensuite and communal bathroom facilities appropriate for residents at the facility. Communal toilets and bathrooms have appropriate signage and easy access locks. Hot water temperatures are monitored and maintained at/or below 45 degrees celsius. Fixtures and fittings are appropriate and fit for purpose. Residents interviewed report adequate toilet and showering facilities and that their privacy is always respected.

**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 and corridors are spacious. Large equipment (eg, wheel chairs and hoists) is able to be easily manoeuvred around the bed and personal spaces and within the corridors. Five HCA's interviewed (one rest home, three hospital and one dementia unit) report that rooms have sufficient space to allow cares to take place. Residents were observed manoeuvring wheelchairs in rooms safely.

**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

Communal areas are available for relaxation, dinning and for entertainment. All lounges and dining rooms are easy to access and can 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 and all 11 residents (five rest home and six hospital) interviewed report they can move around the facility and staff assist them if required.

E3.4b:There is adequate space to allow maximum freedom of movement while promoting safety for those that wander in the dementia unit

**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

Oceania has policies to guide staff when doing laundry or cleaning. The laundry manual includes guidance on the following: laundry policy, transport of laundry procedure, soiled line procedure, washing, wool washing, drying, processing storage, speciality linen, cleaning, chemical handling. Material Safety Data Sheets are kept on site. There is a cleaning handbook which includes guidance on how to clean all equipment. The cleaners have a cleaning schedule task list and a cleaning schedule.

Laundry services audits are completed on a regular basis. The laundry and cleaning room are designated areas and are clearly labelled and able to be locked when not in use. All chemicals are labelled with manufacturer’s labels.

There is sluice area in the laundry and another sluice rooms in the facility for the disposal of soiled water or waste. Stained clothes and whites are soaked as needed.

**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

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

Oceania has a comprehensive emergency plan dated January 2012. In addition Oceania has produced an Emergency Evacuation Toolkit to guide facility managers so that they can train all registered nurses and health care assistants on the plan. There are flip charts displayed on the wall of the facility to guide staff in an emergency. The facility has an approved fire evacuation scheme which was approved on 16 October 2000. Fire evacuations are held six monthly and the time of the drill is varied. Appropriate training, information, and equipment for responding to emergencies is provided (Staff training in fire safety last occurred in April 2013).

Fire equipment is available (eg, extinguishers and fire blankets). The extinguishers were last checked in 2013. There is a civil defence kit (sighted). The site stores more than three litres of water for three days for each resident. The civil defence kit includes a torch, a radio, batteries, gumboots, waterproof clothing, gloves, handtowels and other items. There is access to gas BBQs. There are emergency medical supplies held in case of an infectious outbreak which includes continence products and additional PPE. There is 24 hours a day, seven days a week registered nurse cover so that residents can be provided with first aid if needed. All registered nurses have current first aid certificates. Caregivers in the dementia unit all have current first aid certificates. There is an up-to-date register maintained that lists all residents. Emergency food supplies sufficient for three days are kept in the kitchen and extra blankets are available. Hoists have battery packs. Hoists are checked by an external contractor. The facility has oxygen cylinders for use in an emergency. The call bell system is electric and indicator panels are placed throughout the facility. Residents have easy access to the call bells and staff answer bells promptly (confirmed in discussion with 11 residents (five rest home and six hospital) and 13 family members (four rest home, five hospital and four dementia unit).

**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 through external windows in each bedroom. Heating is a mix of electric panel heaters and under floor heating. There is adequate ventilation. Facility temperatures are monitored by staff. The facility manager reported that the heating is able to be adjusted as to the season and individual resident need. There is an external area designated for residents who smoke.

**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

There is a restraint policy. There is a Regional Restraint 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 one resident on the register with an enabler in the form of a bedrails. The files reviewed of one resident identified as having an enabler in the form of a bedrail included a comprehensive enabler assessment that covered alternatives and least restrictive options.

The service currently has nine residents assessed as requiring restraints,(seven in the hospital (three residents with: bed rails, one resident with: low bed and alarm mat and three residents with: lap belts, low beds and alarm mats) and two residents in the dementia unit (bed rails)assessed as requiring restraints. 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, facility meetings, regional restraint meetings and at an organisational level.

E4.4a:The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

**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

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 policy identifies that restraint is used as a last resort.

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. There is one resident requiring the use of an enabler in the form of a bed rail.

The clinical nurse leader who is an RN is the restraint coordinator. A job description in place and is signed and dated for the restraint coordinator position.

**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 the restraints coordinator in partnership with the resident and their family/whanau. 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.

Nine restraint files were reviewed (seven in the hospital and two residents in the dementia unit (bed rails) assessed as requiring restraints). All nine 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 residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of nine residents (seven in the hospital and two in the dementia unit) with restraints 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 RN and staff 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.

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 the clinical nurse leader who 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 RN meetings. Monthly clinical indicators reported to Oceania support office by the manger benchmark the use of restraint and can highlight is there are any issues corrective actions. Any restraint incidents/adverse events are discussed at the RN and quality meeting 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.

**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 nine 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 Regional Restraint Approval Group and information is disseminated throughout the organisation. The organisation and facility are proactive in minimising restraint usage. There is an Oceania national restraint approval 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 policy and infection prevention and control programme description are available. There is a job description for the infection prevention and control coordinator and clearly defined guidelines and accountabilities located in the staff file and in the infection control manual. The infection prevention and control (IPC) committee includes a cross section of staff all areas of the service.

The infection control committee is part of the health and safety committee. Minutes for meetings in 2013 show the infection control agenda is covered at every meeting.

The coordinator and committee have access to professional advice within the organisation and they have developed close links with the GP's. There are monthly infection prevention and control meetings through the health and safety committee. Information from these meetings is passed onto the registered nurse and staff meetings. Minutes are available for staff and are on display on the wall by the staff room. The facility has signage if the need to use it for outbreaks and displays this information as needed. Visitors are encouraged to stay away if sick. There is a staff health policy in place to ensure staff do not spread infections. There have been no recent outbreaks.

**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 health and safety is made up of a cross section of staff from all areas of the service including; (but not limited to) the which includes cleaning, laundry, care givers, registered nurses and management. Meetings are held monthly (minutes sighted for 2013 ). The facility also has access to infection prevention and control nurses from the DHB, public health nurses, and G.P's and can consult with Oceania's clinical quality managers for opinions and guidance.

**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: Oceania's infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines. The infection Control manual issued February 2012, includes policy on 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, waste management and other policies. There is also policy on waste disposal, and notification of diseases. Infection control procedures are included in the kitchen, laundry and the housekeeping manuals. External expertise can be accessed as required. Policy development is primarily driven by Oceania management with input from staff as required.

**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 and providing education and training to staff. The IPC coordinator has attended education through the southern DHB. She and the RN on the committee provide the education for staff. They use outside resources to provide education as well (eg DHB IPC nurse specialists). Education was last provided for staff in April 2013. Fourteen staff attended. Staff are also introduced to infection control principles at orientation and through their on-going professional development when they study for aged care qualifications through Oceania modules.

The orientation package for all staff includes specific training around hand washing and standard precautions. Resident education is expected to occur as part of providing daily cares. Care plans can also reference infection control as needed. Residents and relatives are provided with education on influenza prior to flu vaccinations occurring. This education is on-going during the flu season.

**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 issued February 2012, 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 (both asymptomatic and symptomatic, plus those treated with antibiotics and those not treated with antibiotics). Data are entered into the log form and then logged electronically. The log form is then filed in the resident's file. All infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator, which is supplied to management and head office. Standardised definitions of infections are in place throughout Oceania and are 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 action plans are put in place. internal audits occur (last audit was completed in May 2013). There is close liaison with the GP's who advise and provide feedback to the service .

Quality Improvement initiatives are developed and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. Infection numbers are counted per month and graphed. The numbers of infections per month per area are very low. Oceania benchmarks infection rates between facilities over time and results are displayed to inform all staff. There is a flu vaccination programme in place. The manager forwards infection rates data as per clinical indicators which are reported to Oceania Support Office monthly. Oceania benchmarks the clinical indicators against other similar Oceania sites. Reports for 2013 were sighted.

**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:**