

Oceania Care Company Limited - Woburn Rest Home

CURRENT STATUS: 16-Sep-13

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

GENERAL OVERVIEW

Oceania Woburn provides care for up to 33 residents at rest home and dementia level care. Occupancy during the audit was 27 residents with 17 in the rest home and 10 of 11 using dementia services.

There is an Oceania management team that provides support for the service including the quality and clinical manager who meets monthly with the facility manager. The facility manager is a registered nurse with a current annual practicing certificate and has six years' experience in aged care and experience in an intensive care unit. Staffing is appropriate to the needs of the residents with staff working in the dementia unit trained in dementia care.

Oceania has an organisational total quality management plan and key operations quality initiatives that are implemented at Woburn. The quality and risk management programme includes management of complaints, incidents, accidents, health and safety and hazards with maintenance kept up to date. There is an internal audit programme implemented.

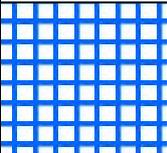
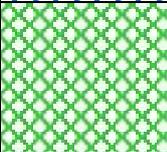
All residents and relatives spoke positively about the care and support provided by staff and management.

There are improvements required around sign off of resolution of corrective actions, care planning interventions and discussion of infection control data at meetings.

AUDIT SUMMARY AS AT 16-SEP-13

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained

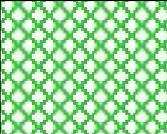
Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

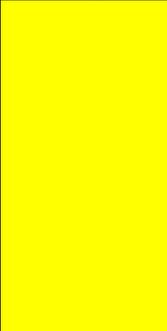
Consumer Rights	Day of Audit 16-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained

Organisational Management	Day of Audit 16-Sep-13	Assessment
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk

Continuum of Service Delivery	Day of Audit 16-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk

Safe and Appropriate Environment	Day of Audit 16-Sep-13	Assessment
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained

Restraint Minimisation and Safe Practice	Day of Audit 16-Sep-13	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained

Infection Prevention and Control	Day of Audit 16-Sep-13	Assessment
Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk

AUDIT RESULTS AS AT 16-SEP-13

Consumer Rights

The service displays posters and pamphlets describing the Code of Health and Disability Services Consumers' Rights. Information about resident rights is also provided on admission to the facility. There is a complaints management process that meets the requirements of Right 10 of the Code. Staff and residents are aware of the complaints process and there is an up to date register documented. Resident values and beliefs are discussed in the initial assessment phase following admission and are documented in resident files. Staff are trained in resident rights and apply these in practice. Residents are encouraged to participate in community activities when possible and are supported to access activities that interest them.

Residents and family have the opportunity to participate in a residents' meeting and there are annual satisfaction surveys for both residents and family. The service has in place a policy for informed consent. Required consent forms are evident in resident files reviewed. Residents and family interviewed praised the service for excellence of support provided.

Organisational Management

The day-to-day services of the facility are overseen by the facility manager (registered nurse) who is supported by a clinical and quality manager with a registered nurse providing support for all clinical activities. The facility manager is experienced and educated to perform the roles of authority identified in their job descriptions.

Quality and risk management systems reflect the principles of continuous quality improvement and meet contractual requirement with the District Health Board. Human

resources management processes are conducted in accordance with good employment practice and legislative requirements. Staff skill mix and staffing numbers mean that residents are well supported and there is a training programme implemented relevant to the roles of staff. Staff in the dementia unit are trained in managing challenging behaviour and in dementia related topics.

The service has implemented policies around the management of consumer records and integrated files. All entries into the integrated file are legible, signed and dated.

Key improvements in the service since the last certification audit have focused on making the dementia unit and reception area more welcoming and improving implementation of policies including documentation, medication, frequency of meetings, care planning including personalising of these.

An improvement is required to sign off resolution of corrective actions.

Continuum of Service Delivery

The service have clearly documented assessment and screening criteria for admission to the facility. Residents are only declined entry when the needs of the resident are greater than what the service can render or when there is not bed available.

Services are delivered within the timeframes as required by their contract and each stage of service is provided by suitably qualified and experienced staff members .

The person centred care plans in the rest home identify goals for all the residents' needs, as identified through assessment, however the care plans do not consistently describe the required interventions to achieve these goals.

The previous requirement for improvement relating to the dementia unit's care plans not including habits, routines, idiosyncrasies and specific behaviour management strategies for challenging behaviour is now fully implemented. Nursing and GP evaluations and assessments are documented, resident focussed and record the degree of achievement towards meeting the desired outcomes

Activities are planned and provided to ensure residents maintain skills, resources and interests that are meaningful to them.

The service has a management system implemented to ensure safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicines reconciliation which are aligned with and comply with legislation, protocols and guidelines. The service ensures all staff members responsible for medicines management processes are competent. There are no residents that self-administer medicines. Food, fluid and nutritional needs of residents are provided within recognised guidelines appropriate to the service.

An improvement is required to ensure care planning interventions are fully documented.

Safe and Appropriate Environment

In-service education, which includes specific learning related to healthcare waste, emergency procedures and appropriate security measures, to keep residents and visitors

safe, is undertaken by all staff. Residents are provided with safe, adequate, age appropriate facilities that are furnished to reflect the home like nature of the resident's needs. There is a reactive maintenance process and a long term maintenance programme in place. Safe and hygienic cleaning and laundry services are provided for residents and the facility is clean, neat and tidy. All laundry is carried out on site. The service has adequate heating and air-conditioning throughout. There is a dedicated outdoor smoking area which does not expose non-smokers to tobacco smoke. The dementia unit is secure and residents were settled on the days of the audit.

Restraint Minimisation and Safe Practice

The responsibility for the restraint process and approval of restraints and or enablers are clearly defined in policy. The service do not currently use any restraints and the service has one rest home resident who uses an enabler. The GP confirms restraint use is actively minimised. The responsibility for restraint is clearly defined in the restraint coordinator's position description and lines of accountability are documented. The tour of the facility did not identify any use of restraint in the rest home or the dementia unit.

Infection Prevention and Control

Woburn infection prevention and control policies and procedures implemented by the service reflect accepted good practice and infection prevention and control principles in care delivery. There are adequate resources to allow for a managed environment which minimises the risk of infection to residents, staff and visitors. The programme is relevant to the size and scope of the service and is monitored by the infection control co-ordinator (facility manager). The infection control co-ordinator ensures the surveillance methods are adhered to and monthly infection surveillance data are recorded, collated and reported to management through monthly reporting to head office.

An improvement is required to documentation of discussion of infection control data.

Woburn Home

Oceania Care Company Limited

Certification audit - Audit Report

Audit Date: 16-Sep-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RGON MN, MBA Lead auditor, B Ed, Dip Tchg, Adv Dip Child and Family Health	11.00	6.00	16-Sep-13 to 17-Sep-13
Auditor 1	XXXXXXXX	RN, LA RABQSA	11.00	6.00	16-Sep-13 to 17-Sep-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX	RN, BN, Lead Auditor		3.00	

Total Audit Hours on site	22.00	Total Audit Hours off site <i>(system generated)</i>	15.00	Total Audit Hours	37.00
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Staff Records Reviewed	6 of 30	Client Records Reviewed <i>(numeric)</i>	8 of 27	Number of Client Records Reviewed using Tracer Methodology	2 of 8
Staff Interviewed	6 of 30	Management Interviewed <i>(numeric)</i>	2 of 2	Relatives Interviewed <i>(numeric)</i>	5
Consumers Interviewed	6 of 27	Number of Medication Records Reviewed	16 of 27	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	1

Declaration

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

I confirm that Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 23 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

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified													
				Hospital Care							Rest Home Care		Residential Disability Care				
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability	
Woburn Home	33	27		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

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All residents and relatives spoke positively about the care and support provided by staff and management.

There are improvements required around sign off of resolution of corrective actions, interventions and discussion of infection control data.

1.1 Consumer Rights

The service displays posters and pamphlets describing the Code of Health and Disability Services Consumers' Rights. Information about resident rights is also provided on admission to the facility. There is a complaints management process that meets the requirements of Right 10 of the Code. Staff and residents are aware of the complaints process and there is an up to date register documented. Resident values and beliefs are discussed in the initial assessment phase following admission and are documented in resident files. Staff are trained in resident rights and apply these in practice. Residents are encouraged to participate in community activities when possible and are supported to access activities that interest them.

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1.2 Organisational Management

The day-to-day services of the facility are overseen by the facility manager (registered nurse) who is supported by a clinical and quality manager with a registered nurse providing support for all clinical activities. The facility manager is experienced and educated to perform the roles of authority identified in their job descriptions.

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1.3 Continuum of Service Delivery

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1.4 Safe and Appropriate Environment

In-service education, which includes specific learning related to healthcare waste, emergency procedures and appropriate security measures, to keep residents and visitors safe, is undertaken by all staff. Residents are provided with safe, adequate, age appropriate facilities that are furnished to reflect the home like nature of the resident's needs. There is a reactive maintenance process and a long term maintenance programme in place. Safe and hygienic cleaning and laundry services are provided for residents and the facility is clean, neat and tidy. All laundry is carried out on site. The service has adequate heating and air-conditioning throughout. There is a dedicated outdoor smoking area which does not expose non-smokers to tobacco smoke. The dementia unit is secure and was settled on the days of the audit.

2 Restraint Minimisation and Safe Practice

The responsibility for the restraint process and approval of restraints and or enablers are clearly defined in policy. The service do not currently use any restraints and the service has one rest home resident who uses an enabler. The GP confirms restraint use is actively minimised. The responsibility for restraint is clearly defined in the restraint coordinator's position description and lines of accountability are documented. The tour of the facility did not identify any use of restraint in the rest home or the dementia unit.

3. Infection Prevention and Control

Woburn infection prevention and control policies and procedures implemented by the service reflect accepted good practice and infection prevention and control principles in care delivery. There are adequate resources to allow for a managed environment which minimises the risk of infection to residents, staff and visitors. The programme is relevant to the size and scope of the service and is monitored by the infection control co-ordinator (facility manager). The infection control co-ordinator ensures the surveillance methods are adhered to and monthly infection surveillance data are recorded, collated and reported to management through monthly reporting to head office.

An improvement is required to documentation of discussion of infection control data.

Summary of Attainment

1.1 Consumer Rights

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

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

1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	FA	0	2	0	0	0	3
Standard 1.2.2	Service Management	FA	0	1	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems	PA Low	0	7	1	0	0	9
Standard 1.2.4	Adverse event reporting	FA	0	2	0	0	0	4
Standard 1.2.7	Human resource management	FA	0	4	0	0	0	5
Standard 1.2.8	Service provider availability	FA	0	1	0	0	0	1
Standard 1.2.9	Consumer information management systems	FA	0	4	0	0	0	10

Organisational Management Standards (of 7):	N/A:0	CI:0	FA: 6	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 34):	CI:0	FA:21	PA:1	UA:0	NA: 0		

1.3 Continuum of Service Delivery

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

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 11	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:20	PA:1	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

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

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

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	FA	0	0	0	0	0	6
Standard 2.2.1	Restraint approval and processes	Not Applicable	0	0	0	0	0	3
Standard 2.2.2	Assessment	Not Applicable	0	0	0	0	0	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	0	6
Standard 2.2.4	Evaluation	Not Applicable	0	0	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	0	1

Restraint Minimisation and Safe Practice Standards (of 6):	N/A: 5	CI:0	FA: 1	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: 0	
Criteria (of 21):	CI:0	FA:0	PA:0	UA:0	NA: 0		

3 Infection Prevention and Control

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

Infection Prevention and Control Standards (of 5):									
N/A: 0	CI:0	FA: 4	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0			
PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0				
Criteria (of 29):	CI:0	FA:8	PA:1	UA:0	NA: 0				

Total Standards (of 50)	N/A: 5	CI: 0	FA: 42	PA Neg: 0	PA Low: 3	PA Mod: 0	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: 89	PA: 3	UA: 0	N/A: 0				

Corrective Action Requests (CAR) Report

Provider Name: Oceania Care Company Limited
 Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:16-Sep-13 End Date: 17-Sep-13
 DAA: Health Audit (NZ) Limited
 Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.2.3	1.2.3.8	PA Low	<p>Finding: Resolution of issues raised e.g. through internal audits, maintenance records is not always documented.</p> <p>Action: Document resolution of issues raised e.g. through internal audits.</p>	6 months
1.3.6	1.3.6.1	PA Low	<p>Finding: The PCCP's in the rest home do not consistently record interventions to support the goals and identified needs of the residents.</p> <p>Action: The person centred care plans (PCCP) to consistently record interventions to support identified needs and goals of residents.</p>	3 months
3.5	3.5.7	PA Low	<p>Finding: There is limited documentation of discussion of infection control in the meeting minutes</p> <p>Action: Document evidence of discussion of infection control including trends in the meeting minutes.</p>	6 months

Continuous Improvement (CI) Report

Provider Name: Oceania Care Company Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:16-Sep-13 End Date: 17-Sep-13

DAA: Health Audit (NZ) 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The code of health and disability rights is incorporated into care.

Discussions with three of three health care assistants (AM/PM/night with two staff working in the rest home and one in the dementia unit), the facility manager, the regional manager and the activities coordinator identified their familiarity with the code of rights.

A review of eight of eight care plans including five rest home and three dementia and monthly staff meetings confirms that the service functions in a way that complies with the code of rights.

Training around the code of rights and complaints was last provided in February 2013.

The auditors sighted respectful attitudes towards residents on the day of the audit and six of six rest home residents confirm that they are treated with respect and dignity with staff 'going the extra mile', 'excellent staff who are respectful and understanding'.

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 Ma L V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is a resident rights policy that includes roles and responsibilities.

D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, advocacy services and the code of rights. The resident information booklet states where the code of rights pamphlet, advocacy pamphlet and information around the Health and Disability Advocacy service can be found in the service and the facility manager states that this can be given when residents and family come to look at the service.

Code of rights leaflets and advocacy pamphlets are available at the main entrance and there are three posters in different languages (Maori, English and sign language) in the dementia unit.

If necessary, staff will read and explain information to residents. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.

Six of six rest home residents and five of five family members (two rest home and three dementia) interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process.

The service has started going over the rights at the end of each resident meeting two monthly (sighted in meeting minutes).

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>D3.1b, d, f, i The service has a philosophy that promotes quality of life and involvement for the resident in decisions about their care, respects their rights and maintains privacy and individuality.</p> <p>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. Interviews with six of six rest home residents and five of five family members (two rest home and three dementia) identify that personal belongings are not used as communal property.</p> <p>E4.1a Three family members interviewed stated that their family member was welcomed into the dementia unit and three of three family members from the dementia unit confirm that their family members are treated with respect and dignity - observed on the day of the audit.</p> <p>There are policies around independence, personal privacy, dignity and respect and these are referenced to the Privacy Act.</p> <p>D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified in the assessment and care plan and activity planning process.</p> <p>Six of six rest home residents and five of five family members (two rest home and three dementia) interviewed state that they receive respectful care and support. All state that staff knock before they enter the room and this was observed to occur on the day of the audit.</p> <p>Residents and family members interviewed as well as three health care assistants, registered nurse and the facility manager state that there is no evidence of abuse or neglect of residents and residents and family state that there is excellent care provided.</p>	

The health care assistants can describe the process of identifying and reporting any abuse or neglect.
Training around abuse and neglect has been provided for staff in November 2012.

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

D20.1i A3.2 Policies documented include a Maori perspective of health with cultural policies in place and there is a Maori Health Plan.

The service has policies to support practice i.e. guidelines for the provision of culturally safe services for Maori residents and cultural awareness. There is one Maori resident in the dementia unit and staff who identify as Maori.

Interviews with three health care assistants and registered nurse confirm that they are aware of the need to respond appropriately to individual cultural difference.

The service is working with two other Oceania facilities in Napier/Hastings to link the Maori resident into cultural programmes offered at their facilities. The facility manager states that there are no other Maori services available for the resident in Waipukurau currently. The service also encourages family to be involved in the resident's care and support and to provide a cultural perspective to the service as much as possible - confirmed by the family member interviewed.

The file reviewed specifically for the resident identifies that there is a cultural assessment completed with a plan that identifies the proposed links to other rest homes.

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

D3.1g The service provides a culturally appropriate service by asking residents and family members what their cultural needs are at each assessment and review and any needs are included in the activities plan and review.

D4.1c Eight of eight care plans and activity plans reviewed include the residents social, spiritual, cultural and recreational needs and this is consistently documented. During the admission process, the registered nurse and facility manager along with the resident and family complete the documentation. Reviews are evident in the files reviewed.

There are no residents who identify as requiring an interpreter however the facility manager is able to describe how an interpreter would be accessed through the DHB.

Staff were observed on the day of the audit to respect resident values by asking for their opinion and giving residents choice.

Five of five family members (two rest home and three dementia) felt that they were involved in decision making around the care of the resident and state that staff respect cultural beliefs and individual values. This was confirmed by the six residents interviewed.

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

Discrimination, harassment, professional boundaries and expectations are covered in the code of conduct that all staff are required to read and sign before commencing employment. Staff can describe how professional boundaries are maintained.

Discussions with the registered nurse and the facility manager and a review of the complaints register identify that there have been no complaints regarding alleged harassment, coercion, discrimination or abuse of any kind.

Six of six rest home residents and five of five family members (two rest home and three dementia) state that there is no evidence of abuse or neglect.

The GP interviewed state that there is no evidence of abuse or neglect and praised the service for the care provided.

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

A2.2 Services are provided at Woburn that adhere to the health and disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 All approved service standards are adhered to noting that some improvements are required as a result of this current audit for certification.

D17.7c There are implemented medication competencies for caregivers completed annually.

Three of three health care assistants interviewed describe the service as being an excellent place to work and they praise the manager and registered nurse for being approachable and hands on. They state that they have ample access to continence products and equipment (sighted with evidence of individualised continence products). They also described care for specific residents that is in line with the care plan documented and in line with good practice. The health care assistants interviewed have a sound understanding of principles of aged care and state that they have been supported by the service for on-going education including training around the aging process.

Six of six rest home residents and five of five family members (two rest home and three dementia) spoke very positively about the excellence of the care provided.

There are clear ethical and professional standards and boundaries within job descriptions.

All policies are updated by the external consultant in conjunction with the manager and director as required.

The facility manager, registered nurse and caregiver (team leader) from the dementia unit are able to describe best practice in the dementia unit with activities offered. On the two days of the audit, the dementia unit was observed to be very settled with interaction from staff and family members with residents.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>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. D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b Five of five relatives state that they are always informed when their family members health status changes. Interpreters are available through the DHB if required. There have been no residents who have required or do require interpreting services.</p> <p>D11.3 The information pack is available in large print if required and advised that this can be read to residents. Six of six rest home residents and five of five family members (two rest home and three dementia) interviewed state that there is good communication with the staff and all 'know' the facility manager, the registered nurse and staff. All family members state that they are informed when there is an incident and the incident forms reviewed (15 of 15) reviewed reflects this.</p> <p>Information around the dementia unit is provided to family as part of the welcome pack and this is individualised to Woburn. There are two monthly resident meetings (used to be monthly) and six monthly family meetings. Training last occurred for staff around open disclosure in September 2013.</p>	

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

Residents at Woburn are provided with information on choices to make an informed consent.

Woburn has well developed policies and procedures that support the provision of services and complies with the Code of Health and Disability Rights.

Information on code and complaints is available in reception and is included in the information pack and discussed with residents and families at admission (confirmed by residents and family interviewed). There is a consent form, an advance directive and a process relating to advance directives when the resident cannot consent.

All files sampled (eight of eight) have appropriate consent forms and resident deemed competent signed advanced directives (five of five rest home files reviewed completed appropriately).

All residents have end of life forms completed noting that none have advance directives.

ARC requirements are met

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 five of five family identified that the service provides opportunities for the family/EPOA to be involved in decisions.

ARC D4.1e, The resident file includes information on resident's family and chosen social networks.

Resident right to access advocacy services is identified for residents as part of the resident information pack and pamphlets are available in the service. The information identifies who the resident can contact to access advocacy services with phone numbers provided.

Staff are aware of the right for advocacy and how to access and provide advocacy information to residents if needed and training has been provided last in August 2013.

The service has booked Aged Concern to talk with residents about advocacy services at the end of October 2013.

Of the six residents interviewed, all are aware of rights and knew that there are pamphlets available in the facility.

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 five of five family indicate that they are encouraged to be involved with the service and care.

D3.1.e Discussion with three of three health care assistants, the facility manager, registered nurse and five of five relatives confirms that the service supports and encourages residents to remain involved in the community and external groups. Examples of links into the community include shopping, visiting family and two who attend their own church services.

There are progress notes (stamp that records family communication) and a family communication page and this records communication with family. Visitors were sighted coming and going on the days of the audit and were welcomed into the service.

All family members interviewed state that they are always made to feel welcome and a part of the service and state that they can visit whenever they like including three of three in the dementia unit.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has complaints management policies and procedures in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack.

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

D13.3g: The complaints procedure is provided to relatives on admission as confirmed by five of five family interviewed.

Staff including the three health care assistants are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau.

Residents and family confirm they are aware of the complaints process and they would make a complaint to the manager if necessary.

There is a complaints register in place. Three complaints tracked indicate that the issues and responses are addressed as per timeframes in the policy. The manager states that there have been no complaints that have required authorities to be notified and none have been lodged with the HDC.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>The philosophy is documented and this is included in the welcome pack.</p> <p>Oceania has extensive support systems in place for managers and clinicians and the service has a regional manager. The regional manager interviewed is a registered nurse and has previous experience as a clinical manager at rest home, hospital and dementia level.</p> <p>The facility manager is a registered nurse with a current APC and she has six years' experience in aged care and experience in ICU. The facility manager states that the regional manager provides support and there are monthly meetings and meetings as required between the facility manager and quality and clinical manager. The quality and clinical manager has monthly quality and clinical meetings with the general manager clinical and quality and other regional managers.</p> <p>The facility manager provides a monthly report to the operations manager who provides operational oversight for the service.</p> <p>The GP interviewed praised the service for continuing improvements in care as the occupancy has increased.</p> <p>The service provides rest home and dementia level care for a potential 33 residents with 27 occupied on the day of the audit (17 rest home and 10 of 11 dementia).</p> <p>ARC,D17.3di (rest home, dementia), The facility manager has maintained more than eight hours annually of professional development activities related to managing the service.</p>	

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

There is a quality and clinical manager and operations manager who provide support for the service. The regional manager provides second in charge in the absence of a facility manager. The facility manager states that this has not been an issue to date as she has not required leave at this point. The quality and clinical manager is supported by the registered nurse who would pick up an extra day (currently works 32 hours a week).

ARC requirements are met

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that there are service operational management strategies and an implemented quality and risk programme which includes individually appropriate care.

There is a Woburn quality plan 2013 that is reviewed through staff and health and safety meetings (minutes sighted). The plan focuses on key components of the quality programme.

The service has Oceania policies and procedures and associated implementation systems to provide a 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. Policies and procedures 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.

D5.4 The service has the following policies/ procedures to support service delivery; continence, challenging behaviour, pain management policy and procedure, personal grooming and hygiene policy, skin, wound care policy and procedures. Transportation of subsidised residents policy and procedure includes costs, resident, and staff safety.

Interviews with three health care assistants, the registered nurse and the facility manager confirm that this is a successful method for communicating changes to policy. The facility manager reports she discusses policy updates in staff meetings, confirmed by review of staff meeting minutes and the regional manager confirms that she ensures that the service has updated policies.

D19.3 There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. There are policies around management of challenging behaviour, restraint and enablers and a health and safety management system.

There is a quality and risk management programme being implemented at Woburn. The monitoring programme includes restraint compliance, building compliance, cleaning, consent, consent, fire, food service, individual care plans, infection control and hand washing, laundry services, lifting medication, privacy

of information, resident admission, resident care, activities, resident rights, safety, resident satisfaction, staff education disturbing behaviour management. Frequency of monitoring is determined by the internal audit schedule. Corrective action plans are in place to address issues identified through surveys, audits and other quality improvement measures with evidence of resolution in some audits and against other data documented including meeting minutes.

D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and managing this population appropriately. After each fall, there is a post falls analysis completed as sighted in a review of incidents and accidents. Other strategies for managing falls include mattresses with support trialled, sensor mats.

A resident satisfaction survey last completed in August 2013 indicates that there is a high level of satisfaction from the 18 questionnaires returned.

Monthly meetings are in place that include health and safety, staff meetings including quality and infection control, restraint meetings three monthly. There are six monthly family meetings (last held in March 2013) and two monthly resident meetings (used to be monthly). Minutes sighted indicate that meetings are held as per schedule.

There is a preventative maintenance schedule completed annually and this includes documentation of maintenance completed in 2013.

There is a risk management register and hazards documented. A review of these indicate that these are signed off when resolved. A list of current hazards is kept with actions implemented to proactively prevent accidents.

Key improvements in the service since the last certification audit have focused on making the dementia unit and reception area more welcoming and improving implementation of policies including documentation, medication, frequency of meetings, care planning including personalising of these.

Improvements are required to ensuring that resolution of issues raised e.g. through internal audits is documented.

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

There is a quality and risk management programme being implemented at Woburn. The monitoring programme includes restraint compliance, building compliance, cleaning, consent, consent, fire, food service, individual care plans, infection control and hand washing, laundry services, lifting medication, privacy of information, resident admission, resident care, activities, resident rights, safety, resident satisfaction, staff education disturbing behaviour management. Frequency of monitoring is determined by the internal audit schedule.

Corrective action plans are in place to address issues identified through surveys, audits and other quality improvement measures with evidence of resolution in some audits and against other data documented including meeting minutes.

Finding Statement

Resolution of issues raised e.g. through internal audits, maintenance records is not always documented.

Corrective Action Required:

Document resolution of issues raised e.g. through internal audits.

Timeframe:

6 months

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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

Incidents/accidents are investigated and analysis of incidents trends with graphs documented occurs monthly. There is a discussion of incidents/accidents in monthly staff meetings and graphs are displayed on the notice board in the staff room.

Discussions with the quality and clinical manager and the facility manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has not been a need to notify authorities since the service was opened.

There is an open disclosure policy and five of five family members interviewed stated they are informed of changes in health status.

15 of 15 incident forms reviewed indicate that family are informed in the event of an incident.

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

D17.7d: There are implemented competencies for all registered nurses around medication and evidence in an registered nurse file that these have been completed.

Current practicing certificates are sighted for the registered nurse and facility manager. Current APC's are also included for health professionals associated with the service e.g. doctor, podiatrist, pharmacist.

Six of six staff files include a signed contract, application form, evidence of training and job description.

Six of six files reviewed indicate that staff have completed an orientation programme that is relevant to support for people using rest home level and dementia level care - confirmed by the health care assistants.

E4.5f Three of three health care assistants who work in the dementia unit have completed the Oceania certificate in residential care through Tairawhiti polytechnic dementia unit training. Two health care assistants have also completed the 'walking in another's shoes' training programme provided by the DHB and one is enrolled.

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 are not used in the service and any casual staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

The registered nurse and facility manager confirm that they have completed at least eight hours training a year (training records sighted).

Six of six rest home residents and five of five family members (two rest home and three dementia) interviewed state that staff are competent, caring and knowledgeable. They also state that the registered nurse and the facility manager are very visible and state that this provides leadership for the service and provides a point of contact for them.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are policies, systems and a roster in place that meets the requirements of the contract and supports safe staffing levels for service delivery. There are HR policies in place that outlines staffing responsibilities, staff levels and skill mix of the rest home, 24 hour on call management availability.

There are 30 staff including the facility manager, registered nurse (30 hours a week), 19 health care assistants, 1 maintenance/grounds man, 1 diversional therapist and 1 activities coordinator, three kitchen cooks and two kitchen assistants.

There is a roster in place that meets the contract requirements - sighted with evidence that staff are replaced if off sick.

Staff are rostered as follows:

Dementia unit: A health care assistant on duty as follows - 6.45am-3.30 am, 7.30am-1030am, 4.30pm-8.30pm, 3.15pm-11pm, 10.45pm-7am.

Rest home: A health care assistant on duty as follows: 7am-3.30 (senior caregiver), 8.30am-10am, 3pm-11pm, 4pm-11pm, 10.45pm-7am, 11pm-2am.

Three of three health care assistants (AM/PM/night with two staff working in the rest home and one in the dementia unit), the facility manager, the regional manager and the registered nurse interviewed report that there are enough staff on duty and they are able to get through the work allocated to them. Staff interviewed confirm that the roster provides adequate cover.

The facility manager provides on call services at all times.

Both residents and family interviewed confirm there are sufficient staffing levels to meet resident's needs and the health care assistants confirm that when they have had to seek advice from the facility manager on call, there is always support there.

The registered nurse and health care assistants are aware of when to call emergency services.

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 service retains relevant and appropriate information to identify residents and track records. This includes information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service.

There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.

D7.1 Entries are legible, include dates and are signed by the relevant health care assistant, registered nurse, manager including designation.

Individual resident files demonstrate service integration (eight of eight reviewed). This includes medical care interventions and records of the activities officer. Medication charts are in a separate folder with medication and this is appropriate to the service.

ARC requirements are met

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
Assessment and screening criteria for entry to the service are clearly communicated to residents and their family of choice as well as the referral agency, confirmed during the facility manager and the RN interview. Sighted the information pack that is given to new residents and their family / whanau on admission. ARC requirements are met.	

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

Interviews with the facility manager and RN confirm decline of entry when the resident's needs are beyond the scope of service delivery for the facility e.g. hospital level of care and when the service do not have any available beds. Sighted the information pack that is given to new residents and their family / whanau on admission which includes information relating to the scope of the service.

ARC requirements are met.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Each stage of service is provided by suitably qualified and experienced staff members. The RN on duty leads the team and is responsible for assessments, care planning, evaluation and review and exit from the service.

The stages of service provision is provided with in the timeframes that safely meeting the needs of residents. Nursing reviews occur six monthly and the medical reviews are completed by the GP's on a three monthly basis, however interventions are not consistently recorded to support identified goals (refer 1.3.6.1) ARC requirements are met.

Tracer methodology - Rest Home:

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.

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

The needs, outcomes and goals of residents are identified through the assessment processes and are documented, serving as the basis for the person centred care plans, sighted assessments for all the resident files reviewed and confirmed at the clinical leader and the facility manager interviews.

ARC requirements are met.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>The person centred care plans (PCCP) in the rest home identify goals for all the residents' needs, as identified through assessment, however the PCCP's do not consistently describe the required interventions to achieve these goals (refer see 1.3.6.1).</p> <p>The service use 24-hour challenging behaviour management plans with a 'behaviour clock' divided into two-hourly timeframes, showing what type of behaviour is to be expected at what time of the day and identified interventions for management of that behaviour, sighted documentation and confirmed during the facility manager and the RN interviews. The service has a challenging behaviour monitoring record which describe the types of behaviour, recording the day, time the type of behaviour and the staff member signing.</p> <p>ARC requirements are met.</p>	

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: FA	Risk level for PA/UA:
Finding Statement		

Corrective Action Required:

Timeframe:

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

Residents receive adequate and appropriate services in order to meet their assessed needs, confirmed at the clinical leader and the facility manager interviews.

The dementia unit's PCCP's include the habits, routines, idiosyncrasies and specific behaviour management strategies for challenging behaviour and other goals and needs of the residents, however the PCCP's in the rest home do not consistently record interventions to support the goals and identified needs of the residents. ARC requirements are not fully met.

Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

The dementia unit's PCCP's include the habits, routines, idiosyncrasies and specific behaviour management strategies for challenging behaviour and other goals and needs of the residents, however the PCCP's in the rest home do not consistently record interventions to support the goals and identified needs of the residents.

Finding Statement

The PCCP's in the rest home do not consistently record interventions to support the goals and identified needs of the residents.

Corrective Action Required:

The person centred care plans (PCCP) to consistently record interventions to support identified needs and goals of residents.

Timeframe:

3 months

STANDARD 1.3.7 Planned Activities

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Activities are planned and provided to ensure residents maintain skills, resources and interests that are meaningful to them. The activities are coordinated by a diversional therapist and an activities coordinator, taking turns working one week on and one week off. The service developed two different activities programmes for the rest home and dementia unit, focussing on the specific needs, wants and abilities of the residents in the areas of care, sighted the activities programmes, attendance records and confirmed at the activity coordinator's interview. Interviews with residents in the rest home and family members of the residents in the dementia unit confirm they are satisfied with the activities offered by the service and enjoy participating. ARC requirements are met.

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

Nursing and GP evaluations and assessments are documented, resident focussed and record the degree of achievement towards meeting the desired outcomes, sighted nursing evaluations of person centred care plans, risk assessment evaluations and confirmed at the RN, the GP and family interviews. Evaluations are documented and resident focussed. ARC requirements are met.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Residents are given the choice and have options to access other health and disability services in the community, c confirmed during resident, family and the RN interviews. The resident files reviewed show evidence of residents being referred to services in the community.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Staff members confirm that risks are identified and reduced for residents when in transition, exiting, being discharged or transferred to other services. The service provider documents personal information of residents, contact details of the next of kin, observations, weight, blood glucose levels, food and fluids, known allergies, diseases, pain assessment, current conditions, mobility aids and copy of the medication chart, a mini care plan and the latest progress notes to minimise risks for the residents during transition, exit, discharge or transfer, sighted records and confirmed during the clinical leader, RN and facility manager interviews and sighted transfer documents in resident files.

ARC requirements are met.

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: FA
<p>The service has a management system implemented to ensure safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicines reconciliation which are aligned with and comply with legislation, protocols and guidelines, sighted the medicines management policies and confirmed during the RN and the business and care manager interviews.</p> <p>The service ensures all staff members responsible for medicines management processes are competent, sighted competencies for two RN's and 12 health care assistants (HCA's).</p> <p>There are no residents that self-administer medicines, confirmed at the RN interview and residents were not observed administering their own medicines during the onsite audit, also confirmed during the GP interview. Observed a medicines round on the second day of the onsite visit.</p>	

Medicines management information is recorded to a level of detail that comply with legislation and guidelines, assessed 10 medicines charts in the rest home and eight in the dementia unit. Medicines charts are legible, doctor's reviews are within three months, the GP signs and dates each entry as well as each discontinued medicine, allergies and sensitivities of residents are recorded and all charts have photo identification.

ARC requirements are met.

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: 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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Food, fluid and nutritional needs of residents are provided within recognised guidelines appropriate to the service. Sighted the summer menu review approved on 10 September 2013. Residents with additional needs or requirements have their needs met, the RN sends a copy of the nutritional assessment to the cook who uses the information to ensure residents dietary needs are met, confirmed at the RN, the cook, resident and family interviews. ARC requirements are met.

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

There are implemented policies to guide staff in waste management.

Three of three health care assistants and the maintenance staff interviewed are aware of practices outlined in relevant policy.

Gloves, aprons, and goggles are available for staff.

Infection control policies state specific tasks and duties for which protective equipment is to be worn.

Chemicals are labelled and there is appropriate protective equipment and clothing for staff.

There is a locked cupboard for chemicals and this remained locked at all times during the audit.

ARC requirements are met

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

Legislation and regulatory requirements appear to be met for local authorities and the MoH. Building maintenance is carried out when necessary and records maintained.

There is access to necessary and essential equipment.

The building holds a current warrant of fitness which expires on 23/3/14. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2013.

Health and Safety meetings include maintenance and preventative maintenance.

The facility is carpeted with vinyl surfaces in bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet or lino if required. The corridors are carpeted. Hand rails are available around the hall ways. There is adequate space around the facility for storage of mobility equipment.

There is an outside area with shade and seating that is observed to be well maintained with paths and handrails.

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, one hoists, heel protectors, transfer belts. Interviews with three health care assistants from the dementia unit confirm there was adequate equipment.

E3.3e: There are quiet, low stimulus areas that provide privacy when required in the dementia unit.

E3.4.c There is a safe and secure outside area that is easy to access with a circular path with four entry points back into the service.
Staff have last received training around chemical management in May 2013.
ARC requirements are met

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 service is divided into two areas - rest home and dementia unit. There are adequate numbers of toilets and showers with access to a hand basin and paper towels. There are 19 rooms in the rest home which have ensuites. The dementia unit has five toilets and a staff toilet with the resident toilets located between each room.

Communal toilets in the rest home are located near the lounge. There is a staff toilet and shower in the rest home and a visitor's toilet.

ARC requirements are met

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Residents rooms are of an appropriate size in both the rest home and dementia unit to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in toilet and bathroom areas. The lounge areas in each area are spacious and activities for all residents are able to be carried out in the lounge areas.

ARC requirements are met

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Each area has a lounge. There is a separate dining area for each area.
Seating and space is arranged to allow both individual and group activities to occur.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander with a large outdoor area.
ARC requirements are met

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The Oceania group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry (March 2013 with 100% compliance) and cleaning audits (April 99.4% compliance) are completed as per the internal audit programme.

The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Laundry chemicals are within a closed system (Ecolab) to the washing machine.

Material safety data sheets are displayed and there is secure chemical storage areas.

The laundry and cleaning areas have hand-washing facilities.

The cleaners were observed during the audit including in the dementia unit and staff always have the trolley within sight.

ARC requirements are met

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 Mal 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. The Oceania group emergency and disaster manual includes dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. Emergencies, first aid and CPR is included in the mandatory in-services programme every two years. Regular fire drills are completed - last completed in October 2012 and April

2013 - records sighted with the fire service attending every second drill - confirmed in records. The fire service also gives a talk which includes information around emergencies including tsunamis, floods and earthquakes - last provided October 2013.

All staff have a current first aid certificate - sighted in six of six files reviewed. There are always at least two staff on duty with first aid certificates - sighted in rosters reviewed.

The service has alternative cooking facilities (gas BBQ with two gas bottles) available in the event of a power failure. Battery operated emergency lighting is in place for two hours. There are also extra blankets available. There is a civil defence kit for the whole facility stored in the dementia unit. There is water storage available. There is a civil defence folder that includes procedures specific to the facility and organisation. There is sufficient food in an emergency for over a week for all residents. The facility manager confirms that there is sufficient water for residents for three days in the event of an emergency in large storage tanks in the roof.

Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. There are two pagers carried by the senior caregivers in the rest home (the dementia unit pager is away getting repaired). The caregiver in the dementia unit and the senior carer in the rest home carry walkie talkies and can communicate at any time.

There are emergency bells in communal areas e.g. the lounge in the dementia unit which connects to the call bell system. These operate as panic buttons. There is one in the lounge in the rest home area.

The entire facility is secured at night and there are security lights outside. There is a bell outside the reception area for visitors who need to access the service at night. Visitor's book and resident sign out book available. The service has a security check audit - last completed last in May 2013 with 100% compliance.

Review of documentation provides evidence of a letter from New Zealand Fire Service dated the 21 June 2000 approving the fire evacuation scheme for the facility (evacuation plan dated 13/3/2000).

ARC requirements are met

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

General living areas and resident rooms are appropriately heated and ventilated. There is electric heating in the dementia unit and radiators in the rest home. All rooms have external windows with plenty of natural sunlight.

Six of six rest home residents and five of five family members (two rest home and three dementia) confirm that there is adequate heating at all times.

ARC requirements are met

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:

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

There are comprehensive infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. There are policies including infection control management and a documented IC programme. Policies include hand washing, standard precautions, single use items, MRSA, PPE. There are clear lines of accountability to report to the facility manager on any infection control issues and the facility manager reports to head office through the operations and quality and clinical manager on a monthly basis.

There is a job description for the infection control coordinator.

The infection control coordinator can describe how they would manage an outbreak noting that the facility manager (infection control coordinator) states that there have not been any outbreaks in the service.

An annual infection control report has been completed by Oceania in April 2013 - report sighted with the next annual review to be completed in February 2014.

ARC requirements are met

Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

The infection control coordinator (facility manager - registered nurse) can describe access to the infection control nurse and specialist through the DHB. Oceania's management team and the GP provide input into infection control when required. Oceania is engaging an infection control nurse specialist to review annual policy and practice.

The infection control coordinator attends infection control training through attendance at the bi-monthly DHB infection control meetings and last completed the full day infection control training in September 2012 through the DHB.

The registered nurse and facility manager have access to infection control information through the internet if required.

ARC requirements are met

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

There is comprehensive infection control policies that supports the Infection Control Standard SNZ HB 8134:2008. There are modified dates identified for all infection control policies and procedures. Policies are documented as reviewed April 2013.

The policies include written material relevant to the service. The infection control policies link to other documentation and uses references where appropriate.

D 19.2a: Infection control policies include hand hygiene, standard precautions, staff illness, outbreak management, cleaning and disinfection, single use items and construction/renovations.

The facility manager and staff interviewed including the facility manager and three health care assistants are familiar with the infection control policies.

ARC requirements are met

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

Infection control training is provided by the infection control coordinator and the DHB. Training includes hand washing, outbreak information, standard precautions and topical issues.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. Resident meeting minutes include feedback on infection prevention and control.

Infection control training last occurred for staff in June and September 2013 and staff complete annual hand washing competencies - training records sighted in six of six files reviewed.

ARC requirements are met

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

The surveillance policy is documented. The staff meeting meets monthly and also act as the infection control committee. A monthly infection summary report is completed. Surveillance methods and processes including implementation of an internal audit (last completed May 2013 with 82% compliance) are appropriate for the size of this facility (rest home and dementia level). All infections are collected via the infection report form.

Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.

The infection control coordinator then completes a monthly infection summary which is expected to be discussed at staff meetings.

An improvement is required to documentation of discussion of infection control in the meeting minutes noting that the facility manager and the three health care assistants can describe the infections.

ARC requirements are met

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: PA

Risk level for PA/UA: Low

The infection control coordinator then completes a monthly infection summary which is expected to be discussed at staff meetings.
The facility manager and the three health care assistants can describe the infections in the service.

Finding Statement

There is limited documentation of discussion of infection control in the meeting minutes

Corrective Action Required:

Document evidence of discussion of infection control including trends in the meeting minutes.

Timeframe:

6 months