

## **Oakwoods Lifecare (2012) Limited**

**CURRENT STATUS: 10-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**

Oakwood Lifecare is certified to provide rest home and hospital level care for up to 83 residents which includes 35 serviced apartments. On the day of the audit there were 42 residents (18 hospital and 24 rest home). Family and residents interviewed all spoke positively about the care and support provided. The service has continued to implement the quality and risk management system and identify and improve shortfalls.

This audit identified improvements required by the service in the following areas; medication management, infection control, nursing assessments, care plan documentation, an aspect of restraint documentation and the monitoring of fridge/freezer temperatures.

### **AUDIT SUMMARY AS AT 10-SEP-13**

Standards have been assessed and summarised below:

#### **Key**

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights	Day of Audit 10-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.		<b>Standards applicable to this service fully attained</b>

Organisational Management	Day of Audit 10-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.		<b>Standards applicable to this service fully attained</b>

Continuum of Service Delivery	Day of Audit 10-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.		<b>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk</b>

Safe and Appropriate Environment	Day of Audit 10-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.		<b>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk</b>

<b>Restraint Minimisation and Safe Practice</b>	Day of Audit 10-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.		<b>Some standards applicable to this service partially attained and of low risk</b>
<b>Infection Prevention and Control</b>	Day of Audit 10-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.		<b>Some standards applicable to this service partially attained and of low risk</b>

## AUDIT RESULTS AS AT 10-SEP-13

### Consumer Rights

Residents and their families/whānau are informed of their rights as part of the resident information pack. Residents stated that caregivers always respected their privacy and this is reinforced through the training with caregivers. Initial and on-going assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. Residents are encouraged to continue with their spiritual activities.

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

### Organisational Management

Oakwood Lifecare has a quality and risk management system in place that is being implemented. This includes a set agenda for the staff meetings that ensures that all aspects of the quality improvement system is reviewed, discussed and corrective actions signed off. Key components of the quality management system including management of complaints,

implementation of an internal audit schedule, incidents and accidents, review of infections through the surveillance programme, review of risk and monitoring of health and safety including hazards and maintenance (planned and reactive) to the building and grounds. There are meetings held regularly to ensure that all aspects of the quality and risk management programme are discussed with relevant staff including the weekly heads of department (HOD) meeting, monthly quality improvement meetings, infection control and health and safety committee, registered/enrolled nurse meetings, two monthly diversional therapy meetings and monthly care facility meetings. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents. Family, staff residents and family state that there are sufficient staff on duty at all times.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

### **Continuum of Service Delivery**

Oakwood Lifecare has documented entry criteria, which is communicated to residents, family and referral agencies. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Resident and family interviewed confirmed their input into care planning, care evaluations and access to a typical range of life experiences and choices. Documentation and observations made of the provision of services demonstrate that consultation and liaison is occurring with other services and residents interviewed confirm that care provided is consistent with meeting their needs. Sampling of residents' clinical files validates the service delivery to residents. Aspects of assessments and documented interventions require improvement. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes and this is noted on a short term care plan. Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. An appropriate medicine management system is implemented. Policies and procedures record service provider responsibilities. Staff responsible for medicine administration are trained and have current medication competencies. Improvements are required in relation to aspects of medication management. Food service is provided on site and kitchen staff have completed food safety training. Freezer temperatures require monitoring. Residents' individual needs are identified, documented and reviewed on a regular basis.

### **Safe and Appropriate Environment**

Oakwood Lifecare has documented processes for waste management. The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemical safety training is provided to staff. Improvements are required around safe chemical storage and management. There is a current building warrant of fitness. The maintenance role entails checks for safety of the facility and implementing requests from the maintenance book. The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid

certificate. All rooms are single with hand basin facilities. Some have partial ensuites. Sufficient shower and toilet facilities are available. General living areas and resident rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. There are outside paved areas with suitable furniture and natural shading. Residents are being provided with safe and hygienic cleaning and laundry services, which are appropriate to the setting.

### **Restraint Minimisation and Safe Practice**

Oakwood Lifecare has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option. There are four residents with an enabler (bedrail) in use and three restraints (bedrails, and one resident also has a lap belt.) The restraint coordinator, nurse manager, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. Staff receives training on restraint minimisation and managing residents' behaviours that can be challenging. There is an improvement required around restraint documentation.

### **Infection Prevention and Control**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service.

There is an established and implemented infection control programme that is linked into the risk management system. The combined health and safety and infection control committee includes a cross section of staff all areas of the service.

The infection control co-ordinator (enrolled nurse) and contracted quality consultant are responsible for the development of the infection control programme and its review. The programme is reviewed annually. The facility has access to professional advice as it has developed close links with the G.P's, local laboratory the infection control and public health departments.

There are three monthly health and safety and infection control meetings. The meetings include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and care facility meetings. Minutes are available for staff. Staff attend education on infection control annually.

# **Oakwoods Lifecare**

Oakwoods Lifecare (2012) Limited

Certification audit - Audit Report  
Audit Date: 10-Sep-13

## Audit Report

To: HealthCERT, Ministry of Health

<b>Provider Name</b>	Oakwoods Lifecare (2012) Limited
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Premise Name	Street Address	Suburb	City
Oakwoods Lifecare 2012	357 Lower Queen Street	Richmond	Nelson

<b>Proposed changes of current services</b> (e.g. reconfiguration):

<b>Type of Audit</b>	Certification audit and ( <i>if applicable</i> )	
<b>Date(s) of Audit</b>	<b>Start Date:</b> 10-Sep-13	<b>End Date:</b> 11-Sep-13
<b>Designated Auditing Agency</b>	Health and Disability Auditing New Zealand Limited	

## Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXX	RN, Auditor Certificate	12.00	8.00	10-Sept-13 to 11-Sept-13
Auditor 1	XXXXXXX	RCpN, Health auditor, AdDipBusMan, Cert QA	12.00	6.00	10-Sept-13 to 11-Sept-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXX			2.00	

Total Audit Hours on site	24.00	Total Audit Hours off site (system generated)	16.00	Total Audit Hours	40.00
Staff Records Reviewed	9 of 91	Client Records Reviewed (numeric)	7 of 42	Number of Client Records Reviewed using Tracer Methodology	2 of 7

<b>Staff Interviewed</b>	10 of 91	<b>Management Interviewed (numeric)</b>	2 of 2	<b>Relatives Interviewed (numeric)</b>	3
<b>Consumers Interviewed</b>	9 of 42	<b>Number of Medication Records Reviewed</b>	14 of 42	<b>GP's Interviewed (aged residential care and residential disability) (numeric)</b>	1

## **Declaration**

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

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

Dated this 16 day of October 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	Kinds of services certified														
	Hospital Care								Rest Home Care		Residential Disability Care				
	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential 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
Oakwoods Lifecare 2012	53	42	48	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input 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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## *1.1 Consumer Rights*

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## *1.2 Organisational Management*

Oakwood Lifecare has a quality and risk management system in place that is being implemented. This includes a set agenda for the staff meetings that ensures that all aspects of the quality improvement system is reviewed, discussed and corrective actions signed off. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections through the surveillance programme, review of risk and monitoring of health and safety including hazards and maintenance (planned and reactive) to the building and grounds. There are meetings held regularly to ensure that all aspects of the quality and risk management programme are discussed with relevant staff including the weekly heads of department (HOD) meeting, monthly quality improvement meetings, infection control and health and safety committee, registered/enrolled nurse meetings, two monthly diversional therapy meetings and monthly care facility meetings.

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### *1.3 Continuum of Service Delivery*

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## *2 Restraint Minimisation and Safe Practice*

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## *3. Infection Prevention and Control*

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## 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	FA	0	8	0	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: 7 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0  
PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0

Criteria (of 34): CI:0 FA:22 PA:0 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	PA Low	0	0	1	0	0	5
Standard 1.3.5	Planning	FA	0	2	0	0	0	5
Standard 1.3.6	Service delivery / interventions	PA Moderate	0	0	1	0	0	5
Standard 1.3.7	Planned activities	FA	0	1	0	0	0	3
Standard 1.3.8	Evaluation	FA	0	2	0	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	FA	0	1	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	FA	0	1	0	0	0	2
Standard 1.3.12	Medicine management	PA Moderate	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	PA Low	0	2	1	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0 PA Crit: 0	CI:0 UA Neg: 0	FA: 8 UA Low: 0	PA Neg: 0 UA Mod: 0	PA Low: 2 UA High: 0	PA Mod: 2 UA Crit: 0	PA High: 0
Criteria (of 51):	CI:0	FA:17	PA:4	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	PA Moderate	0	1	1	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: 7      PA Neg: 0      PA Low: 0      PA Mod: 1      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:16      PA:1      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	1	0	0	0	6
Standard 2.2.1	Restraint approval and processes	FA	0	1	0	0	0	3
Standard 2.2.2	Assessment	FA	0	1	0	0	0	2
Standard 2.2.3	Safe restraint use	FA	0	3	0	0	0	6
Standard 2.2.4	Evaluation	FA	0	2	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	PA Low	0	0	1	0	0	1

Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0      CI:0      FA: 5      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 21):      CI:0      FA:8      PA:1      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	PA Low	0	0	1	0	0	4
Standard 3.3	Policies and procedures	FA	0	1	0	0	0	3
Standard 3.4	Education	FA	0	2	0	0	0	5
Standard 3.5	Surveillance	FA	0	2	0	0	0	8

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: 0	CI: 0	FA: 43	PA Neg: 0	PA Low: 4	PA Mod: 3	PA High: 0	PA Crit: 0	UA Neg: 0
	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0					
Total Criteria (of 219)	CI: 0	FA: 94	PA: 7	UA: 0	N/A: 0				

## Corrective Action Requests (CAR) Report

Provider Name: Oakwoods Lifecare (2012) Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date: 10-Sep-13 End Date: 11-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

<b>Std</b>	<b>Criteria</b>	<b>Rating</b>	<b>Evidence</b>	<b>Timeframe</b>
1.3.4	1.3.4.2	PA Low	<p><b>Finding:</b> One rest home resident with assessed dementia, with challenging behaviours including wandering, has not had behaviours assessed on which to develop a behaviour monitoring and management plan</p> <p><b>Action:</b> Conduct all required assessments for identified needs - in particular, behaviour assessments for residents with identified issues and risks.</p>	3 months
1.3.6	1.3.6.1	PA Moderate	<p><b>Finding:</b> a) one rest home resident with dementia and wandering behaviours does not have management of behaviours recorded in the intervention section of the long term care plan; b) one rest home resident has not had monthly weights recorded; c) one hospital resident does not have interventions for the management of epilepsy and diabetes documented in the long term care plan and weight has not been monitored monthly.</p> <p><b>Action:</b> a), b) and c): Ensure that all required interventions are recorded on the long term care plan and implemented</p>	1 month
1.3.12	1.3.12.1	PA Moderate	<p><b>Finding:</b> a) Three of 15 medication charts reviewed evidenced that the GP had reviewed medication over the three month time frame; b) three of 15 medication administration signing sheets for non-packed items evidenced gaps in signing sheets for eye drops and eye ointments; c) two incidents of transcribing medication orders to long term care plans</p> <p><b>Action:</b> a) Ensure GP's conduct three monthly medication reviews as per ARC contract requirements; b) ensure all medications are signed for appropriately c) cease transcribing medication orders to long term care plans.</p>	immediately and 1 month

1.3.13	1.3.13.5	PA Low	<p><b>Finding:</b> Temperature recordings for the large chest freezer are not monitored or recorded.</p> <p><b>Action:</b> Conduct temperature monitoring and record readings for the large chest freezer to ensure safe storage of frozen foods.</p>	3 months
1.4.1	1.4.1.1	PA Moderate	<p><b>Finding:</b> a) Updated material safety data sheets (consistent with new chemical provider) not currently available in the laundry; b) chemicals are not stored securely in the laundry area and c) one of two sluice rooms is not secure with chemicals stored on the bench.</p> <p><b>Action:</b> a) Provide current material safety data sheets in line with new chemical provider; b) and c) ensure all chemicals are stored safely and securely.</p>	1 month
2.2.5	2.2.5.1	PA Low	<p><b>Finding:</b> File reviewed for a resident who had emergency restraint (one episode) implemented: the restraint approval group had met to discuss the continued need for restraint and had discontinued the use of the restraint the following morning after the restraint had been initiated. Monitoring of the restraint (lap belt) was documented when in use and the RN had received the consent of the family to implement the restraint, verbally via a telephone conversation. However the progress notes reviewed did not document that the restraint had been discontinued.</p> <p><b>Action:</b> Ensure the progress notes reflect any changes to residents continued need for restraint.</p>	3 months
3.2	3.2.1	PA Low	<p><b>Finding:</b> Towels were observed stored on open shelving in shower rooms.</p> <p><b>Action:</b> Ensure towels are stored in linen cupboards and infection control policies and procedures are implemented.</p>	3 months

## **Continuous Improvement (CI) Report**

Provider Name: Oakwoods Lifecare (2012) Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date: 10-Sep-13 End Date: 11-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

# 1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

## OUTCOME 1.1 CONSUMER RIGHTS

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

### STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

Evaluation methods used: D  SI  STI  MI  CI  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 four caregivers, who work across the facility, identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with nine residents (five rest home and four hospital) and three family (one rest home and two hospital) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided on 14-May-13 with 10 attendees.

**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  Mal  V  CQ  SQ  STQ  Ma  L

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

Code of rights leaflets are available at the front entrance of the facility, and in each wing. Code of rights poster is on the wall in the reception area to the hospital and on walls in hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. 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. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement as evidenced in seven of seven files reviewed (three rest home and four hospital). D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, learning from complaints, COR pamphlet, advocacy and H&D Commission.

**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  Mal  V  CQ  SQ  STQ  Ma  L

### How is achievement of this standard met or not met?

Attainment: FA

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated.

Part of the home's philosophy states: " All residents are treated as individuals, shown patience, dignity and respect"

The mission statement is "To encourage independence within a safe and caring environment supported by friendly, trained and dedicated staff and management, who work together to make a happy home."

There is a policy that covers abuse and neglect and staff have completed training on 23-Jul-13 with 13 attendees.

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

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

D4.1a Seven of seven resident files (four rest home (which included one resident in serviced apartments receiving rest home care) and three hospital) reviewed identified that cultural and /or spiritual values, individual preferences are identified.

A personal privacy and safety audit was completed 30-Apr-13 with no corrective actions required.

### 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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment:** FA

There are current policies and procedures for the provision of culturally safe care for Māori residents. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. Cultural awareness education occurred as part of the annual in-service education programme in September 2012.

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

D20.1i The service has developed links with local iwi. There are currently no Maori residents residing at the facility however there are Maori staff who are able to support Maori residents if required.

**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:**

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**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

#### **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  Mal  V  CQ  SQ  STQ  Ma  L

How is achievement of this standard met or not met?	Attainment: FA
The service's philosophy focuses on residents' right to be accepted as an individual and being given the opportunity to enhance the values in their lives thereby it enables residents to be individuals. This flows through into each person's care plan and could be described by four caregivers interviewed. During the admission process, the registered nurses along with the resident and family/whanau complete the documentation. Regular reviews are evident and the involvement of family/whanau is recorded in the resident care plan. Three family members interviewed feel that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day.	
D3.1g The service provides a culturally appropriate service by implementing the philosophy of care which is: "to promote a quality lifestyle, in a supportive environment, encouraging our residents to maintain independence in a safe, comfortable care setting. All residents are treated as individuals, shown patience, dignity and respect."	
D4.1c Seven of seven care plans reviewed (four rest home and three hospital) included the residents social, spiritual, cultural and recreational needs. A Cultural safety audit was completed 28-May-13 and corrective actions required were evidenced to be signed by the nurse manager on completion.	

**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.**

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

#### **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  Mal  V  CQ  SQ  STQ  Ma  L

#### **How is achievement of this standard met or not met?**

**Attainment:** FA

Staff employment policies/procedures include confidentiality, house rules and staff expectations. Code of conduct policies also include respect for personal belongings. Job descriptions include responsibilities of the position. Signed copies of all employment documents are included in staff files. Two registered nurses interviewed were able to describe appropriate boundaries between staff and residents and their families. D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with caregivers could describe how they build a supportive relationship with each resident. Staff are aware of and alert to the potential for racial and sexual harassment.

Performance appraisals are conducted and staff receive supervision.

Discussions with nine residents (five rest home and four hospital) identify that privacy is ensured and that staff are very caring.

Discussions with two registered nurses, one enrolled nurses and four caregivers described how professional boundaries are maintained. Discussions with the manager and a review of complaints identified no complaints of this nature.

**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.**

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		

**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  Mal  V  CQ  SQ  STQ  Ma  L

#### **How is achievement of this standard met or not met?**

**Attainment: FA**

A2.2 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are developed and reviewed by the quality consultant and nurse manager to maintain best practice. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through residents meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.

There is an internal audit schedule. It includes (but is not limited to): admission procedures, laundry and cleaning, food service, infection control, medication competency, activities programme, use of restraint, safety, manual handling, informed consent, continence management, call bell audit, cultural safety, weight monitoring, care plans, personal privacy and dignity, wound and skin care, and staff training/human resources.

Nine residents (five rest home and four hospital) and three family members (one rest home and two hospital) interviewed spoke very positively about the care provided.

D1.3 All approved service standards are adhered to.

D17.7c. There are implemented competencies for the nurse aides and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

#### **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**

There is an open disclosure policy, a complaints policy, an accident/incident policy and adverse events policy.

Nine residents (five rest home and four hospital) and three family members (one rest home and two hospital) stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur three monthly and the owner/manager, nurse manager and registered nurses have an open-door policy.

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

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.

D16.4b The three family members interviewed (one rest home and two hospital) stated that they are always informed when their family member's health status changes or of any other issues arising.

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.

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

### **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  Mal  V  CQ  SQ  STQ  Ma  L

#### How is achievement of this standard met or not met?

Attainment: FA

The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process and at resident reviews. Four caregivers interviewed are familiar with the code of rights and informed consent and described the link between the home's philosophy and choice and consent on a daily basis. Informed consent forms are evident on seven of seven resident files reviewed (four rest home and three hospital). There is an advanced directive resuscitation decision form that is completed appropriately. Resuscitation orders are completed for residents who are competent to make the decision. Education on informed consent was conducted as part of code of resident rights in May 2013 with 10 attendees. The admission agreement records informed consent and this is signed by residents and/or family.

D13.1 There were seven admission agreements sighted and evidence signing.

D3.1.d Discussion with three family members identifies that the service actively involves them in decisions that affect their relatives lives.

**Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.**

#### Audit Evidence

Attainment: FA

Risk level for PA/UA:

#### Finding Statement

Corrective Action Required:

Timeframe:

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

Timeframe:

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

Timeframe:

### **STANDARD 1.1.11 Advocacy And Support**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment:** FA

Client right to access advocacy services is identified for residents. Leaflets are available at the entrance of the service. The information identifies who the resident can contact to access advocacy services. The diversional therapist is the resident advocate. The information pack provided to residents prior to entry includes advocacy information.

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy training was provided on 14-May-13 with 10 attendees.

D4.1d; Discussion with nine residents (five rest home and four hospital) and three family members (one rest home and two hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.

D4.1e: Seven of seven resident files reviewed includes information on residents family/whanau and chosen social networks

**Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.**

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**How is achievement of this standard met or not met?**

**Attainment:** FA

D3.1h Discussion with two registered nurses, one enrolled nurse, four caregivers, nine residents (five rest home and four hospital) and three family members (one rest home and two hospital) identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e Interviews with the diversional therapist and activities coordinator described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Residents are assisted to meet responsibilities and obligations as citizens e.g. voting / census. Activities programmes include opportunities to attend events outside of the facility including activities of daily living

e.g. shopping. Entertainers are included in the home's activities programme. The diversional therapist and activities coordinator described how outings in the facility owned van are tailored to meet the interests of the residents.

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**STANDARD 1.1.13 Complaints Management**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should

direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation. These demonstrate that both verbal and written complaints are actively managed. There is a complaints register, which is completed for documenting complaints or concerns. Advised by the nurse manager that she is responsible for complaints management.

There have been 16 complaints for 2013 - (12 of these complaints relate to the care facility and four for the village)- All are recorded on the register and documentation includes response letters and communication between the parties. Eleven of twelve complaints to the care facility have been resolved. One is relating to a missing residents dressing gown (family notified facility after the dressing gown had been missing for two months). The facility searched resident's wardrobes, storage drawers, laundry and linen cupboards and were unable to find the garment. Nurse manager advised that although the family are happy with the response and investigation initiated to find the missing item of clothing it has not been documented as resolved as the item was not found.

Nine residents (five rest home and four hospital) and three family members (one rest home and two hospital) advised that they are aware of the complaints procedure and how to access forms.

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

A complaints audit was completed 20-Mar-13.

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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## 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

Oakwood Lifecare provides geriatric - hospital/medical and rest home level care for up to 83 residents, this includes 35 serviced apartments which are certified to provide rest home level care. There were 42 residents on the day of audit - 18 hospital and 24 rest home level (including one resident in the serviced apartments assessed as requiring rest home level care)

The service requested to have Medical added to their certification. There is 24 hour Registered Nurse cover, physiotherapy and other allied health professionals available to support the application for Medical to be added to certification.

The service is managed by the village manager (owner/operator) and nurse manager (RN) and they have contracted an external quality consultant who has provided the quality programme/system and support for this to be fully implemented.

The service has a current strategic plan and quality plan for 2013. The quality programme is managed by the village manager (who is the owner operator), nurse manager and quality consultant.

Oakwood Lifecare has set specific quality goals for 2013 one of the goals is to refurbish the care facility to provide an improved living environment for residents. This is to commence in October 2013 and a plan has been developed so that minimal disruption/ intrusion is caused to residents, staff and the delivery of service.

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

#### 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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment:** FA

During a temporary absence of the village manager, this position is covered by the nurse manager. A senior registered nurse provides clinical management in the absence of the nurse manager. The service has well developed policies and procedures at a service level and a strategic plan and quality improvement plan that are structured to provide appropriate safe quality care to people who use the service including residents that require rest home and hospital level care.

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

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### **STANDARD 1.2.3 Quality And Risk Management Systems**

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

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

#### **How is achievement of this standard met or not met?**

**Attainment: FA**

Oakwood Lifecare has a quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, health and safety, incidents and accidents, complaints, policy and procedure review and the annual quality report. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

Progress with the quality plan is monitored through the weekly heads of department (HOD) meeting, monthly quality improvement meetings, infection control and health and safety committee, registered/enrolled nurse meetings, two monthly diversional therapy meetings and monthly care facility meetings. The HOD meeting agenda and the care facility meeting's agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Minutes are maintained and easily available to staff. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The HOD meetings incorporates heads of department from around the facility including kitchen, laundry, nurse manager and village manager. Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Oakwood Lifecare's commitment to on-going quality improvement. Discussions with two registered nurses, one enrolled nurse and four caregivers confirm their involvement in the quality programme. Resident/relative meetings take place three monthly - last conducted 08-Aug-13 (minutes sighted).

Audits are conducted and include: cleaning, laundry, resident files, cultural, medication management, informed consent, incidents and accidents, wound documentation, restraint, and infection control. The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control manual, infection control programme and corresponding policies. There are restraint minimisation and safe practice policies and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

Policies and procedures align with the client care plans. Policies are provided by a contracted quality consultant who provides the service with regular updates and visits the facility once a month, or more frequently if required.

D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

D19.3 there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g Falls prevention strategies such as falls risk assessment, walking aids, physiotherapy assessment, use of appropriate footwear, correct seating, increased supervision and monitoring and use of sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the registered nurse who completes the follow up. All incident/accident forms are seen processed by a registered nurse, the nurse manager completes any additional follow up. The nurse manager collates and analyses data to identify trends. Results are discussed with staff through the quality improvement meetings, RN/EN meetings, care facility meetings, HOD meetings, combined infection control and health and safety meetings. Audits for 2012 and 2013 have been completed and document management around non-compliance issues identified via corrective action plans. Finding statements and corrective actions have been documented.

A resident/relative survey was distributed in August 2013. The external quality consultant will collate the results of the survey. Advised by the village manager that the results will be communicated to consumers via a letter and discussed at the next resident's meeting.

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4** There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

- (a) Event reporting;
- (b) Complaints management;
- (c) Infection control;
- (d) Health and safety;
- (e) Restraint minimisation.

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:**

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

#### **STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

**How is achievement of this standard met or not met?**

**Attainment: FA**

There is an incident and accident reporting policy. Incidents, accidents are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at monthly quality improvement meetings and care facility meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and three family members interviewed (one rest home and t hospital) stated they are informed of changes in health status and incidents/accidents. Incident reports for August 2013 were reviewed and include 24 falls, 6 skin tears from falls, 4 skin tears (not falls related), 1 medication error and one lost property (clothing). A

sample of 12 reports evidenced that all reports were completed appropriately including assessment and follow up by a registered nurse and family notified as appropriate. Monthly incident/accident analysis occurs with subsequent annual summary and analysis.

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

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

### **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  Mal  V  CQ  SQ  STQ  Ma  L

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

The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurses, pharmacist, podiatrist, physiotherapist and general practitioners is kept and these were sighted. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed (three registered nurses, three caregivers, one diversional therapist, one cleaner and one laundry assistant). Reference checks are completed before employment is offered as evidenced in staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Four caregivers were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The caregivers gave an example of where recently a new staff member had been buddied up with a more experienced caregiver for orientation. The caregiver approached the nurse manager after the orientation period and advised that the new caregiver needed to have the orientation time extended. The period of orientation was extended to ensure a thorough orientation and full understanding of policies and procedures. Orientation checklists evident in all nine staff files reviewed.

Discussion with the village manager, nurse manager, registered nurses, enrolled nurses and caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Four caregivers interviewed have either completed the national certificate in care of the elderly or have completed an aged care education programme. Two caregivers stated that they had attended the NZACA caregiver study day in 2013.

There is an assessor who supports staff with their learning and assesses the ACE programme. Registered and enrolled nurses attend external training including conferences, seminars and sessions by the Nelson and Marlborough District Health Board. The nurse manager has attended education and training sessions from external providers in 2012-13 and has recently attended the NZACA conference in August 2013. Education provided in 2013 includes: policies and procedures, personal cares and skin integrity, dementia, wound care, restraint minimisation, infection control, chemical safety training, food safety, manual handling, swallowing difficulties and hydration, abuse and neglect, incontinence, weight management and nutrition, health and safety, fire, civil defence and emergency. Open disclosure and advocacy training was last conducted in May 2013. Fire evacuation drill last conducted 27-Aug-13. On review of nine staff files, annual performance appraisals have been conducted and are up to date.

A staff training/human resource audit was completed on 24-Jun-13 with no corrective actions required.

**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.**

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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.

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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.

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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  Mal  V  CQ  SQ  STQ  Ma  L

#### **How is achievement of this standard met or not met?**

**Attainment: FA**

There is a staff rationale and skill mix policy which include rostering and acuity levels. Sufficient staff are rostered on to manage the care requirements of the residents. There is a registered nurse on duty at all times. There is a roster in place that meets the contract requirements - sighted with evidence that staff are replaced if off sick.

Nine residents (five rest home and four hospital) and three family members (one rest home and two hospital) identify that staffing is adequate to meet the needs of residents.

**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  Mal  V  CQ  SQ  STQ  Ma  L

#### **How is achievement of this standard met or not met?**

**Attainment: FA**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurse's stations. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

D7.1 entries are legible, dates and signed by the relevant caregiver or RN /EN including designation  
Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts and wound care charts are in a separate folder.

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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:
<b>Finding Statement</b>		

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment:** FA

The nurse manager and RN's are involved in screening and admission of new residents as described by the nurse manager and two registered nurses and two enrolled nurses. Registered nurses are trained and experienced in clinical assessments and the admission requirements. All permanent residents have a needs assessment completed prior to admission and this was evident in seven of seven resident records sampled (four rest home and three hospital).

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

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

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

**Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.**

Audit Evidence	Attainment: FA	Risk level for PA/UA:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

### **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  Mal  V  CQ  SQ  STQ  Ma  L

How is achievement of this standard met or not met?	Attainment: FA
The decision to decline entry is made based on the consumers' needs assessment and level of care required. Consumers who have been declined entry to the service are notified via the referring agency	

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

### **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

Care plans are developed and reviewed / evaluated by registered nurses for residents residing in the continuing care facility or enrolled nurse with oversight from the nurse manager for rest home residents in the serviced apartments (one rest home resident file reviewed). All clinical staff complete progress notes on every shift. Family members are kept informed about the resident's care, confirmed at six family interviews (two rest home and four hospital). Nine resident interviews (five rest home and four hospital) confirm their involvement in the admission process, care planning and evaluation. Clinical staff (one nurse manager, two registered nurses, two enrolled nurses and four caregivers) interviews confirm residents and/or family members are involved in all stages of service provision. All seven care plans reviewed (four rest home and three hospital) demonstrate the care plans are developed by the RN (or EN in apartment area with oversight and sign off by nurse manager), signed off by the resident and/or family member. Family communication is recorded in the residents' clinical files, sighted in all residents' files reviewed. Verbal handovers between shifts are conducted, confirmed at staff interviews and observed on audit day. Two GP interviews were conducted and with confirmation that staff inform the GP's of any medical issues and concerns in timely manner. The GP prescribed treatments are followed by staff.

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to): falls risk, pressure area risk, pain assessment, nutrition assessments, continence assessments, and challenging behaviour assessments (exceptions refer #1.3.4).

D 16.5c.iii: All seven residents records sampled had initial assessments developed within the expected timeframes.

Tracer - Rest Home resident

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

Tracer - Hospital resident

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

D16.2, 3, 4: The seven files reviewed (four rest home and three hospital), identified that in all files an assessment was completed within 24 hours and six of seven files identify that the long term care plan was completed within three weeks (one recent admission). There is documented evidence that the care plans were reviewed by a RN and amended when current health changes. All seven care plans evidenced evaluations completed at least six monthly.

D16.5e: Seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has seen the resident at least three monthly.

**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  Mal  V  CQ  SQ  STQ  Ma  L

### How is achievement of this standard met or not met?

**Attainment:** PA Low

The RN (or EN with RN oversight for rest home apartment resident) completes an initial assessment on admission in consultation with the resident, the family and from supporting documentation provided by other allied health professionals such as the GP, and referrers who have been involved in the clients care prior to their admission. Risk assessments include: falls risk, pressure area, pain, nutrition, and continence. Challenging behaviour assessments have not been utilised for one rest home resident with identified issues. Improvements are required in this area. Wound assessments are conducted as required. The initial assessment and care plan includes all aspects of holistic care: personal grooming and hygiene, skin care and pressure area care, mobility, nutrition and weight management, elimination, communication, rest and sleep, behavioural management, medical history and medications, cultural, spiritual and social needs. The admission form includes all personal details including GP of choice, date of admission and contact details for the next of kin.

The resident and/or family/whanau are included in the initial assessment. Information and assessed needs for new residents is communicated to all staff at shift handovers.

### 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:** PA

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

The initial assessment and care plan includes all aspects of holistic care: personal grooming and hygiene, skin care and pressure area care, mobility, nutrition and weight management, elimination, communication, rest and sleep, behavioural management, medical history and medications, cultural, spiritual and social needs. Risk assessments include: falls risk, pressure area, pain, nutrition, and continence. Challenging behaviour assessments have not been utilised for one rest home resident with identified issues. Wound assessments are conducted as required.

#### Finding Statement

One rest home resident with assessed dementia, with challenging behaviours including wandering, has not had behaviours assessed on which to develop a behaviour monitoring and management plan

#### Corrective Action Required:

Conduct all required assessments for identified needs - in particular, behaviour assessments for residents with identified issues and risks.

#### Timeframe:

3 months

### 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  Mal  V  CQ  SQ  STQ  Ma  L

### How is achievement of this standard met or not met?

**Attainment:** FA

Service delivery plans are individualised and developed to meet the needs of the resident. There is resident and family participation evidenced by written approval on the service delivery plan. Residents have input into their care planning and review, confirmed at nine of nine resident interviews (five rest home and four hospital). Residents have individual integrated files. The facility ensures access to regular GP care, confirmed at two GP interviews.

Residents interviewed state they are satisfied with service delivery. Short term care plans for changes in health needs such as infections, pain management, weight loss and dietary intake, and wounds. These are placed with the long term service delivery plan and evaluated at regular intervals and signed off as resolved.

The long term care plan includes safety/potential for injury/risk assessment, mobility, continence/elimination, activities of daily living, dietary needs, medication, sleep/comfort/sexuality and intimacy, pain management, communication/sensory, memory loss/confusion, behaviour management, respiratory function, spiritual/cultural/social, skin/wound care.

A care plan audit was conducted in July 2013 with minimal corrective actions which have been addressed, signed off and reported to staff meetings. Advised by the nurse manager and quality consultant that since change in ownership (December 2012), new documentation, including assessments and care plans have been introduced. Seven of seven files reviewed evidence use of the new documentation as required. Education and training for staff has been provided by the nurse manager and quality consultant to roll out the new policies, procedures and associated forms (December 2012).

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

D16.3f; Resident files reviewed identified that family were involved.

**Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.**

Audit Evidence	Attainment: FA	Risk level for PA/UA:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
<b>Finding Statement</b>		

**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 Moderate

There are adequate supplies of dressing supplies and there is specialist input if required. There are comprehensive wound care assessments and wound care plans for residents with wounds.

A continence assessment identifies the continence products required for the individual day and night use. Bowel management is monitored daily.

All hospital level residents are assessed by the physiotherapist and a mobility support guide is developed (as confirmed on interview with physiotherapist).

Rest home residents are assessed by the physiotherapist as required. Mobility aids are made available.

Seven resident files were reviewed - four rest home and three hospital. On review of care plans, it is noted that all required interventions are recorded as per long term care plan sections for four of seven residents. Three of seven residents care plans require further documentation and detail relating to interventions for identified issues. Improvements are required in this area.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for eight residents.

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

#### **Audit Evidence**

**Attainment:** PA

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

Seven resident files were reviewed - four rest home and three hospital. On review of care plans, it is noted that all required interventions are recorded as per long term care plan sections for four of seven residents. Three of seven residents care plans require further documentation and detail relating to interventions for identified issues. These residents include two rest home and one hospital. One rest home resident has been assessed as requiring dementia specific rest home care, has wandering behaviours and is awaiting placement. Assessment for behaviours has not been conducted (link #1.3.4). The long term care plan does not reflect the interventions required to monitor the resident, redirection strategies or diversional therapy activities required to ensure the resident's safety. One rest home resident's weight has not been monitored monthly - recorded for March, April, and May 2013 but not since. One hospital level resident with diabetes and epilepsy does not have interventions recorded for the management of epilepsy or the management of hypo or hyperglycaemic incidents. There are also gaps in recording and monitoring of weight for this resident.

#### **Finding Statement**

- a) one rest home resident with dementia and wandering behaviours does not have management of behaviours recorded in the intervention section of the long term care plan;  
b) one rest home resident has not had monthly weights recorded; c) one hospital resident does not have interventions for the management of epilepsy and diabetes documented in the long term care plan and weight has not been monitored monthly.

**Corrective Action Required:**

a), b) and c): Ensure that all required interventions are recorded on the long term care plan and implemented

**Timeframe:**

1 month

### **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  Mal  V  CQ  SQ  STQ  Ma  L

#### **How is achievement of this standard met or not met?**

**Attainment: FA**

The diversional therapist works 21 hours per week and works mainly in the hospital unit and the activities co-ordinator works 20 hours a week and works predominantly with the rest home residents. Both staff members report directly to the nurse manager and meet formally three monthly. The activities staff also attend three monthly regional meetings with other activities coordinators.

The programme for residents is interesting, varied and appropriate to the resident's needs. Weekly programmes in large print are displayed for the residents. Hospital level residents have a programme which is designed to their needs and abilities and involves one to one activities and small groups. The programme for all residents also includes: bowls, housie, quizzes, walks, exercises, happy hour, cards, newspaper reading, cooking, craft, outings and reminiscing. There are visiting entertainers who provide music. Links are maintained with community groups such as Probus, Multiple Sclerosis support group, and church groups. The dining room in the hospital unit is used for activities as well as a large lounge in the rest home. These areas have suitable seating. There is a large screen TV and a selection of DVD's in the rest home lounge. Red Cross volunteers also provide assistance with activities. Pet therapy is welcomed with visits from an animal breeder who has three dogs and a goat.

Festivities and theme days are enjoyed. Birthdays are celebrated and special events are catered for such as special family events, wedding anniversaries. The facility has two vans - one with wheel chair hoist. Both activities staff have current first aid certificates and current drivers licences. Resident and management meetings are held three monthly with activities on the agenda. This allows for resident feedback and suggestions on the activities programme. Meeting minutes are made available to the residents.

The residents have a diversional therapy resident profile completed after admission. The activities care plan includes individual needs, intellectual, physical, group, community/outings, arts and crafts, spiritual/cultural and behaviours. The activities plan is developed by the diversional therapist with individual goals for all residents. Interventions record each resident's needs and requirements for activities in seven of seven files reviewed. The evaluations are written at least six monthly and progress notes are documented monthly. There is a resident attendance record kept.

D16.5d Seven resident files reviewed (four rest home and three hospital) identified the individual spiritual, cultural and social needs are reviewed six monthly. Individualized activity care plans are developed that reflect the resident's interests.

**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.**

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

#### **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  Mal  V  CQ  SQ  STQ  Ma  L

#### **How is achievement of this standard met or not met?**

**Attainment:** FA

All service delivery plans are evaluated at least six monthly or earlier if clinical needs change. Risk assessments are evaluated six monthly or earlier should the needs change. Five of seven residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes (two recent admissions - one hospital and one rest home resident in serviced apartment). The GP reviews residents' medical condition every three months. Evaluations are conducted by the RNs with input from the resident, family, caregivers, and GP. Family are notified of any changes in resident's condition, evidenced in residents' files sampled . Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed.

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

ARC: D16.3c: All initial care plans were evaluated by the RN within three weeks of admission

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

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment:** FA

There is a physiotherapist contracted to the service for 12 hours per month. She conducts an assessment on all new hospital admissions and documents a mobility support guide. Rest home residents are seen if required (confirmed on physiotherapist interview).

A dietitian is available if required for all residents. Nutritional assessments are completed by the RN's. The service has home GP who is readily available to the service. Other GP's attend Oakwood as residents are able to retain their own GP following admission to the service. The pharmacy provides all pharmaceuticals and available to staff for advice. A local palliative care nurse interviewed advised that she visits weekly or more frequently as required and responds to referrals for pain or symptom management and palliative care.

There is documented evidence of referrals to speech language therapist, podiatrist, orthotics, palliative care team, and the needs assessment coordination unit as required. The resident and/or family have all the information to make an informed choice on treatment options.

D16.4c; the service provided an examples of where a residents condition had changed and the resident was reassessed for dementia specific care.

D 20.1 discussions with two registered nurses and the nurse manager identified that the service has access to other health professionals.

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

#### **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  Mal  V  CQ  SQ  STQ  Ma  L

How is achievement of this standard met or not met?	Attainment: FA
There is a transfer/discharge policy in place. When a transfer takes place there is a transfer form and copy of medication charts included in transfer notes. All relevant documentation accompanies the resident. Two RN's interviewed were knowledgeable in the transfer/discharge process.	

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

### **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  Mal  V  CQ  SQ  STQ  Ma  L

#### **How is achievement of this standard met or not met?**

**Attainment: PA Moderate**

The medication management system, policies and procedures meet legislative requirements. There is a pharmacy contract in place. Fifteen drug charts were sampled (nine rest home and six hospital residents). All medication drug charts are clear, legible and signed by the GP. Current practicing certificates were sighted for all GP's and pharmacist associated with the service. There is photo identification on every chart. Allergies, adverse reactions, cautionary advice or special instructions are recorded. As required medications (PRN) are recorded with detail included relating to indications for use. All medication orders identify the GP signature. Drug charts are reviewed three monthly by way of medication review stamp in the medical notes signed by the GP in 12 of 15 charts reviewed. Three of 15 were over the time frame of three months.

The medico blister pack system is used. Reconciliation of medications is completed by the RN's. Medications are stored safely in a locked treatment room situated in the hospital unit. Resident topical treatments/eye drops are kept in one of two medication trolleys. Medication trolleys are locked and the controlled drugs are kept in a locked safe in the treatment room. There is a weekly physical stocktake of all Controlled Drug's and these are double signed when checked out and administered. Medication fridge temperatures are recorded daily. Two medication rounds were observed and the registered nurse and the enrolled nurse observed completed the medication round following the correct procedures.

There is currently one rest home resident self-medicating inhalers. Assessment and competency has been completed for this resident by the registered nurse. Verbal order forms are available. Standing orders are used for over the counter medications only - reviewed by all GP's in July 2013. There is a medications competent specimen signature list. All prescribing entries were completed appropriately. It was noted that administration signing sheets for packed medications were completed. Signing sheets for eye drops and eye ointments evidenced gaps in signature signing sheets for three of 15 residents medication charts reviewed. Improvements are required in this area. On review of seven residents care plans it was noted that on two care plans there was transcribing of medication orders -one for insulin and one for controlled drug medications. Improvements are required in this area. Registered nurses and enrolled nurses who are medication competent administer medications. Senior care givers also complete medication competencies for checking and assistance with rest home resident's medication rounds is required. Annual medication competencies have been completed. RN's do not complete syringe driver training or competency as this is managed by the Palliative care nurses if required. Medico representatives and registered nurses provide education and the pharmacist is readily available. .

D16.5.e.i.2; 15 medication charts: nine rest home and six hospital identified that the GP had seen and reviewed the resident three monthly for 12 of the 15 residents. Medication chart are all completed and signed correctly.

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

#### **Audit Evidence**

**Attainment: PA**

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

Drug charts are reviewed three monthly by way of medication review stamp in the medical notes signed by the GP in 12 of 15 charts reviewed. Three of 15 were over the time frame of three months. All prescribing entries were completed appropriately. It was noted that administration signing sheets for packed medications were completed. Signing sheets for eye drops and eye ointments evidenced gaps in signature signing sheets for three of 15 residents medication charts reviewed. On review of seven residents care plans it was noted that on two care plans there was transcribing of medication orders -one for insulin and one for controlled drug medications.

### **Finding Statement**

a) Three of 15 medication charts reviewed evidenced that the GP had reviewed medication over the three month time frame; b) three of 15 medication administration signing sheets for non-packed items evidenced gaps in signing sheets for eye drops and eye ointments; c) two incidents of transcribing medication orders to long term care plans

### **Corrective Action Required:**

a) Ensure GP's conduct three monthly medication reviews as per ARC contract requirements; b) ensure all medications are signed for appropriately c) cease transcribing medication orders to long term care plans.

### **Timeframe:**

Immediately and 1 month

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

### **Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

### **Finding Statement**

### **Corrective Action Required:**

### **Timeframe:**

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

### **Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

### **Finding Statement**

### **Corrective Action Required:**

### **Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment:** PA Low

The head cook at Oakwood Lifecare works Monday to Friday and leads the food services staff in the provision of nutritious meals to rest home, hospital and retirement village residents. There is a four weekly spring/summer and autumn/winter menu. A dietitian is available if required. The kitchen is informed of any dietary changes and interventions required such as modified, special diets or weight loss management. The four weekly menus were last reviewed by the dietitian in April 2013. A weight monitoring and nutrition audit was conducted in June 2013. Residents weights are monitored at least monthly with exceptions (link #1.3.6)

The head cook is responsible for the ordering of food items, stock rotation, correct storage of foods, temperature monitoring of chiller and fridges. A large chest freezer located outside the kitchen - however, temperature recordings are not monitored or recorded. Improvements are required in this area. The kitchen holds at least three days of food for use in an emergency. Emergency cooking facilities are available with gas hobs and a gas bbq.

All food is cooked on the premises in the well-equipped and spacious kitchen with a combi oven and thermawave oven. There are food preparation, cooking, serving, dishwashing, delivery, storage and hand washing areas. Daily hot food temperatures are recorded and within the acceptable range. Food is plated and covered prior to being transported to the continuing care unit in hot box trolleys. Breakfasts are served to residents in their rooms. Lunches and teas are served in either of the two dining rooms. Staff were observed assisting residents with their meals and drinks during the days of audit.

Staff wear appropriate protective apparel and safe footwear. All staff are trained in food safety and chemical safety.

All chemicals and safety data sheets are supplied by Ecolab. Quality control checks are done monthly. Residents provide feedback on food and suggestions at the resident meetings held three monthly.

Kitchen staff are responsible for all cleaning duties and an implemented schedule is in place.

There are Food Service policies and procedures available.  
D19.2 staff have been trained in safe food handling.

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

Audit Evidence	Attainment:	Risk level for PA/UA:
<b>Finding Statement</b>		
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:	Risk level for PA/UA:
<b>Finding Statement</b>		
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:	Risk level for PA/UA:
The head cook is responsible for the ordering of food items, stock rotation, correct storage of foods, and daily temperature monitoring of chiller and fridges. A large chest freezer is located outside the kitchen - however, temperature recordings for the freezer are not monitored or recorded.	PA	Low
<b>Finding Statement</b>		
Temperature recordings for the large chest freezer are not monitored or recorded.		

**Corrective Action Required:**

Conduct temperature monitoring and record readings for the large chest freezer to ensure safe storage of frozen foods.

**Timeframe:**

3 months

## 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 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  Mal  V  CQ  SQ  STQ  Ma  L

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

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Infectious waste is disposed of appropriately. There are puncture proof containers for the disposal of sharps. Policies and procedures for the use and storage of chemicals are in place in line with legislation. The service has recently changed providers to Ecolab who have provided and installed automatic chemical dispensers for cleaning, laundry and kitchen. Safety Data sheets available and accessible for cleaning staff and are located in the locked chemical/cleaning cupboard. Laundry staff do not currently have access to material safety data sheets and chemicals are not stored securely in this area. Improvements are required in this area. A chemical spills kit is available and there is an emergency flip chart detailing instructions in the case of chemical spills. Protective clothing is available including: face shields, aprons, and gloves. One of two sluice rooms was noted to be unlocked with chemicals on the bench. Improvements are required in this area. Two registered nurses, two enrolled nurses, four caregivers, one cleaner and one laundry person interviewed were knowledgeable in the management of infectious waste, chemical safety and emergency procedures.

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

Safety Data sheets available and accessible for cleaning staff and are located in the locked chemical/cleaning cupboard. Laundry staff do not currently have access to material safety data sheets and chemicals are not stored securely in this area. A chemical spills kit is available and there is an emergency flip chart detailing instructions in the case of chemical spills. Protective clothing is available including: face shields, aprons, and gloves. One of two sluice rooms was noted to be unlocked with chemicals on the bench.

**Finding Statement**

a) Updated material safety data sheets (consistent with new chemical provider) not currently available in the laundry; b) chemicals are not stored securely in the laundry area and c) one of two sluice rooms is not secure with chemicals stored on the bench.

**Corrective Action Required:**

a) Provide current material safety data sheets in line with new chemical provider; b) and c) ensure all chemicals are stored safely and securely.

**Timeframe:**

1 month

**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  Mal  V  CQ  SQ  STQ  Ma  L

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

The building displays a current building warrant of fitness which expires on 1-Dec-2013. The physical environment with the wide corridors and spacious rooms allow easy access, movement and promote independence for residents with mobility aids. Handrails are appropriately placed.

Documentation and indicators considered during the audit and via sampling supports that the service is meeting the relevant requirements as identified by relevant legislation, standards and codes. A process is in place for planned maintenance, upgrading and replacing equipment as required. There is a maintenance plan in place for 2013. Hot water temperatures are monitored and recorded monthly and were evidenced to be within the accepted limits for residential aged care.

All electrical equipment is checked and tagged annually and recently completed in June 2013. This includes standing and sling hoists. Clinical equipment is calibrated, checked annually and tagged (September 2013). Daily maintenance requests are addressed. A maintenance person is contracted to provide scheduled and reactive maintenance with use of sub-contractors for specialised work e.g. plumber or electrician. Post-earthquake environmental inspections have been conducted in August 2013. An environment and equipment audit was last conducted in April 2013.

There are adequate storage areas for hoists, wheelchairs and other equipment. Two RN's, two enrolled nurses and four caregivers interviewed confirmed there are adequate resources to safely deliver care including hoists, transfer boards, slippery sams, lifting belts and walking frames.

There quiet sitting areas and private rooms available within the Rest Home and Hospital wings. External areas are attractively landscaped, well maintained and walk ways are safe. There are courtyards with outdoor seating. Shade sails and umbrellas provide shade in the summer. There is a designated resident smoking area.

D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3:: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, mobility aids, lifting aids.

D15.2e: There are quiet, low stimulus areas that provide privacy when required.

D15.3b There are safe outside areas that are easy to access

**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  Mal  V  CQ  SQ  STQ  Ma  L

<b>How is achievement of this standard met or not met?</b>	Attainment: FA
The continuing care unit (rest home and hospital) has 48 single bedrooms - 38 with partial ensuites (toilet, hand basin). The unit is divided in to a 10 bed rest home Lodge, 20 bed hospital wing and 18 bed rest home wing. All beds are certified as swing beds. The attached retirement village serviced studio units and apartments are also certified for rest home level care to make a total of 83 care beds. There is currently with one rest home resident in a ground floor studio unit. On the day of audit there were 18 hospital residents and 23 rest home residents plus one rest home resident in a studio unit. The rest home lodge has communal facilities including two toilets, one shower and one bathroom. The 20 bed hospital unit rooms have partial ensuite and communal facilities of two showers and one toilet. The rest home unit (18 rooms) all have partial ensuite with a further two showers and one toilet. There is adequate room in the bathrooms to safely shower and toilet residents using shower/toilet chairs or hoist. Privacy is assured with privacy locks on the communal and ensuite areas. Staff were observed knocking on residents doors and where appropriate seeking permission to enter. All toilets/ensuites/bathrooms have a vacant/occupied slide sign. There are appropriately placed and secure handrails in the ensuites and communal toilets. Aids such as high rise toilet seats are made available to promote resident independence.	

**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  Mal  V  CQ  SQ  STQ  Ma  L

##### **How is achievement of this standard met or not met?**

**Attainment: FA**

All the bedrooms at rest home and hospital level are spacious enough to allow residents to safely move about the furnishings with their mobility aids and for the use of a standing or lifting hoist. There is adequate space to allow residents to personalize their rooms. Residents were observed safely moving around the facility.

**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  Mal  V  CQ  SQ  STQ  Ma  L

##### **How is achievement of this standard met or not met?**

**Attainment: FA**

There are two large lounges available for entertainment and recreation. Within the two dining areas is seating to accommodate both group and individual activities to occur. There is a smaller lounge available to residents and their families/visitors. Tea and coffee making facilities are available in the dining room

for residents and visitors. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. There is adequate space to store mobility aids while residents are having their meals.

D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

Attainment: FA

The service has in place policies and procedures for management of laundry and cleaning practices. Product user charts, chemical safety data sheets for chemicals used in the facility are available in the cleaning room but not the laundry (link #1.4.1) Residents interviewed (nine - five rest home and four hospital) state they are satisfied with the cleaning and laundry service at the facility.

The laundry area is spacious with dirty/clean flow for processing linen. There are colour coded linen bags and all linen and personal clothing items are sorted prior to washing. The laundry person ensures the cleaning schedule is maintained including mopping of floors and clearing dryer filters daily.

Laundry staff cover the seven days per week and have been provided with chemical safety training in April 2013.

The environment , lounges, dining room, bedrooms and utility areas are clean and tidy. Cleaning staff carry out duties that include but not limited to: general rubbish collection, cleaning of ensuites and communal toilets and bathrooms, dusting, vacuuming of all carpeted areas. The cleaner's trolley is well equipped. Chemicals are on the trolley and this is not left unobserved. The trolley is stored in a locked cleaner's cupboard. Plastic aprons are worn by cleaning staff to prevent contamination of uniforms. Protective apparel is available to wear in outbreak situations. Cleaning staff have attended chemical safety, and safe manual handling education.

Internal audits are carried out with corrective actions completed for laundry and housekeeping. (July 2013).

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

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

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

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

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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment:</b> FA
The service has a fire and emergency manual. There is currently a trained person with a first aid certificate on each shift. Oakwood Lifecare has a NZFS approved fire evacuation scheme, dated 9-May-2007. A call bell light alerts staff to the area in which residents require assistance. The home has one main entrance where visitors and contractors must sign in before entering the facility. Fire drill last conducted 27-Aug-2013. A civil defence kit is stocked and checked six monthly. Water is stored - sufficient for at least three days. Alternative heating and cooking facilities are available. Call bell system evident and in	

use in the resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. A night porter is employed to conduct security checks of the continuing care facility and the retirement village. Emergency and Disaster manual includes fire and evacuation procedures, CPR, clinical emergencies, a disaster plan including food and supplies, earthquake response, bomb threat, hold up, security of documentation, loss of staff cover, loss of water supply, loss of electricity, gas leak. Registered nurses have current first aid certificates. The activities staff also hold current first aid certificates as they are responsible for residents during off site activities and outings.

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

**Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.**

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
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**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
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**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.**

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
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**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment:** FA

The continuing care facility is heated via heat pumps in the hall way and dining/lounge areas and by panel heating in resident rooms. Each bedroom can be individually adjusted to maintain a warm and comfortable environment. The bedroom and lounge windows can open to allow ventilation.

All bedrooms have an external window with a pleasant view. The windows allow sufficient natural light in during the day. Residents interviewed advised that the facility is maintained at a comfortable temperature.

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**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:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

## OUTCOME 2.1 RESTRAINT MINIMISATION

### STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

#### How is achievement of this standard met or not met?

Attainment: FA

Oakwood Lifecare has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers.

The policy includes that enablers are voluntary and the least restrictive option. Forms include a restraint and enabler register, a restraint assessment form, a restraint authorisation form and restraint monitoring form.

Strategies are in place to minimise the use of restraint including, bed noodles, sensor mats, hi-low beds, mobility aids and regular observation of residents.

There are four residents with an enabler (bedrail) in use and three restraints (bedrails, and one resident also has a lap belt.).

Two enabler files were reviewed and included consent and assessment.

Two restraint files were reviewed and both contained assessments, consents and evaluation of the need for continued use of restraint. Restraint monitoring forms were evidenced completed by staff.

**Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.**

#### Audit Evidence

Attainment: FA

Risk level for PA/UA:

#### Finding Statement

#### Corrective Action Required:

#### Timeframe:

## OUTCOME 2.2 SAFE RESTRAINT PRACTICE

Consumers receive services in a safe manner.

### **STANDARD 2.2.1 Restraint approval and processes**

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

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

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

#### **How is achievement of this standard met or not met?**

**Attainment:** FA

The restraint coordinator is a registered nurse. She has a restraint coordinator position description and has been in the role for six months. The restraint co-ordinator and nurse manager have both attended education on restraint minimisation and prevention. Assessment and approval processes for a restraint intervention includes input from the restraint coordinator, nurse manager, resident/or representative and medical practitioner.

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

##### **Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

##### **Finding Statement**

##### **Corrective Action Required:**

##### **Timeframe:**

### **STANDARD 2.2.2 Assessment**

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

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

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

#### **How is achievement of this standard met or not met?**

**Attainment:** FA

The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, nurse manager, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. Consent for the use of restraint is completed with evidence of family involvement. A 'restraint authorisation form' is used to document approval. These were sighted in the two files reviewed where restraint is being used.

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

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

### **STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

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

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

#### **How is achievement of this standard met or not met?**

**Attainment: FA**

The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified. An assessment form/process is completed for all restraints. The two files reviewed had a completed assessment form and care plans that reflect risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the two files reviewed. The two files reviewed have a restraint authorisation form detailing the reason for restraint and the restraint to be used. In resident files reviewed, monitoring forms had been completed. Evaluation of restraint is completed at Restraint Approval Group monthly meetings that reviews the restraint

episode. Minutes of meeting held 06-Sept-13 were sighted. The continued need for restraint is also discussed and evaluated three monthly at care plan review. The service has a restraint/enabler register that is updated each month.

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

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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

**Finding Statement****Corrective Action Required:****Timeframe:**

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

**Audit Evidence****Attainment:** FA**Risk level for PA/UA:****Finding Statement****Corrective Action Required:****Timeframe:****STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

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

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

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

The service has documented evaluations of restraint every month. The restraint process considers the items listed in # 2.4.1. In the two restraint files reviewed, evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner.

Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator and Restraint Approval Group. A restraint evaluation is completed for each resident using restraint. Evaluation of restraint was evidenced completed monthly and at care plan review. The evaluations had been completed in the two files reviewed with the resident, family, restraint co-ordinator and medical practitioner.

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

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

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

Audit Evidence	Attainment: FA	Risk level for PA/UA:
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		

**Timeframe:**

### **STANDARD 2.2.5 Restraint Monitoring and Quality Review**

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

ARC 5.4n ARHSS D5.4n, D16.6

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

#### **How is achievement of this standard met or not met?**

**Attainment:** PA Low

The service actively reviews restraint as part of the internal audit and reporting cycle. A restraint/enabler minimisation safe practice audit was conducted on 18-Mar-13. Reviews are completed monthly, or sooner if a need is identified. Reviews are completed by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported to the monthly restraint approval group.

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

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

#### **Audit Evidence**

**Attainment:** PA

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

The service actively reviews restraint as part of the internal audit and reporting cycle. A restraint/enabler minimisation safe practice audit was conducted on 18-Mar-13. Reviews are completed monthly, or sooner if a need is identified.

#### **Finding Statement**

File reviewed for one resident who had emergency restraint (one episode) implemented: the restraint approval group had met to discuss the continued need for restraint and had discontinued the use of the restraint the following morning after the restraint had been initiated. Monitoring of the restraint (lap belt) was documented when in use and the RN had received the consent of the family to implement the restraint, verbally via a telephone conversation. However the progress notes reviewed did not document that the restraint had been discontinued.

#### **Corrective Action Required:**

Ensure the progress notes reflect any changes to residents continued need for restraint.

**Timeframe:**

3 months

### **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  Mal  V  CQ  SQ  STQ  Ma  L

#### **How is achievement of this standard met or not met?**

**Attainment:** FA

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service.

The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The combined health and safety and infection control committee includes a cross section of staff all areas of the service.

The infection control co-ordinator (enrolled nurse) and contracted quality consultant are responsible for the development of the infection control programme and its review. The programme is reviewed annually. The facility has access to professional advice as it has developed close links with the G.P's, local laboratory the infection control and public health departments.

There are three monthly health and safety and infection control meetings. The meetings include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and care facility meetings. Minutes are available for staff.

The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy.

During an outbreak of Norovirus in December 2012, the service completed a short term care plan for each resident affected, daily clinical observations, an outbreak meeting was held and an Infection Control Outbreak Management Report Form was completed. Public Health and NMDHB were informed of the outbreak. Communication with family/whanau is documented.

**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  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

Attainment: PA Low

The health and safety and infection control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the nurse manager, registered nurses, enrolled nurses and other staff. The facility also has access to an infection control nurse, public health, local laboratory and GPs.

**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:** PA

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

The health and safety and infection control committee is made up of a cross section of staff from all areas of the service including; (but not limited to) the nurse manager, registered nurses, enrolled nurses and other staff. The facility also has access to an infection control nurse, public health, local laboratory and GPs.

**Finding Statement**

Towels were observed stored on open shelving in shower rooms.

**Corrective Action Required:**

Ensure towels are stored in linen cupboards and infection control policies and procedures are implemented.

**Timeframe:**

3 months

**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  Mal  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 support the Infection Control Standard SNZ HB 8134:2008.

D19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by an external provider and reviewed and updated annually. Oakwood's infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment., personal protective equipment, medical waste disposal and sharps and spills management.

**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  Mal  V  CQ  SQ  STQ  Ma  L **How is achievement of this standard met or not met?****Attainment:** FA

The infection control coordinator is responsible along with the nurse manager for coordinating/providing education and training to staff. The IC coordinator has attended a "Bug Control" IC seminar in 2013. There are internal and external seminars available for training as well as access to the infection control nurse, microbiologist, pharmacist, and local laboratory for additional education for both the co-ordinator and the staff. The orientation package includes specific training around hand hygiene and standard precautions. Training on infection control was held on 03-Apr-13 with 21 attendees. Education on hand hygiene occurred 27-Aug-13 with 17 staff completing a hand hygiene assessment. Education on Food safety occurred 16-Apr-13.

Resident education is expected to occur as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education around influenza and gastro bugs. During the outbreak of Norovirus in December 2012 resident/staff education was provided on Norovirus, infection control procedures e.g hand hygiene, isolation of those residents infected, cleaning and laundry, staff remaining at home if they have symptoms, and hand hygiene.

**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:**

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**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.**

<b>Audit Evidence</b>	<b>Attainment:</b> FA	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

### **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

<b>How is achievement of this standard met or not met?</b>	<b>Attainment:</b> FA
The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.	
Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided.	
Infection control data is collated monthly and reported at the quality, and infection control meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators.	
Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.	
Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.	

**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:
<b>Finding Statement</b>		
Corrective Action Required:		
Timeframe:		

**Criterion 3.5.7** Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
<b>Finding Statement</b>		
Corrective Action Required:		
Timeframe:		